Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003420	A. BUILDING: ______ B. WING ______	R-C 02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE REHAB & HC	**5533 NORTH GALENA ROAD PEORIA HEIGHTS, IL 61614**

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S 000	Initial Comments First certification revisit to survey date 12/21/2023	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) 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. 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		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 02/23/24

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c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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.

300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition.

These requirements were not met as evidenced by:

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Based on observation, interview, and record review the facility failed to assess a resident for safe positioning while in her wheelchair, failed to assess a resident's fall risk, failed to implement fall interventions, failed to update the fall care plan with revised fall interventions, and failed to provide adequate supervision for one of three residents (R7) reviewed for falls with major injuries in the sample of 10. These failures resulted in R7 falling forward out of her wheelchair and hitting her head on two separate occasions within 10 days apart requiring treatment at the emergency department and hospitalization. After the first fall R7 sustained a subdural hematoma (brain bleed), pain, bruising to the left eye, and a laceration extending from the middle of R7's forehead to the center of the top of R7's head that was bleeding and required 10 staples for closure. After the second fall, 10 days after the first fall, R7 ripped the original laceration open approximately five more inches, which required five more staples to close the laceration.

Findings include:

The facility's Fall Prevention dated 11/10/2018 documents, "Policy: To provide for resident safety and to minimize injuries related to falls; decrease falls and still honor each resident's wishes/desires for maximum independence and mobility. Responsibility: All staff. All falls will be discussed in the morning quality assurance meeting and any new interventions will be written on the care plan. Fall Prevention Interventions: 9. Positioning in chair. 34. Physical Therapy (PT) referral for ambulation, transfer training, and strengthening. 35. Occupational Therapy (OT) referral for positioning. CNA (Certified Nursing Assistant)/Charge Nurse: Know resident's care

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plan; Know and ensure resident's preventative measures and that they are in place and being used; Director of Nursing (DON): Safety rounds; know and ensure resident's plan of care is being followed through direct observation of care delivered; Quality Assurance Analysis and ensure documentation of the root cause and new intervention is recorded in the medical record during the morning quality meeting. MDS-C (Minimum Data Set Coordinator): Help facilitate discussion with QA (Quality Assurance) morning team to determine necessary changes to plan of care after each fall or near fall; Ensure plan of care is updated with a new intervention after each fall; Update the care plan after each fall. Reasons for falls and what to do about them: Poor sitting balance OT eval (evaluate) lap tray, lap buddy cushions-wedge, pummel, wheelchair arm rolls, rolls at hips foot buddy, elevated footrests, tilt chair, geri (geriatric) chair."

R7's Admission Record documents R7 is a 92-year-old admitted to the facility on 10-10-19 with diagnoses of Dementia, Glaucoma, Difficulty in Walking, Cognitive Communication Deficit, Anxiety Disorder, and Muscle Weakness.

R7's MDS (Minimum Data Set) Assessment dated 10-14-23 documents R7 is severely cognitively impaired.

R7's Progress Note dated 1-14-24 at 1:00 PM and signed by V4 (Agency RN/Registered Nurse) documents, "(R7) was sitting in her w/c (wheelchair) leaned forward and fell out of w/c. (R7) hit her head on the corner of wall next to bathroom door. On assessment for injuries laceration noted to her top of her head. Pressure applied to laceration and no other injuries noted at the time of incident. Neuro's (Neurological

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Checks) within normal. (R7) didn't lose consciousness and was alert from time of incident until EMS (Emergency Medical Services) arrived. (R7) had intermittent confusion which is baseline for resident. (R7) able to perform AROM (Active Range of Motion) to extremities without difficulty. 911 called for transport."

R7's Incident Report Form-IDPH (Illinois Department of Public Health) Notification form dated 1-20-24 and signed by V2 (Director of Nursing) documents, "Date of Incident: 1-14-24. Describe what happened, cause injury: (R7) has an unwitnessed change of plane while sitting in wheelchair. (R7) has a BIMS (Brief Interview of Mental Status) score of five with diagnoses of Dementia, DM (Diabetes Mellitus), and CHF (Congestive Heart Failure). (R7) sent to (hospital) ER (Emergency Room) for evaluation. Resident CT (Computed Tomography) scan reveals a subdural hematoma. Laceration to top of head closed with staples. Root cause: Trunk weakness. Intervention: Referred to hospice for appropriate seating."

R7's Hospital Records and CT results dated 1-14-24 through 1-17-24 document R7 was admitted to the hospital on 1-14-24 after sustaining a ground level fall at the facility resulting in a laceration, traumatic injury of the head, pain, and a subdural hematoma.

R7's Hospital Progress Note dated 1-14-24 documents, "(R7) presents after ground level fall while at the skilled nursing facility. Fall was witnessed by facility staff who reported that they witnessed (R7) leaning forward on her wheelchair before completely falling forward and hitting her forehead on the edge of a wall. Facility staff also report that (R7) has been insisting on sleeping in

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her wheelchair lately. Unclear if this was a mechanical "lift" fall from wheelchair as we have received mixed reports one that it was witnessed, she was reaching for something from her wheelchair, another report that she may have been sleeping in her wheelchair, and lastly that it may not have been witnessed. (R7's) daughter and skilled nursing staff report that as of one month ago, (R7's) dementia had rapidly progressed to include dementia with psychosis reporting that (R7) was displaying sensory disturbances, agitation, and aggressive behavior, Four-centimeter bleeding laceration on her forehead. 10 staples were placed in (R7's) forehead."

R7's Medical Record does not include a completion of a fall assessment within one year prior to R7's fall on 1-14-24.

The facility's Fall Log Audits Form dated 12-1-23 through 1-14-24 documents, "1-14-24 R7's Intervention: Refer to PT/OT at re-admission."

R7's Post Fall Root Cause Worksheet dated 1-14-24 documents, "Root Cause: Untreated UTI (Urinary Tract Infection). (R7) fell asleep in wheelchair." Interventions to prevent another fall need to be implemented today. Requesting a (high back padded reclining chair) chair from hospice."

R7's A.I.M. (Acute Illness Management) for Wellness Event Record dated 1-24-24 at 8:10 AM documents, "(R7) fell in her room and had a laceration on top of her head with bleeding. 911 called. Transported to emergency department for further treatment. New onset of pain observed. Head pain/headache."

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R7's Hospital Emergency Room Note dated 1-24-24 documents R7 was evaluated and treated in the emergency department and returned to the facility.

R7's Progress Notes dated 1-24-24 at 8:30 PM document R7 returned to the facility from the emergency department with a laceration closed with staples.

R7's Progress Notes dated 1-26-24 at 1:26 PM documents R7 had bruises and swelling on the face and under the eyes from a recent fall.

R7's current Fall Care Plan documents, "The resident reviewed shows risk for falls. Risk factors include confusion, deconditioning, gait/balance problems, glaucoma, history of asthma, and COPD (Chronic Obstructive Pulmonary Disease). Interventions: 1-16-24 OT and PT to evaluate and treat. 1-24-24 will request (high back padded reclining chair) chair upon return from hospital."

On 1-26-24 at 9:45 AM V4 (Agency RN) stated, "I was working on 1-14-24 when (R7) fell. (R7) was in the hallway in her wheelchair and was bending forward. I saw (R7) fall forward out of her wheelchair and hit her head on the corner of the wall. (R7) had a laceration to her forehead and a lot of bleeding, I applied pressure to (R7's) forehead and called 911. (R7) was sent to the emergency room for treatment."

On 1-26-24 from 10:00 AM through 10:50 AM R7 was sitting in a wheelchair across from the nurse's desk. R7 was bent over with her head and arms resting on her knees. R7 had a laceration that was approximated with staples, extending from the middle of her forehead to the

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center of the top of her head. R7 had a golf-ball size reddish-purple bruise surrounding her left eye. R7 was not within direct supervision of staff during this entire time.

On 1-26-24 at 10:55 AM V5 (Agency LPN/Licensed Practical Nurse) stated, "On 1-24-24 (V8/R7's Family Member) found (R7) on the floor in her room around 8:00 AM. (R7) was on the ground in front of her wheelchair and had busted the laceration on her head open. (R7) had fallen out of a normal wheelchair. The seat of the wheelchair (R7) fell out of was not any lower than the seat of a normal wheelchair. The laceration was opened and bleeding, I put pressure on the laceration and had other staff call 911. (R7) was sent to the emergency room. I left my shift and was not working when (R7) returned from the emergency room."

On 1-26-24 at 11:00 AM V8 stated, "I found (R7) on the floor in front of her wheelchair (on 1-24-24). The wheelchair (R7) fell out of was the same wheelchair (R7) has had for years. (R7) was bleeding from her forehead. I got the nurse. I work at the facility and see (R7) every day I work. (R7) has been leaning over in her wheelchair and her health has been deteriorating for about a month now. (R7) is always sleeping in her wheelchair. (R7) has been declining for a while."

On 1-26-24 at 12:20 PM V7 (CNA) stated, "(R7) has always been in the same wheelchair as she has had. For the past three months or so, (R7) has been leaning over in her wheelchair and has gotten a lot weaker. I do not think (R7) can hold herself upright. I do not know of any new fall interventions for (R7) since her falls."

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On 1-26-24 at 12:30 PM V10 (R7's Power of Attorney) stated, "I visit (R7) around two times a week. For at least a month (R7) has been weaker and having more behaviors. (R7's) dementia is progressing. (R7) started to lean over in her wheelchair. After (R7) fell on 1-14-24 I decided to admit (R7) to hospice. After the first fall (1-14-24) (R7) fell again and ripped her laceration open on her head further. (R7) had ten staples after the first fall. After the second fall (1-24-24) (R7) had to have five more staples to close the laceration. (R7) has had the same wheelchair since she has been at the facility. (R7) did not get a different wheelchair after the falls."

On 1-26-24 at 12:40 PM V9 (CNA) stated, "(R7) has been getting weaker for the past three month and has been leaning over in her wheelchair. (R7) never leaned over before. (R7) used to be able to transfer herself and now needs staff help. (R7) has been having behaviors. (R7) has had the same wheelchair since her first fall on (1-14-24). The seat on (R7's) wheelchair does not adjust any lower than it has always been."

On 1-26-24 at 1:00 PM V2 (Director of Nursing) stated, "(R7) did not have a fall risk assessment done prior to (R7's) fall on 1-14-24. (R7) has never had an assessment done, therapy evaluation done, or interventions developed or implemented to address (R7's) decline in condition or (R7) leaning forward in her chair. (R7) was supposed to have a therapy evaluation after the fall on 1-14-24 for trunk support and strengthening. (R7) returned to the facility on 1-17-24 with hospice services and did not get the therapy evaluation or services. We (facility staff) decided to have hospice bring (R7) a different wheelchair that had a seat that lowers closer to

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S9999	Continued From page 9 the floor to prevent (R7) from falling out forward. After (R7) had another fall on 1-24-24, we decided to switch (R7) to a (high back padded reclining chair) chair. We also decided (R7) should be within supervision of staff at all times. (R7's) fall care plan was not updated to include keeping (R7) within supervision of staff or ensuring (R7) is in wheelchair that has a seat that lowers. I did not know the staff did not use the wheelchair with the seat that lowers to the floor prior to the fall on 1-24-24. Staff should have known better and should be using the new wheelchair and supervising (R7). We still have not gotten the (high back padded reclining chair) chair from hospice. We did not receive hospital notes as to what the hospital did after (R7's) fall on 1-24-24. I know (R7) received more staples to close (R7's) laceration because (R7) ripped the laceration back open after falling again." On 1-26-24 at 1:10 PM V2 (Director of Nursing) observed R7 sitting in her wheelchair in the hallway. V2 proceeded down to R7's room and found another wheelchair, provided from hospice, sitting in the corner of R7's room. V2 stated the chair located in R7's room is the one staff should have been using for R7. (A)	S9999		