STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012165	A. BUILDING: _____ B. WING _____	C 01/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY REHAB AT NORTHMOOR	1500 WEST NORTHMOOR ROAD PEORIA, IL 61614

(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 #2120092/IL129975	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)6) 300.3240 a) 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**	

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S9999	Continued From page 1 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations are not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement fall interventions, provide adequate supervision, and provide assistance of two for Activities of Daily Living (ADL's) for one of three residents (R2) reviewed for falls with injury in the sample of three. These failures resulted in R2 being left unattended during ADL's, falling out of bed, sustaining a right hip fracture and experiencing excruciating pain. Findings include: The facility's Fall policy, dated 6-4-18, documents, "It will be the standard of this facility to complete an initial assessment, on-going monitoring/evaluation of resident conditions and subsequent interventions development in an attempt to prevent falls and injuries related to	S9999		

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S9999	Continued From page 2 falls. Based on evaluation of falls, pertinent interventions will be implemented by staff such as, but not limited to: resident education if appropriate, staff re-educating regarding transfer techniques and safety during ADL (Activities of Daily Living) care, and maintaining close proximity of frequently used times." R2's Minimum Data Set (MDS) Assessment, dated 11-10-20, documents R2 has diagnoses of Cerebral Palsy, Aphasia (loss of ability to understand or express speech), Paraplegia, Seizure Disorder, and Depression. This same MDS documents R2 is severely cognitively impaired and requires extensive assistance of two staff physical assistance for bed mobility, transfers, dressing, and toilet use. R2's Fall Risk Care Plan, dated 10-9-20, documents, "Goal: I will not sustain a fall related injury by utilizing fall precautions through the review date 2-10-21. Interventions: 5-21-20 Keep (R2's) bed in low position at all times while in bed. 5-21-20 Floor mats/landing strips at bedside per medical doctor orders. 11-4-20 Prior to assisting (R2) to bed verify that both floor mats are present on each side of (R2's) bed every shift." R2's Progress Notes, dated 12/31/2020 at 12:26 PM, and signed by V5 (Registered Nurse/RN), document, "(R2's) bed was in low position and (V3/Certified Nursing Assistant/CNA) had moved the fall mat to perform cares on (R2). (R2) was having cares performed on her when (V3) walked away from (R2's) bed to grab a bed pad and (R2) rolled out of bed onto the floor. Staff assisted (R2) back to bed after this nurse evaluated (R2). (V6/Licensed Practical Nurse) then asked (V5) to assess (R2's) right hip area due to seeing that the	S9999		

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S9999	Continued From page 3	S9999		

right hip was protruding and (R2) was crying out in pain and grabbing at the right hip area. (V5) noted that the area looked abnormal. 911 was then called to have (R2) transported to the hospital for an evaluation."

R2's Right Femur X-Ray, dated 12-31-20, documents, "Impression: Right intertrochanteric femur fracture (right hip fracture)."

R2's Hospital Admission History and Physical, dated 12-31-20, documents, "Closed right femoral intertrochanteric fracture: fell from bed at the nursing home. Orthopedics consulted."

V3's typed statement, dated 12-31-20, documents, "I was assigned to (R2) on 12-31-20. I was providing cares to (R2) and moved (R2's) floor mat out of the way to provide cares and get (R2) dressed. I realized that I needed a bed pad, so I went to the utility room to retrieve one. Upon arriving back to (R2's) room, (R2) had rolled out of bed onto the floor."

R2's Surgical Report, dated 1-2-21, documents, "Procedure: Open reduction internal fixation right femur with c-arm."

V3's Employee Counseling Form, dated 1-4-21, documents, "Reason for counseling: Violation of safety rules. (V3) was getting (R2) dressed for the day (12-31-20) and had to leave (R2's) room to go get a fresh bed pad. Floor mats were not properly in place which resulted in a fall to (R2)."

On 1-11-21 from 11:10 AM to 12:30 PM, R2 was lying in bed facing the left side of the bed. R2 had an eight-inch floor mat on the floor next to the left side of the bed. During this time there was no floor mat next to the right side of R2's bed.

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S9999	Continued From page 4	S9999		

On 1-11-21 at 12:10 PM, V2 (Director of Nursing) stated, "On 12-31-20 (V3) removed (R2's) floor mat and left (R2's) room to go and get a bed pan. When (V3) left (R2) unattended, (R2) rolled out of bed on the left side of the bed. (R2) sustained a right hip fracture. Whenever (R2) is left in bed unassisted, (R2) is to have floor mats on both sides of the bed. (V3) should have made sure he had all supplies at the bedside before caring for (R2) and should have made sure that the floor mats were put back beside (R2's) bed before leaving (R2) unattended. (V3) did not make sure (R2's) bed was in the lowest position when leaving (R2) unattended. According to (R2's) MDS, (R2) should have had two staff assisting (R2) with dressing and toileting."

On 1-11-21 at 12:30 PM, V2 (Director of Nursing/DON) stated R2's right side floor mat was missing and was in another resident's room. V2 stated R2 is to have bilateral floor mats at all times when R2 is in bed.

On 1-11-21 at 12:40 PM, V7 (CNA) stated she did not know that R2 was supposed to have bilateral floor mats at all times while in bed.

On 1-12-21 at 8:30 AM, V5 (RN) stated, "On 12-31-20 (V6/LPN) called me to assess (R2). (V3) had moved (R2's) floor mat and had left the room to get a bed pad. (R2) fell out of bed when (V3) left (R2) unattended, and (R2) sustained a right hip fracture. (R2) was in excruciating pain. I sent (R2) to the emergency department."

On 1-12-21 at 9:40 AM, V3 stated, "On 12-31-20 I was getting (R2) ready to get up. I moved (R2's) floor mat to provide cares to (R2). I was dressing (R2) and needed a clean bed pad. I had to leave

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S9999	Continued From page 5 (R2's) room to get a bed pad and forgot to put the floor mat back next to (R2's) bed. I had left (R2's) bed raised and not in the lowest position when I left (R2's) room. When I returned to (R2's) room, (R2) had fell out of the bed and was lying on her right side in pain. (R2) was whimpering and crying. I immediately got the nurse (V6/Licensed Practical Nurse). I know (R2) needs two staff to provide cares, but I did not have time to ask any other staff to help with (R2's) cares." (A)	S9999		