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
	IL6004428	A. BUILDING: ______ B. WING ______	C 12/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSBORO REHAB & HCC	1300 EAST TREMONT STREET HILLSBORO, IL 62049

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S 000	Initial Comments Complaint 2148894/IL140825	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) 300.3240a) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. Section 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. The plan shall be reviewed at least every three months.	S9999		

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Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements are not met as evidenced by:

Based on interview, observation and record review, the facility failed to implement fall prevention interventions after falls for 3 of 3 residents (R1, R2, R3) reviewed for falls in the sample of 9. This failure resulted in R2 falling, on two separate occasions, suffering a left radius fracture and refracture of the left hip and pelvic fracture, requiring R2 to be sent out for emergent care.

Findings include:

1. R2's face sheet, undated, documents R2 has a diagnosis of Fracture of the Left Femur, Fracture of the Left Wrist and Hand, Unsteadiness on Feet, Abnormalities of Gait and Mobility and Muscle Weakness.

R2's Fall Risk Data Collection, dated 11/10/21, documents R2 is at high risk for falls.

R2's Minimum Data Set (MDS), dated 11/14/21, documents R2 is cognitively intact; requires an extensive assist with bed mobility, transfers; is dependent with toileting; balance is unsteady and has a history of falls.

R2's Care Plan, dated 11/10/21, documents R2 is at risk for falls and is to have the following fall interventions in place: "Call don't fall" sign, call light within reach, personal items within reach,

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gripper strips beside bed, mat on floor beside bed when resident is in bed and a scoop mattress.

On 12/1/21 at 10:45am, R2 stated she fell at home and broke left hip, prior to coming to the facility. R2 stated she has fallen twice since she's been at the facility and has re-broken her left hip and left wrist. R2 stated she doesn't know what happened or what caused her to fall.

On 12/1/21 at 10:45am, R2 was observed in room, in bed, with a splint on left wrist. R2's personal items were on a bedside table to the left of R2. R2 stated she is unable to use her left hand/wrist due to a fracture, therefore is unable to reach the items to the left of her. There was no "Call don't fall" sign, no gripper strips at bedside or a floor mat in place during the observation.

On 12/1/21 at 11:20am, V3, Certified Nursing Assistant (CNA), provided incontinent care for R3. After providing care, V3 left R2's call light clipped to the left outer side of R2's mattress, out of R2's reach.

On 12/2/21 at 8:25am, R2 was observed in her room in bed. The "Call don't fall" sign, gripper strips at bedside nor the floor mat to bedside, were in place.

R2's progress note, dated 11/10/21 at 3:10pm, documents R2 was found on the floor in room. R2 was lying on back "approximately 10 steps from the bed." When questioned, R2 stated the Orthopedic doctor told "me I could walk, and my hip isn't broke any longer because the doctor fixed it." R2 was noted to have a hematoma to the back of head with a small open area. R2 was complaining of pain to the left wrist and arm with swelling and bruising noted. R2 was sent to the

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emergency room for further evaluation and treatment.

R2's X-Ray report of the left wrist, dated 11/10/21, documents a "Subtle transverse linear lucency distal radial metaphysis, could be a non-displaced fracture."

R2's Hospital History and Physical, dated 11/10/21, documents a diagnosis of Radius Fracture.

R2's progress note, dated 11/19/21 at 12:10am, documents R2 was observed sitting on the floor beside the bed facing the closet, with both legs extended in front of her, towards the foot of the bed. R2 was complaining of pain and stiffness in the left hip, left shoulder, upper left back and mid lower back. Resident sent to the emergency room for further evaluation and treatment.

R2's CT of the pelvis, dated 11/19/21, documents minimally displaced acute fractures involving the posterior aspect of the proximal left femur around the prosthesis stem.

R2's CT of the head/brain, dated 11/19/21, documents a punctate subdural hematoma.

On 12/1/21 at 11:30am, V5, Registered Nurse (RN), stated R2 has a fractured pelvis, is alert and oriented and knows to use her call light. V5 states R2 fell and broke her hip because she wouldn't wait for anyone to help her.

On 12/2/21 at 9:00am, V2, Director of Nurses (DON), stated "R2 fell the first night she was at the facility (11/10/21), broke her wrist and R2 wasn't using her call light or it had been on for very little time. (R2) got up without assistance."

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S9999	Continued From page 5 R2 told V2 that she thought she could get up on her own because the doctor "fixed her hip." V2, DON, stated R2 fell on 11/19/21 and had a new fracture to the left hip and a hairline fracture to the pelvis. V2 stated R2 had the call light on. V2 stated R2 said " that it took the girls too long" so she got up on her own. V2 stated she checked the "call light log" and R2's call light had been on for less than two minutes. The "call light log" was requested at that time. On 12/2/21 at 3pm, V2 stated she was unable to access/print the "call light log." On 12/2/21 at 3:45pm, V10, Licensed Practical Nurse (LPN), stated R2 is non-compliant with fall precautions. V10 stated she worked on 11/19/21, R2's call light went off and she (V10) was at the nurse's station and immediately went to R2's room. V10 stated R2 was observed on the floor and "didn't wait for help." V10 stated R2's call light was on for less than 2-3 minutes before V10 entered her room. 2. R1's Face Sheet, undated, documents R1 has a diagnosis of Cerebral Infarction and Muscle Weakness. R1's Fall Risk Data Collection, dated 7/30/21, documents R1 is at high risk for falls. R1's MDS, dated 10/19/21, document R1 has moderate cognitive impairment; requires an extensive assistance of two with bed mobility, transfers and toileting; balance is unsteady. R1's Care Plan, dated 6/28/21, documents R1 is at risk for falls with the following interventions: "Call don't fall" sign. R1's progress note, dated 9/15/21 at 10:14pm,	S9999		

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documents R1 was heard yelling help and upon entering R1's room, was observed on the floor, back against the wheelchair and chair alarm underneath. No injuries were noted.

R1's progress note, dated 9/20/21 at 12:51pm, documents R1 slipped out of wheelchair while attempting to grab a fork off of the ground.

R1's progress note, dated 11/24/21 at 9:30am, documents R1 "experienced a fall."

R1's progress note dated 11/24/21 at 10:29am, documents R1 was found lying on the floor in the bathroom. "Seemed to be trying to take self to the bathroom as resident was incontinent of bowel. No injuries noted except a small laceration to right ear."

R1's SBAR (Situation, Background, Assessment, Response) Communication Form, dated 11/24/21 at 9:30am, documents a chair alarm is to be in place.

On 12/1/21 at 2:15pm, R1 was observed in room, up in wheelchair. The "Call don't fall" sign nor the chair alarm was in place. R1 was pleasantly confused . R1 states he has experienced no falls.

On 12/2/21 at 8:20am and 10:20am, R1 was observed up in wheelchair and the chair alarm was not in place.

On 12/2/21 at 12:50am, V8, CNA, stated R1 uses call light and has had recent falls, but was unable to provide any details of the falls.

3. R3's Face Sheet, undated, documents R3 has a diagnosis of Symptoms and Signs of Cognitive

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S9999	Continued From page 7 Functions and Awareness, Abnormalities of Gait and Mobility, Weakness. R3's Fall Risk Data Collection, dated 10/1/21, documents R3 is at low risk for falls. R3's MDS, dated 10/29/21, documents R3 has severe cognitive impairment; requires an extensive assistance of one with bed mobility, toileting and transfers; requires supervision with ambulation; balance is unsteady. R3's progress note, dated 11/3/21 at 12:45am, documents R3 was on the floor in closet . without clothes on, urine and bowel movement was on the floor. Bruising was noted to the right elbow and R3 complained of pain to the right side of head. No bumps or bruising noted to R3's head. R3's progress note, dated 11/21/21 at 3:50pm, documents R3 was in the bathroom, taking clothes off, staff heard a yell and upon observation, R3 was observed lying on side. Feet located toward sink, with nightgown and incontinence brief off. A 3 centimeter (cm) by 0.3cm skin tear to the upper posterior left arm and a 0.5cm by 0.5cm skin tear to the upper posterior left arm was noted. "Resident is always taking clothes off throughout the day." R3's Care Plan, dated 10/1/21, documents R3 is at risk for falls with the following interventions: assist to bathroom after meals, gripper socks, gripper strips at bedside and keep bathroom light on. The care plan fails to list new fall interventions for R3's falls on 11/3/21 or 11/21/21. On 12/2/21 at 9am, V2, DON, stated the fall interventions are listed on the resident's care plans and she would expect fall interventions to	S9999		

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S9999	Continued From page 8 be in place. On 12/2/21 at 1:50pm, V12, CNA, and V13, CNA, both state they would look at the resident's care plans to see what fall interventions were to be in place. The "Fall Policy", dated 9/17/19, documents "Residents found to be at high risk for falls are placed on the Fall Program and interventions are implemented to meet individual needs. Following any falls, the facility staff completes an Occurrence Report. Details of the fall will be recorded and potential causal factors identified and investigated. Interventions will be implemented and care plan updated." (B)	S9999		