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S 000	Initial Comments Annual Health Survey Complaint Investigation #2418660/IL179768	S 000		
S9999	Final Observations Statement of Licensure Violations ONE OF FOUR 300.625c)1)2) Section 300.625 Identified Offenders c) If the results of a resident's criminal history background check reveal that the resident is an identified offender as defined in Section 1-114.01 of the Act, the facility shall do the following: 1) Immediately notify the Department of State Police, in the form and manner required by the Department of State Police, that the resident is an identified offender. 2) Within 72 hours, arrange for a fingerprint-based criminal history record inquiry to be requested on the identified offender resident. The inquiry shall be based on the subject's name, sex, race, date of birth, fingerprint images, and other identifiers required by the Department of State Police. The inquiry shall be processed through the files of the Department of State Police and the Federal Bureau of Investigation to locate any criminal history record information that may exist regarding the subject. The Federal Bureau of Investigation shall furnish to the Department of State Police, pursuant to an inquiry under this subsection (c)(2), any criminal history record information contained in its files.	S9999		

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S9999	Continued From page 1	S9999		

These REQUIREMENTS were NOT met as evidenced by:

Based on interview and record review the facility failed to order fingerprints on a resident with a HIT for a qualifying offense on their registry background checks for 1 of 5 residents (R280) reviewed for the identified offender protocol/new admissions to the facility in the sample of 18.

The findings include:

R280's Admission Record showed R280 was admitted to the facility on 10/7/24.

R280's criminal history background check dated 10/7/24 showed a "HIT" for a qualifying offense of aggravated battery.

A facility email dated 10/21/24 showed the facility did not attempt to scheduled fingerprinting for R280 until 10/21/24.

On 10/21/24 at 11:18 AM, V5 Social Services Director stated she did not order fingerprints on R280 until 10/21/24. V5 stated she had not notified the State Police of R280's admission and that R280 was an identified offender until 10/21/24. V5 stated, "I don't know what the regulations say about how soon fingerprints should be done."

The facility's Identified Offender Policy dated 10/2022 showed, "If the results of a resident's criminal history background check reveal that the resident is an identified offender the facility shall do the following: Immediately notify the Department of State Police, in the form and manner required by the Department of State

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Police, that the resident is an identified offender. Within 72 hours, arrange for a fingerprint-based criminal history record inquiry to be requested on the identified offender resident ..."

(C)

TWO OF FOUR

300.610a)
300.1210a)
300.1210b)
300.1210c)
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

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as

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applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

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.

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These REQUIREMENTS were NOT met as evidenced by:

Based on observation, interview and record review the facility failed to ensure effective fall interventions were in place for resident's safety who is a high risk for falls and has a history of falls. This failure resulted in R45 falling out of bed and sustaining a left hip fracture needing surgical repair for 1 of 18 residents (R45) reviewed for safety in the sample of 18.

The findings include:

R45's Physician Order Sheet show R45 is 85 year old with diagnoses of vascular dementia, hypertension, weakness and left hip fracture

R45's facility assessment dated 9/27/24 show R45 is severely cognitively impaired (BIMS of 1)

R45's fall risk assessment dated 10/19/2024 show R45 as a high risk for falls.

On 10/21/24 at 9AM, R45 was in bed moaning "I am sore." V19 (Registered Nurse) was with R45 at this time and said R45 has a hip fracture due to fall.

On 10/21/24 at PM, V20 (R45's daughter) said she was very disappointed at the facility. "My mom has had four (4) falls. All of these falls were her trying to go to the bathroom. Staff knew this is what she does so they needed to check on her often to see if she needed to use the bathroom. Staff should have made a schedule for her to go to the bathroom before she even tries to get up on her own. She (R45) had injuries due to these falls. She (R45) had large cut in her forehead

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when she fell late last year. She fell face forward while in the bathroom. This latest fall, last week, had resulted in her breaking her hip and had to have surgery to fix her broken hip. Again she was trying to go to the bathroom." V20 said [R45] has dementia and reminders for her not to get up by herself does not work, she won't remember that. R45 is weak and unsteady, she needs her device (walker) and a staff to bring her to the bathroom.

Review of R45's fall incident reports show:

11/7/2023-(fall with injury)
R45 self transferred from her bed into the bathroom...she lost her balance falling forward striking her head on the floor. Laceration to forehead, nose and right hand ...
Careplan documents intervention as follows: Do not leave resident in bathroom unattended.

1/31/24-resident audibly moaning, and door was shut... at 23:15 resident was on the floor in her bathroom ...resident was sitting on the floor in front of her toilet, with her legs stretched out in front of her...
Careplan documents intervention as follows: "Call don't fall" sign. Make sure R45's call light is within reach and encourage to use it for assistance as needed. (R45 has dementia)

9/8/24-This writer was notified by 200 hall nurse resident was in bathroom floor lying on her stomach with her head near the doorframe...
Careplan documents intervention as follows: Encourage leaving bedroom door open for increased visualization and safety.

R45's latest fall dated 10/16/24 (fall with injury) timed at 5:35 AM

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Residents roommate came out of the nurses station to say resident had fallen in her room. Resident was lying at the foot of the bed on her left side...complained of left hip pain...resident sent to ER.

Hospital records dated 10/16/24 show, Fall at (nursing home), patient was getting to go to the bathroom when she fell and landed on her left side. Radiology report dated 10/16/24 show acute comminuted left intertrochanteric fracture. 10/17/24 [R45] had surgery for the left hip fracture.

On 10/23/24 at 9 AM V1 (Administrator) and V2 (DON) said they completed R45's investigation and concluded that R45 was attempting to go to the bathroom again and not waiting for assistance.

A Facility Reported incident sent to the state agency with date of incident 10/16/24 shows, "Resident noted by roommate attempting to self-ambulate from bed. Roommate states she told resident to wait for help and use call light, resident continued to attempt self-transfer and subsequently fell. Resident noted to have her one slipper on and one off. Resident did not use her assistive device. Roommate notified nurse of fall. Injury: Closed intertrochanteric fracture of left hip."
. Resident readmitted to facility (10/19/24) s/p surgical hip pinning for closed intertrochanteric fracture of left hip and new diagnosis of UTI. R45 is alert and oriented x 1. Upon investigation of fall, it was determined that resident did not use her call light or wait for assistance despite reminders to do.

On 10/22/24 at 2:24 PM, V21 (CNA) said she was

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R45's CNA on 10/16/24. R45 gets up to go to the bathroom and does not wait for assistance even when told repeatedly. R45 was toileted at 3:30 AM. V21 said at 5AM, she started to get up other residents. At around 5:30 AM, she heard R45 fell trying to get up unassisted. V21 said R45 might be trying to go to the bathroom at that time, that's also 2 hours after she was toileted earlier. V21 said R45 has dementia and forgets reminders.

On 10/22/24 at 12:45 PM, V22 (LPN) said she was R45's nurse on 10/16/24. She last saw R45 around midnight and R45 was asleep. At around 5:30 AM, R18 (roommate) came to the nurses station and said R45 fell. R45 was at the foot of her bed lying in her left side. R45 got up from her bed unassisted. R45 was sent to the hospital due to left leg pain. She was found to have left hip fracture. V22 said R45 has been reminded to ask for assistance. V22 confirmed R45 has dementia and reminders for her to wait for staff do not work.

R18 (R45's roommate) alert and oriented said she heard a loud sound. She saw R45 on the floor at the foot of R45's bed saying "help me!" R18 said she put her call light on and waited, then went to the desk and said. "Please help she's on the floor! Two of them (staff) came and lifted her to bed then she left to go to the hospital."

This surveyor clarified with V1 (Administrator) and V2 (DON) R45's fall interventions and their effectiveness. V2 confirmed that all of R45's four falls involved R45 trying to go to the bathroom unassisted. R45 has dementia (BIMS of 1). V2 (DON) said more frequent checks and toileting schedule would have been more appropriate interventions for R45 to prevent these falls. V1 (Administrator) said they recognized that

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residents interventions in the careplan were not specifics and resident centered. V1 said they have a started working with their Nurse Consultant regarding this matter.

The facility's Fall Policy dated 9/17/19 shows, The purpose of the fall management program is to develop, implement, monitor and evaluate an interdisciplinary team fall prevention approach and manage strategies and intervention that foster residents independence and quality of life.

(A)

THREE OF FOUR
300.610a)
300.1010h)
300.1210a)
300.1210b)
300.1210d)3)
300.2040b)1)2)

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.

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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.

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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

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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.

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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.2040 Diet Orders

b) Physicians shall write a diet order, for each resident, indicating whether the resident is to have a general or a therapeutic diet. The attending physician may delegate writing a diet order to the dietitian.

1) The resident's diet order shall be included in the medical record.

2) The diet shall be served as ordered.

These REQUIREMENTS were NOT met as evidenced by:

Based on observation, interview and record review the facility failed to accurately assess a residents weight loss and ensure nutritional interventions were implemented for a resident with significant weight loss. This failure resulted in

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R66's significant weight loss. This applies to 1 of 5 residents (R66) reviewed for weight loss in the sample of 18.

The findings include:

R66's face sheet shows he is a 74 year old male admitted to the facility on 8/26/24 with diagnoses including muscle wasting, encounter for orthopedic aftercare following surgical amputation, acquired absence of left leg below the knee, type 2 diabetes, peripheral vascular disease, and a non-pressure chronic leg ulcer of right lower extremity.

R66's weight report provided on 10/22/24 documents:
8/27/24- 208.8 lb (pounds)
9/24/24- 184 lb
10/8/24- 186 lb
10/17/24- 182.2 lb

R66's electronic health medical record documents "Regular Diet, Regular Texture, Regular liquid Consistancy. Needs double portions of meat, eggs and milk at each meal for wound healing, start date: 8/26/24."

R66's Dietary Note dated 10/10/24 documents he triggered significant weight loss of 6% in one month and 11% weight loss since admission. R66 had a left below knee prior to admission, was admitted with a cast to leg per DON (Director of Nursing). Currently has a stage II pressure ulcer to sacrum per DON. Diet regular, double meats, eggs and milk all meals...weight loss may be partially related to cast removal... will advise to increase liquid protein to 30 ml (milliliters) twice a day and continue to monitor weight. R66's weight report shows he lost 4 additional pounds since

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10/10/24.

On 10/21/24 at 12:02 PM, R66 was in his room eating in bed, using his right hand to feed himself.

On 10/22/24 at 8:55 AM, R66 was in his room lying in bed. He said he noticed he has been losing weight but not sure why. An elastic bandage was wrapped to his right leg and left leg below knee amputee. He said he never had a cast on his leg and he has not been seen by V24 (Dietitian) recently.

On 10/23/24 at 9:47 PM, V24 said nutrition assessments are done on admission, quarterly and if a resident triggers for weight loss. She monitors the weight report, if a resident triggers for weight loss the resident should be re-assessed with interventions implemented. She is at the facility twice a week but it could take up to two weeks or longer before she assesses the resident. R66 triggered for significant weight loss last month, he had double proteins in place and she recommended increasing his liquid protein from daily to twice a day. She said she did not physically see him, she was told he had a cast on his leg and contributed part of his weight loss to that. She said she sends the recommendations to V2 DON.

R66's EHR (electronic health record) does not show documentation of a cast to his leg.

R66's Physician Order Sheets dated October 2024 shows orders for liquid protein daily (not twice a day).

The facility's Nutrition (Impaired)/Unplanned Weight Loss Policy states, " The threshold for significant unplanned and undesired weight loss

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will be based on the following criteria: a. 1 month -5% weight loss is significant, greater than 5% is severe...the staff and physician will identify pertinent interventions based on identified causes and overall resident condition, prognosis and treatment wishes...the staff will implement appropriate general or cause-specific interventions, as indicated..."

(B)

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300.1210b)
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300.1210d)1)3)

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.

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:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005276	A. BUILDING: _____ B. WING _____	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIXON REHAB & HCC	800 DIVISION STREET DIXON, IL 61021

(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
S9999	Continued From page 14 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These REQUIREMENTS were NOT met as evidenced by: Based on observation, interview and record review the facility failed to ensure residents pain was managed after undergoing hip surgery. This failure resulted in R45 experiencing severe pain to 1 of 18 residents (R45) reviewed for pain management in the sample of 18. The findings include: R45 has diagnoses that include fractured left hip undergoing hip surgery, dementia, hypertension and weakness. R45 was readmitted to the facility on 10/19/24 after undergoing surgical repair to her left hip fracture caused by a fall. On 10/21/24 at 9AM, R45 was in bed moaning "I am sore." V19 (Registered Nurse/RN) was with R45 at this time and said R45 has a hip fracture due to fall.	S9999		

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S9999	Continued From page 15	S9999		

On 10/21/24 at 12 PM, R45's room was closed but can hear audible moaning. This surveyor entered R45's room. R45 was in the bathroom sitting in the toilet seat. V18 (Certified Nursing Assistant) was with R45. R45 was crying in pain. "It's sore!, it is so painful! I can't take this please, I can't, please help me, it hurt's so bad." V18 asked this surveyor to get the nurse. When V19 (RN) was in the room, she asked R45 "what's wrong?" R45 responded, "this is so painful!" pointing to her left hip. "It is so sore, please help." V19 told R45 "you had hip fracture! of course it will hurt!, do you want to go back to the hospital ?" R45 answered "I don't think that was necessary but my hip hurts so bad, I just want to go lay down!". V17 and V18 (both CNAs) tried to lift R45 up using using a gait belt to her wheelchair. R45 cannot bear weight and cried out " I cannot move!, no please! this is sore" touching her left hip again it is so painful! A walker was then placed in front of R45. R45 was directed to use the walker to get up. R45 said she cannot move, her legs hurts. V3 (Assistant Director of Nursing) came in the room. R45 said she cannot take the pain in her hip any longer. V3 informed R45 she understood R45 was experiencing severe pain and will try to put R45 to bed. V3 (ADON) was able to transfer R45 via sit to stand and R45 was placed in bed. R45 continued to moan. V19 (RN) then gave a pill to R45 and left the room.

At 12:30 PM, This surveyor asked V19 (RN) what did she give R45. V19 said she gave R45 her pain medication. V19 said R45 has an old order of pain meds even before having surgery given four times a day 8AM, 12PM, 4PM, 8PM. Date of order 5/1/24. V19 said R45's pain is increased at this time due to hip surgery. R45's pain level was "6" (severe pain)

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S9999	Continued From page 16 At 2PM V3 ADON said R45 was definitely experiencing severe pain after this hip surgery At 2:48 PM, V18 (CNA) said R45 does this whimpering sound but earlier when R45 was toileted she had this excruciating pain in her hip that she cannot even move. R45's pain had definitely increased. R45's hospital discharge orders dated 10/19/24 after having hip surgery show a new pain med order of Norco 5/325 (Narcotic pain medication) 1 tab every four hours (approximately 3 days ago). Review of R45's Physician Order sheet dated 10/24 and R45's medication administration sheet (MAR) still has R45's old order (5/1/24) of Norco 1 tab four times a day. The new order of R45's Norco (every 4 hours) was not carried out. On 10/22/24 at 1:10 PM, V2 (DON) said when residents were readmitted, medications were reviewed to ensure all the ordered medications were carried out. R45's careplan with a revision date of 10/21/24 show R45 has pain whimpering ...further risk for pain related to recent fall with left hip fracture. R45 does complain of pain during transfers. With intervention that include, monitor residents complaint of pain. Notify physician if intervention are unsuccessful or if current complaint is a significant change from residents past experience. On 10/23/24 at 9AM, V2 (DON) confirmed to this surveyor that R45's pain med from the hospital discharge orders had been corrected to reflect the correct order for R45's pain medications order	S9999		

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S9999	Continued From page 17 last 10/19/24. (Norco 5/325 1 tab every 4 hours.) (B)	S9999		