STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009831	A. BUILDING: _____ B. WING _____	C 12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SWANSEA REHAB HEALTH CARE	1405 NORTH SECOND STREET SWANSEA, IL 62226

(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
S 000	Initial Comments Complaint Investigation: 24410151/IL182433	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.690a) 300.690b) 300.1010h) 300.1010i) 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 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of	S9999		

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that resident.
b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.

Section 300.1010 Medical Care Policies
h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.
i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid procedures.

Section 300.1210 General Requirements for Nursing and Personal Care
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.

This requirement was not met as evidenced by:

Based on interview, and record review, the facility

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failed to physically assess a resident (R2) after a fall. This failure resulted in R2 sustaining a tibial plateau fracture on 11/22/2024 and not being sent to hospital for evaluation until 11/26/2024.

Findings include:

R2's Facesheet documents an admission date of 6/7/2012. Diagnosis include Dementia, Cerebrovascular Accident, Seizures, Hypothyroidism, Hypertension.

R2's Minimum Data Set, MDS, dated 9/26/2024 documents R2 has no cognitive deficits. R2 requires substantial/maximum assist with chair to bed transfers.

R2's Care Plan dated 11/26/2024 documents R2 is at risk for falls. R2 does not understand mobility limits due to cognitive limitations related to dementia and Alzheimer's disease. Actual fall 11/26/2024.

R2's Fall investigation dated 11/27/2024 at 3:00PM documents fall with physical harm/injury. Detailed incident summary documents R2 is a 76-year-old female resident with cognitive impairments.

R2's Fall investigation/Findings: R2 when interviewed stated that she fell but could not provide details of when or how she fell. When asked if it was recent, she stated Yes. R2 stated she feels safe at facility. Staff members who were interviewed stated that R2 runs her wheelchair into doors and doorways. Staff try to redirect her, but she continues to have behaviors. A Certified Nursing Assistant, CNA, stated that 11/22/2024 R2 needed to be lowered to the floor via gait belt but that she was lowered to her bottom without

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incident. When asked about the incident the CNA stated R2 was holding onto the arms of the chair and not letting go during the transfer, so the CNA was going to sit her back into her wheelchair when R2 locked her arms and legs and had to be lowered to the floor.

R2's Nurse's notes dated 11/25/24 at 8:00PM documents left leg swollen, bruised, warm to touch. Reported via secure communication. New order received. Negative Holman's sign bilaterally. No signs/symptoms of pain when active range of motion performed. Call light within reach.

R2's Nurse's notes dated 11/25/24 at 10:00PM documents radiology company notified of X-ray and Doppler order.

R2's Nurse's notes dated 11/26/24 at 1:49AM documents result of X-rays of left femur, left knee and left tibia and fibula sent to secure communication.

R2's Nurse's notes dated 11/26/24 at 6:30PM documents R2 left facility via ambulance with 2 emergency medical technicians, EMTs, to local hospital.

R2's X-ray report dated 11/26/2024 documents frontal and lateral views of the left femur submitted. Tibial lucency can be evaluated with tibial imaging. Impression no acute fracture visualized femur. Impression Age indeterminate tibial plateau fracture.

On 12/12/2024 at 3:20PM V3, Certified Nursing Assistant, CNA, stated, on 11/22/2024 in the evening, I went into R2's room to put here to bed. I had not been here very long, so I didn't know R2

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well. I was told R2 was a one person assist, but she needed to be a 2 person assist. When I began to transfer her after I put the gait belt on her, she locked her arms on the wheelchair and would not let go. I set her down in the wheelchair and talked to her and told her she has to let go of the wheelchair to be able to get in bed. I tried to transfer her again and again she locked her arms on the wheelchair and would not let go. This time she was out further from the wheelchair, and I was unable to get her back in the wheelchair. R2 then slid to the floor. Her legs were bent against her dresser in what looked to be an uncomfortable angle. I left the room to get another CNA to help me. We got her up off the floor and into bed. R2 denied being in pain. I told the nurse I was working with what had happened. I don't know the nurse's name.

On 12/13/2024 at 2:00PM V13, Licensed Practical Nurse, LPN, stated she was working the evening of 11/22/2024 and was R2's nurse. V13 denies being told R2 was lowered to the floor or R2 having any incident at all.

On 12/13/2024 at 2:25PM V15, Certified Nursing Assistant, CNA, stated I helped V3 with R2 when R2 was lowered to the floor. When I went in the room R2 was sitting with her bottom on the floor and her hands were still holding the arms of the wheelchair. Her legs were straight. We got her off the floor and onto the bed. She did not complain of pain.

On 12/17/2024 at 9:45AM V16, Nurse Practitioner, stated I would've expected R2 to have been assessed at the time of her fall on 11/22/2024. When I was notified about R2's leg appearing red and swollen was on 11/25/2024. I then ordered a Doppler and x rays.

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S9999	Continued From page 5 There is no documentation of R2's fall or any assessments on file for 11/22/2024. Facility's undated fall policy states "The facility will evaluate residents for their fall risk and develop interventions for prevention. Upon Admission, the nursing staff/interdisciplinary care team should determine if a resident is at risk for falls and develop appropriate interventions based on the evaluation. The goal is to prevent falls if possible and avoid any injury related to falls. The staff should not utilize a restraint to prevent falls unless they receive written documentation to support the use of the restraint. The care plan should only specify a few interventions at a time so that the staff can determine what intervention is not successful and needs to be changed." (B)	S9999		