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	IL6009559	A. BUILDING: _____ B. WING _____	C 04/24/2023

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EFFINGHAM REHAB & HEALTH C CTR	1610 NORTH LAKEWOOD DRIVE EFFINGHAM, IL 62401

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S 000	Initial Comments Facility Reported Incident of 3/8/23/IL158693	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These requirments are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide the level of supervision necessary to prevent falls and consistently implement fall interventions for a resident assessed as a high risk for falls for 1 of 3 residents (R1) reviewed for accidents and supervision in a sample of 3. This failure resulted in R1 falling out of her wheelchair on 3/8/23, sustaining a right hip fracture.

Findings include:

R1's Minimum Data Set (MDS) dated 2/15/23 documented an admission date of 2/8/23, and listed diagnoses of Sequelae of Cerebral Infarction, Congestive Heart Failure, Bipolar Disorder, Schizoaffective Disorder, Chronic Atrial Fibrillation, Diabetes Type 2, Generalized Muscle Weakness, and Unsteadiness on Feet. This MDS documented that R1 requires extensive assistance from at least two staff members for transfers and toileting and is always incontinent of bowel and bladder. The same MDS documented a Brief Interview for Mental Status (BIMS) Score of 99, indicating R1 is severely cognitively

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S9999	Continued From page 2 impaired that R1 was unable to complete the interview. R1's Fall Risk Assessment dated 4/14/23 documented a score of 20, indicating R1 is at high risk for falls. R1's Care Plan dated 2/9/23 documented a problem area, "Falls: Resident has risk factors that require monitoring and intervention to reduce potential for self-injury," with corresponding interventions," 2/9/23: Pressure pad alarm implemented." 2/14/23: "15-minute checks for 48 hours." 3/8/23: "Implementing (a) 2 hour toileting program." 3/9/23: "Educate staff on (the) importance of pressure pad alarm placement." A Final Report faxed to IDPH (Illinois Department of Public Health) dated 3/16/23 stated, "Summary: (R1) fell on 03/08/23, resulting in injury. DX (Diagnosis) from the ED (Emergency Department): Right hip fracture. Resident Interviews: R1: "I was trying to walk to the bathroom." Investigation Conclusion: Prior to this fall, (R1) was in wheelchair in the tv/common room. Through further investigation, it appears that this resident was attempting to self-ambulate. When staff arrived to resident no obvious signs or symptoms of distress or injury were noted. Residents only complaint of pain was to her right shoulder, all other range of motion was within normal limits. When she was interviewed, she stated she was trying to use the restroom when she fell. Resident was sent to ER (Emergency Room) for evaluation and admitted for right hip fracture. During the time of this fall, her BIMS (Brief Interview for Mental Status) score presented as a 99. Staff noted her orientation presented as x2 (Oriented to two spheres), she also has a dx of Dementia with Behavioral	S9999		

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Disturbances, resulting in the conclusion that resident is unaware of her safety awareness. The IDT (Interdisciplinary Team) met to review this fall, as a result, this resident will continue to utilize a pressure pad (alarm) and staff have been re-educated on her need for one; as well as resident has now been placed on a restorative therapy program for toileting/bladder."

R1's Hospital Discharge Summary dated 3/22/23 documented, "Admit date: 3/8/23. Discharge date: 3/22/23...(R1) is a 65 year old female...who presented from a local nursing home following a fall. She had been seen earlier in (the same) morning also following a fall. (Morning) work up was negative and she was discharged back to the nursing home where she reportedly (later) fell out of bed striking head. CT (Computed Tomography Scan) head imaging was negative for acute findings, and imaging of right hip showed a femoral neck fracture ...Imaging Study, Xray right hip, two views, 3/9/23: Impression: Angulated right femoral neck fracture."

On 04/20/23 at 7:50am, R1 was sitting in her wheelchair in the dining room, watching TV next to a peer. R1 was alert and oriented to self only. V4 and V5 (Certified Nursing Assistants/CNA's) were standing nearby, at that time this Surveyor requested they bring R1 to a standing position, which they did with the use of a gait belt. R1 did not have a pressure pad style alarm in place at this time.

On 4/20/23 at 1:00pm, V4 stated R1's fall interventions include a low bed, and "Almost constant supervision from staff, we check on her every hour to hour and a half," and a pressure pad alarm when up to the wheelchair. V4 stated when he came to work at 6:00am the morning of

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4/20/23, R1 was already dressed and up to her wheelchair and V4 did not realize the alarm was not in place. V4 stated R1 can usually tell staff when she needs to go to the bathroom and additionally, they check her at least every two hours for toileting needs. V4 stated R1's bowel and bladder continence are improving. V4 stated R1 requires the assistance of two staff for transfers. V4 stated R1's cognition varies, but generally she is only alert to self.

On 4/20/23 at 1:10pm, V5 stated R1's fall interventions are a low bed and a pressure pad alarm, for certain when up to the wheelchair, and possibly also when in bed. V5 stated R1 can usually tell them when she needs to use the bathroom, and they check her at least every two hours for toileting needs. V5 stated R1 was already up to her wheelchair when she arrived on 4/20/23 at 6:00am to start her shift, and V5 was not aware the pad alarm was not in place. As far as R1's cognition, V5 stated, "She can usually tell us if she's hungry or has to go to the bathroom, but that's about it." V5 stated R1 has had falls, but none have occurred while V5 was on duty. V5 stated R1 requires the assistance of two staff and a gait belt for transfers.

On 4/20/23 at 3:15pm, V1 (Administrator) stated R1 often gets restless at night and staff get R1 up to the wheelchair to sit in the TV lounge area, which is adjacent to and visible within the nurse's station. V1 stated R1 has diagnoses of chronic mental illness, and requires one or two staff for transfers, depending on her level of cognition that day. V1 stated R1's cognition is variable depending on the day. V1 stated the facility's Fall Investigations are Quality Assurance documents and cannot be shared during the survey process, so the Surveyor interviewed V1, with V1 reviewing

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S9999	Continued From page 5 the fall investigations. R1's fall history is as follows: "2/14/22 at 5:00am. Location: TV lounge. Staff heard R1's pressure pad alarm sounding, staff ran to the area in time for staff to observe R1 in a standing position, and R1 took two steps and fell before staff could reach her. R1 stated she was trying to go to the bathroom. R1 had no injuries but was sent to the ER (Emergency Room) per facility protocol as R1 is on an anticoagulant (Eliquis). ER found no injuries to R1, and R1 returned to the facility with no new orders. Root Cause Analysis: Attempted self- ambulation, lack of safety awareness. Intervention added: Every 15-minute visual checks for a 48- hour period and continue the pressure pad alarm." "3/8/23 at 4:15am. Location: TV lounge. R1 was found sitting on the floor in front of her wheelchair. The pressure pad alarm was in place and was sounding. R1 stated she was trying to get up to go to the bathroom. R1 was sent to the ER per protocol, R1 was returned to the facility with no injuries found and no new orders. Root Cause Analysis: Self ambulation. Intervention Added: Start a toileting program every two hours." "3/8/23 at 9:45pm. Location: TV lounge. Staff were at the CNA desk when they heard R1 yell for help. A few seconds later as staff were running to the area, they heard the pressure pad alarm sounding. R1 was lying on her left side and stated she was trying to get up to go to the bathroom. R1 was sent to the ER where a fractured right hip was diagnosed. Root Cause Analysis: Self ambulation with loose placement of the pressure pad alarm. Intervention added: Retrain staff on proper pressure pad alarm placement and the importance of using the pad."	S9999		

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During this interview, V1 provided documents titled "Care Need Notice" which she stated is an in-servicing document for re-educating staff, and staff signatures were located on the bottom of the documents, which are as follows:

"2/14/23: Related condition: Fall. What to watch for: Resident trying to self-ambulate. What to do: Assist resident with current needs and wants. (Start) 15- minute checks for the next 48 hours starting on 2/14/23 at 11:00am."
"3/8/23: Related condition: Fall. What to watch for: Toileting program every two hours. What to do: Assist resident to use the bathroom and any other needs at least every two hours."
"3/9/23: Related condition: Fall. What to watch for. Pressure pad alarm placement. What to do: Ensure pressure pad alarms are in place correctly when ordered."

On 4/21/23 at 7:45am R1 was sitting in the TV lounge, this time with the pressure pad alarm in place. R1 was alert to herself only.

On 4/21/23 at 9:30am, V11 (Advanced Practice Nurse/R1's Medical Provider) stated the facility has notified her of all R1's falls, including the 3/8/23 fall, which resulted in a right hip fracture. V11 stated R1 has diagnoses of chronic mental illness and has a history of sustaining a CVA (Cerebrovascular Accident). V11 stated her mental status is variable, she is highly impulsive, and oftentimes R1 is alert only to herself. V11 stated R1 is at high risk for falls. V11 stated she does not recall ordering a pressure pad alarm as a fall intervention, but pressure pad alarms can be initiated as a nursing judgement and do not require a provider order. V11 stated she does not recall the facility staff asking for her input about

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fall interventions, but V11 stated it doesn't sound as though the pad alarm has been very effective in preventing the resident from falling. V11 stated she may discuss with staff the possibility of implementing a weighted lap cushion as a fall intervention for R1.

On 4/21/23 at 11:30am, V7 (CNA) stated she worked 6pm to 6am on 3/8/23. V7 stated she can't remember anything unusual about R1's status that evening. V7 stated she remembered R1 being in her wheelchair in the TV lounge watching TV prior to the fall. V7 stated when R1 is restless staff will put her in her wheelchair in front of the TV by the nurse's station so they can keep an eye on her. V7 stated she did not recall if they had tried to put R1 in bed earlier in the evening or not. V7 stated she recalls R1 was wearing gripper socks. V7 stated around 9:00pm, she and other staff were at the CNA desk charting when they heard R1 yell from the TV lounge. V7 stated R1 was laying on the floor on her left side but was complaining of right hip pain. V7 stated R1 said she was trying to go to the bathroom. V7 stated she can't remember if the pad alarm was going off or not. V7 stated R1 wears adult diapers and is on a toileting program where staff check her every two hours to see if she needs to go, and if so, they transfer her onto the toilet. V7 stated she recalls checking R1 at some time prior to the fall, changing her, and the pressure pad alarm was under her. V7 stated after the fact, staff thought maybe the pad alarm slipped and R1 wasn't sitting on the pressure point. V7 stated after the 3/8/23 falls, staff were re-educated on making sure the pad alarm is placed properly.

On 4/21/23 at 11:50am, V6 (Licensed Practical Nurse/LPN) stated R1 is at high risk for falls, and her fall interventions include a pad alarm in bed,

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wheelchair, and recliner, toileting every two hours, and wearing proper footwear. V6 stated R1 is usually incontinent and wears adult diapers. V6 stated R1 at times will get restless at night and try to get out of bed, and when that happens staff get her up to the wheelchair and put her by the nurse's station where they can keep a close eye on her. V6 stated he was working on 6:00pm to 6:00am on 3/7/23 and 3/8/23, so was present for both of R1's 3/8/23 falls. V6 stated the first fall occurred at about 4:00am. V6 stated another resident came to him and said R1 fell. V6 stated when he entered the TV lounge, R1 was sitting on the floor, and V6 thinks the pad alarm was sounding. V6 stated R1 had on gripper socks. V6 stated R1 said she was trying to walk to the bathroom. V6 stated he examined R1 and found no injuries, but R1 was sent to the ER per facility protocol. V6 stated the second fall happened about 9:00pm, one of the CNA staff came to get him and said R1 fell. V6 stated R1 was lying on the floor on her left side in the TV lounge, complaining of right shoulder pain. V6 stated R1 was wearing gripper socks, and R1 stated she had tried to go to the bathroom by herself. V6 stated the pad alarm was not sounding at that time but one of the CNAs might have turned it off by then. V6 stated R1 was sent to the emergency room and was diagnosed with a right hip fracture. V6 stated staff were later re-trained on placing the pad alarm properly as it was apparently determined in the investigation that the pad had slipped and R1 wasn't sitting on the pressure point.

On 4/21/23 at 2:45pm, V1 stated that with regard to the 3/8/23 Care Plan Intervention, "Remind staff of importance of pressure pad alarm," this intervention does not mean the pad was not in use at the time of the fall, it was in place and V1

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wanted it reinforced to staff how important an intervention the pad is. V1 stated to the best of her knowledge, the pad was in place at the time of the fall. V1 stated the investigation showed perhaps the pad rode up while R1 was fidgeting and was up against R1's back. V1 stated another possibility might be that R1 began sliding down in the wheelchair, keeping pressure on the pad until R1 was almost onto the floor. V1 stated when CNA staff begin their shift, they are to first go to the Alarm Tracking Binder and check and then document that all clip and pad alarms are in place and working properly.

A March 2023 Alarm Tracking Sheet documents the slot for "2:00pm to 10:00pm on 3/8/23 Resident Compliance" is blank. An April 2023 Alarm Tracking Sheet for 6:00am to 2:00pm on 4/20/23 documents "Yes" in the slot for "Alarm present and functioning."

On 4/21/23 at 3:10pm, V1 stated she can't explain why the 3/8/23 Alarm Tracking Document 2:00pm to 10:00pm slot is blank, or why the 4/20/23 6:00am to 2:00pm slot was checked when the Surveyor observed the pad was not in place.

On 4/21/23 at 6:45pm, V9 (CNA) stated she was present for both of R1's falls on 3/8/23. V9 stated R1 is a high fall risk whose mental status really depends on the day. V9 stated prior to the fall at around 4:00am, staff checked to see if R1 needed to use bathroom at about 2:00am, they changed R1, and the pad alarm was under her. V9 stated at about 4:00am, V9 was down the south hall and heard the pad alarm sounding from the TV room. V9 stated staff couldn't get to R1 fast enough and when they got there R1 was on the floor. V9 stated the second fall that day

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happened at about 9:00pm, V9 and other staff were at the CNA desk charting. Staff heard R1 yell from the TV room, and as they approached, the alarm sounded. V9 stated R1 was laying on the floor. V9 stated, "We thought afterward that maybe the pad slid up her back, she is often restless and fidgety." V9 stated after these two falls, staff was re-educated about making sure R1 is toileted every two hours and that the pad is in the proper place. V9 stated alarms are to be checked at the beginning of the shift and when they transfer the resident for toileting. V9 stated she doesn't know why the alarm tracker was not filled out for the time of the 3/8/23, 9:00pm fall. V9 stated she was working 4/19/23 from 6:00pm to 6:00am, and when V9 left that morning, R1 had the pad alarm in place. V9 stated that R1 is able to remove the pad out from underneath her and maybe she took it off. V9 stated she is not sure of why the Alarm Tracker was filled out on 4/20/23 from 10:00pm to 6:00am stating the alarm was in place and working, when the Surveyor observed it was not in place.

On 4/21/23 at 7:05pm, V8 (CNA) stated R1 gets restless a lot and tries to get out of bed so staff usually put her in the wheelchair in front of the TV in the TV lounge so she can be seen from the nurse's station. V8 stated sometimes R1 is resistive to laying down in bed. V8 stated he worked on 3/8/23 during both of R1's falls. V8 stated the first fall around 4:00am or so, V8 heard the alarm go off and he ran to TV lounge but R1 was already laying in floor, and R1 said she had to go to the bathroom. V8 stated the second fall occurred about 9:00pm. Some of the staff were charting at the CNA desk when they heard R1 yell, and as they were getting to her, they then heard the pad alarm sounding, and R1 was laying in the floor. V8 stated R1 is checked for toileting

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needs and/or changed at least every two hours. V8 stated R1 would have been checked for toileting needs shortly after starting the shift at 6:00pm. V8 stated he worked on 4/19/23 from 6:00pm to 6:00am, and when he left that morning, R1 had the pad alarm under her. V8 stated he has previously observed R1 take the pad alarm out from underneath her.

On 4/24/23 at 8:55am, V13 (LPN/Care Plan Coordinator) stated new Care Plan interventions are added after each fall occurs. V13 stated for the 2/14/23 fall, staff added an intervention of 15-minute checks for a 48-hour period. V13 stated she does not recall why an ongoing intervention was not added. V13 stated after the evening 3/8/23 fall, staff thought perhaps R1's pad alarm was not properly positioned under her. V13 stated they checked the batteries, which were working. V13 stated she has never observed or heard anything about R1 being able to remove the pad by herself. V13 stated prior interventions are evaluated after each fall occurs. V13 stated V13 feels the pressure pad alarm is an effective intervention for R1. V13 stated staff often put R1 in the TV area so she can be monitored closely.

On 4/24/23 at 10:10am, V12 (LPN/Resident Care Coordinator/CNA Supervisor) stated she has not observed or heard any of her staff report that R1 can remove the pad alarm. V12 stated R1's cognition is, "In and out." V12 stated V12 believes the pad alarm is an effective fall intervention. V12 stated CNA staff are to check all alarms at the beginning of their shift and then every eight hours. V12 stated if the 3/8/23, 2:00am slot on the alarm tracker document was blank, it was probably a documentation error. V12 stated the level of supervision R1 needs depends on her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009559	A. BUILDING: _____ B. WING _____	C 04/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EFFINGHAM REHAB & HEALTH C CTR	1610 NORTH LAKEWOOD DRIVE EFFINGHAM, IL 62401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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cognition that day. V12 stated staff often place R1 in the TV room so staff can monitor her closely. V12 stated she had heard from staff that the Surveyor observed R1 without the pad alarm on the morning of 4/20/23, but she was not in the facility at the time and doesn't know why the pad was not in place.

On 4/24/23 at 12:35pm, V1 stated she had spoken to CNA staff to ask why R1 did not have the pad alarm in place when the Surveyor observed R1 on the morning of 4/20/23, and V1 stated, "No straight answer was given." V1 stated until after the Surveyor left on the evening of 4/21/23, she had never had staff report that R1 can remove the pad, and V1 stated she has never personally observed R1 do this. V1 stated when the Surveyor left on 4/21/23, staff met regarding R1's falls and decided R1 needs some new fall interventions, so they will be contacting V11 for her input.

The Facility's Fall Policy dated 11/10/18 stated," Policy: To provide for resident safety and to minimize injury related to falls...All staff must observe residents for safety...All falls will be discussed in the morning Quality Assurance meeting and any new interventions will be added to the Care Plan."

(A)