STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003198	A. BUILDING: _____ B. WING _____	C 03/21/2025

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FONDULAC REHABILITATION & HCC	901 ILLINI DRIVE EAST PEORIA, IL 61611

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S 000	Initial Comments Complaint Investigation: 2522020/IL187807	S 000		
S9999	Final Observations Statement of Licensure Violationss: 1 of 2 300.690a) 300.690b) 300.690c) 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 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. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional	S9999		

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Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

This REQUIREMENT is not met evidenced by:

Based on observation, interview, and record review the facility failed to notify the State Agency of a resident injury requiring a hospital evaluation and treatment for one (R2) of three residents reviewed for incidents and accidents in the sample of three.

Findings include:

The Incident Log dated 3/20/25 documents R2 received a skin tear on 1/18/25.

The Unwitnessed Incident Report for R2, dated 1/18/25, documents R2 was outside and had an incidental contact with another resident's chair, which resulted in deep lacerations to right leg. R2 leg wound was cleaned, padded dressing applied and wrapped with gauze. R2 was sent out to the local hospital for evaluation.

The Nursing Progress Note for R2, dated 1/19/25 at 2:58 am, documents R2 returned to the facility at 1:30 am with nonsutured wound to right leg laceration.

The local hospital Emergency Department record for R2, dated 1/18/25 documents R2 was evaluated for a triangular shaped wound laceration to her right leg after being struck with a wheelchair. Facility having difficulty controlling the

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bleeding and was sent to emergency department for further bleeding control. "(R2) was offered suture repair versus hemostatic (medical devices designed to control bleeding by promoting blood clot formation) dressing. (R2) elects for hemostatic dressing." R2 was injected lidocaine with epi (epinephrine/local anesthetic), a foam gel, thrombin, gauze dressing and wrapped with self-adhering bandage."

The facility Wound Doctor Note for R2, dated 1/28/25, documents initial visit of a full thickness wound with fat layer exposed, measuring 0.9 cm/centimeters by 0.4 cm by 0.1 cm with 80 percent epithelial (protective) tissue and 20 percent granulation (new connective tissue).

The facility Weekly Wound Tracking for R2, documents new onset right leg Laceration on 1/18/25. On 1/21/25 measured 1.0 cm (centimeters) by 0.4 cm by 0.1 cm with minimal drainage. This laceration is documented as healed on 3/18/25.

On 3/20/25 at 1:15 pm, R2 stated she did get a wound on her right leg when another resident was helping a resident in a wheelchair, and they ran the wheelchair into her right leg. R1 went to the hospital "because it (laceration) was pretty deep." R2 stated the hospital doctor asked if R2 wanted glue or sutures and R2 chose glue. R2 raised her right pant leg to reveal an irregular, indented, circular scar, approximately one centimeter in diameter.

On 3/21/25 at 3:00 pm, V2 DON (Director of Nursing) stated she completes all the accident and incident investigations that occur in the facility. R2 is an independent smoking resident and was out on patio with other residents

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smoking. While moving her wheelchair came into contact with another resident wheelchair, causing the wound.V2 DON confirmed the incident occurred on 1/18/25 at 10:10 pm. V2 confirmed R2 went out to the local hospital via ambulance and returned to the facility with a bandage on her right leg. V2 stated V2 was told if it was not a serious injury it did not need to be reported to the State Agency.

On 3/21/25 at 3:30 pm, V1 AIT (Administrator in Training) stated R2 is an independent smoking resident and was outside around 10:00 pm with other residents smoking. R2 hit her leg on another residents wheelchair. V1 stated the facility did not report to the State Agency because he was told by corporate that if an injury is no larger than a (name of adhesive bandage), it didn't need to be reported to the State Agency.

(C)

Statement of Licensure Violations:

2 of 2

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

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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.

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 is not met evidenced by:

Based on interview and record review, the facility failed to ensure resident safety prior to repositioning for one of three residents (R1) reviewed for incidents and accidents in the sample of three. This failure resulted in R1 sustaining a deep leg laceration requiring a

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hospital visit, receiving 13 stitches, and antibiotic treatment.

Findings include:

The facility's Skin condition Monitoring policy and procedure, dated 1/18, documents "It is the policy of this facility to provide proper monitoring, treatment, and documentation of any resident with skin abnormalities." "1. Upon notification of a skin lesion, wound, or other skin abnormality, the Nurse will assess and document the findings in the nurses' notes and complete the QA (Quality Assurance) form for Newly Acquired Skin condition... 3. Any skin abnormality will have a specific treatment order until area is resolved... 4. Documentation of the skin abnormality must occur upon identification and at least weekly thereafter until the area is healed. Documentation of the area must include the following: c. Prevention techniques that are in use for the resident."

The Residents' Rights for People in Long-Term Care Facilities, dated 1/18, documents "Your rights to safety" includes the following: "The facility must provide services to keep your physical and mental health at their highest practical levels" and "Your facility must be safe, clean, comfortable and homelike."

The undated Certified Nurses Aide/CNA Job Summary documents CNAs "provide personal care and assistance to residents to assure their safety and comfort" and "demonstrates support of the philosophy of (the facility) by adhering to policies, procedures, and established Standards of Nursing Practices."

The Clinical Medical Record for R1 documents

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R1 with the following diagnoses: Chronic Obstructive Pulmonary Disease, Emphysema, Dysphagia, Scoliosis, Osteoporosis, Abnormal Posture, and Muscle Wasting.

The Nurse Progress Note for R1, dated 2/4/25 at 6:44 am, documents nurse was notified of R1 with leg injury and noted R1 with "deep tissue skin tear". CNA reported R1 was injured during transfer from bed to the chair and was sent to the local hospital.

The Skin Tear report for R1, dated 2/4/25, documents Nurse was notified by V6 CNA that R1's leg was injured with "deep tissue skin tear" to her right lower leg, "No injuries observed at the time of incident," and was sent to the local hospital for evaluation.

The local hospital record for R1, dated 2/4/25, documents the reason for R1's visit as "Laceration of right lower extremity, initial encounter. Primary Dx (diagnosis): Leg pain, anterior right" with "laceration repair." The Medication Administration Record documents R1 received the pain medication Norco 7.5-325 mg (milligrams) one time at 8:44 am and lidocaine-Epinephrine 1% 10 ml (milliliters) was injected one time on 2/4/25 at 10:03 am. An x-ray of R1's right tibia and fibula was obtained on 2/4/25 at 9:02 am and findings as: "Laceration related soft tissue changes are seen overlying the mid anterior tibia." R1 was treated for a laceration of right lower extremity.

The current Order Summary Report for R1, documents a 2/5/25 physician order for Cephalexin (antibiotic) 500 mg (milligrams) one capsule four times daily for leg wound.
The Infection Progress Note for R1, dated 2/4/25,

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documents R1 to receive Keflex 500 mg (milligrams) one capsule four times daily for 7 days for leg wound.

The Nursing Progress Note for R1, dated 2/4/25 at 1:47 pm, documents R1 returned from the local hospital with 10.5 cm (centimeter) deep tissue laceration with 13 stitches to R1's right leg mid-calf.

The Nursing Progress Note for R1, dated 2/4/25 at 8:09 pm, documents "New order for Abt (antibiotic) d/t (due to) laceration on LLE (left lower extremity)."

The current Care Plan for R1, documents 2/4/25 Laceration to right lower extremity with intervention to monitor for s/s of infection and on 2/10/25 exchange bed frame.

The Incident Progress Note for R1, dated 2/10/25, documents "After investigation it was determined that the skin tear/laceration occurred while CNA was titling (reclining wheelchair) back due to restlessness. (R1) put her leg over side of chair and received a 10.5 cm (centimeter) laceration to right lower extremity from bottom edge of bed requiring 13 stitches. Intervention: replace bed frame, terminate CNA (V6), and monitor s/s (signs and symptoms) of infection."

The facility Investigation for R1's incident, dated 2/4/25, documents V5 CNA assisted V6 Former CNA to mechanically transfer R1 from her bed to a reclining back wheelchair and left R1 in her room. V5 reported there were no injuries at the time of the transfer. Shortly after V6 saw R1, in her room, attempting to get out of the wheelchair. V6 reported R1's "leg got stuck under edge of bed as V6 was tipping R1's reclining wheelchair

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backward. V4 RN (Registered Nurse) was notified and assessed R1 with "a large bleeding wound on lower anterior and lateral aspect of right lower leg." V3 ADON (Assistant Director of Nursing) reported assessed R1's leg and "noted a large skin tear to anterior/lateral aspect of distal right leg. V6 Former CNA reported to V3 ADON that R1 was attempting to get out of the reclining wheelchair, so V6 Former CNA attempted to recline R1 back and R1's leg hit the lower edge of the bed causing the skin tear.

The facility Final Notification Form for R1, dated 2/10/25, documents R1 received a laceration to right lower leg, was sent to the local hospital. "After investigation it was determined that skin tear/laceration occurred while CNA (V6) was tilting (reclining) chair back due to restlessness. (R1) put her leg over side of chair and received a 10.5 cm (centimeter) laceration to right lower extremity from bottom edge of bed requiring 13 stitches. Intervention: Replaced bed frame, terminated CNA and monitor for s/s (signs and symptoms) of infection."

The Incident Log dated 3/20/25 documents R1 with skin tear on 2/4/25.

On 3/20/25 at 11:00 am. V1 AIT (Administrator in Training) stated R1 required help for everything, was not cognitively intact, and did not move around on her own. V6 Former CNA was moving R1's wheelchair and caught R1's leg on a bolt on the bend of the bed causing a skin tear to R1's leg. R1 was sent out to the hospital and came back with stitches.

On 3/21/25 at 12:12 pm, V3 ADON (Assistant Director of Nursing) stated she was called down to R1's room to assess R1's right leg due to the

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nurses doing shift change report and noted a deep open wound bleeding wound to R1's right leg and a small amount of blood on R1's bed frame. V6 reported (V6) reclined R1's wheelchair and R1's right leg hit the lower edge of the bed frame causing the skin tear. V3 ADON confirmed V6 should have looked to see where R1's legs were prior to moving R1's wheelchair and that V6 was terminated for sleeping on third shift and causing the skin care.

On 3/21/25 at 12:20 pm, V5 CNA stated she helped V6 mechanically lift R1 from her bed into her wheelchair, there were no injuries during that time, and then V5 left R1's room. V5 stated she didn't see R1's wound until R1 returned from the hospital. "It was a pretty large skin tear that was stitched back up."

On 3/21/25 at 3:30 pm, V1 AIT stated V6 should have looked to see where R1's legs were prior to moving R1 and V6 was terminated after working that shift for poor work performance and sleeping on the job. V1 stated the facility does not have a QA form for Newly Acquired Skin condition for R1 due to no longer using the form.

(B)