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
	IL6008510	A. BUILDING: _____ B. WING _____	C 09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-NORMAL	509 NORTH ADELAIDE NORMAL, IL 61761

(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 FRI of 9/5/2022\IL151399	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 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 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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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S9999	Continued From page 1 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. These Requirements were NOT MET as evidenced by: Based on observation, interview and record review the facility failed to provide adequate supervision for a high fall risk resident by failing to implement interventions for fall prevention for one of three residents (R1) reviewed reviewed for falls on the sample list of six residents. This failure resulted in R1 being left unattended by staff members in a dining room area, and then ambulating independently without a wheelchair or staff assistance into the hallway and falling. R1 sustained a fracture to the nasal bone, fracture to the nasal septum, and fracture to the left maxillary sinus requiring surgical intervention. Findings include: On 9/21/22 at 10:45 am R1 had swelling to bridge of R1's nose with an incision site present.	S9999		

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S9999	Continued From page 2 R1's fall risk assessment dated 8/18/22 documents a fall risk score of 80, indicating high risk for falls. R1's care plan initiated on 8/15/2019, documents that, R1 is at risk for falls related to fall with nasal and facial fractures, R1 has impaired cognition, R1 has behaviors and may become resistive or combative, and R1 has a history of sitting self down on floor. The care plan documents interventions as: Offer assist to common area when up in wheelchair, (date initiated: 2/19/2021), and encourage to sit in common area for visual supervision when up in wheelchair (date initiated: 5/2/21). R1's Minimum Data Set Assessment dated 8-18-22 documents "Moving from seated to standing position: 2: Not steady, only able to stabilize with staff assistance." R1's medical record documents on 9/5/2022 at 4:10 PM by V3 Agency Licensed Practical Nurse, "was called by dietary aid to help a resident. when came to area resident was lying on stomach hands on face blood all over face. lacerations to right upper brow, right lower eye and upper nose." R1's Fall occurrence report documents on 9-5-22 at 3:45 PM, Type: Fall, Location: Common Area, Activity: Ambulating. Care prior to fall: visually observed on 9/5/22 at 3:30 PM, Wheelchair not in use. The facility's investigation file documents, "Final report: date of occurrence: 9-5-22 at 3:45 PM. Conclusion: R1 attempted to ambulate without wheelchair or staff assistance from dining room to store, in the main lobby area. While ambulating	S9999		

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S9999	Continued From page 3 R1 fell onto the floor, R1 was attempting to purchase items from store with BINGO earnings although store was closed. R1 is an extensive assistance during locomotion and has a BIMS (brief interview of mental status score) of 3. Upon observation noted laceration to right upper brow, lower eye and upper nose. Transported to Emergency room for evaluation and treatment, facility notified the next morning of fracture to nasal bone, nasal septum left maxillary sinus extending to left pterygoid plate and left pterygoid palatine fossa. Returned to facility on 9-7-22. Facility believes the cause of fall was due to attempting to ambulate independently to purchase an item form store without her wheelchair or staff assistance." On 9/21/22 at 11:04 AM V3 Agency LPN stated, "on 9-5-22 I was notified by a dietary employee, something about blood and a resident, I went down to the dining room hallway area and (R1) was on the floor, lying on (R1's) belly, with (R1's) head lifted up holding (R1's) face with (R1's) hands, it was bleeding, I assessed (R1) and sent (R1) out to the emergency room. (R1) had shoes and socks on, I don't know where her wheelchair was at the time of the fall. (R1) is a fall risk, especially depending on her mood, some days (R1) will try to get up and walk on (R1's) own and other days (R1) just sits in the wheelchair, depending on (R1's) mood we don't leave (R1) alone, that day in report I was told (R1) was in one of (R1's) walking moods, so I knew to keep an eye on (R1's) behaviors. (R1) had went down to play bingo and fell." On 9/21/22 at 9:55 AM V4 Activity Assistant stated, "bingo started around 2:30 PM on 9-5-22, (R1) was sitting at a middle table in the dining room playing and visiting with other residents.	S9999		

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S9999	Continued From page 4 After bingo was over I was picking up the bingo cards and cleaning the tables, (V5 Activity Assistant) had left the dining room to take other residents back to their rooms, (R1) was sitting at the table visiting with (R6). I left to take another resident back to their room, I went to the bathroom and when I returned, no residents were in the dining room, I figured another staff member had taken (R1) back to (R1's) hallway. I went back to the office to chart, about 15 minutes later I heard someone scream, I went out into the hallway and was told that someone from dietary had found (R1) on the floor. I didn't know (R1) had been trying to get up and walk that day. Didn't even cross my mind (R1) would try to get up on her own." On 9/20/22 at 2:08 PM V5 Activity Assistant stated, "on 9/5/22 we started bingo around 2:30 PM in the dining room, I had went down to the lounge area on (R1's) hallway, I pushed (R1) to the dining room, (R1) was sitting in at one of the middle dining room tables, bingo had ended around 3:15 PM, (R1) was sitting in the dining room in (R1's) wheelchair visiting with (R6). I left to take other residents back to their rooms. (V4) was still in the dining room, I came back from the bathroom and there was no more residents in the dining room, (V4) was not in there either, I went back out in the hallway and down to the office, I had a call to do with another resident, I did that. About 10 to 20 minutes later I saw the paramedics in the hallway by the dining room and other staff members, another staff member told me then that (R1) had fell. This was the first time I had seen (R1) come out to Bingo in a long time, (R1) sometimes comes to other events, (R1) doesn't propel her own chair to and from the activities, (R1) has to be pushed in (R1's) wheelchair.	S9999		

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S9999	Continued From page 5 On 9/21/22 at 2:05 PM V2 Director of Nursing stated, "on 9/5/22 (R1) was in the dining room playing bingo, chatting with other residents, bingo had ended, and was then observed on the floor in the hallway outside of the dining room between the bird cage and the glass cabinet purchasing store by a dietary staff member. The activity staff members (V4 and V5) said (R1) was sitting at the table in the dining room talking with another resident and they had started taking other residents back to their rooms. (R1) was then found on the floor. (R1) went to the emergency room, had facial and nasal fractures and had surgery on her nose. The root cause of (R1's) fall was self ambulating after activity to get a bingo prize from the store, we don't know if maybe (R1) seen something she wanted or what because (R1's) wheelchair was in the dining room, (R1) would have walked out of the dining room to the left towards the glass case store area, instead of going right, the direction of (R1's) room. There were no other residents or staff members in the area when the fall occurred." R1's hospital records, dated 9/5/22 document, "CT of face: impression 1- multiple facial fractures, there is a commuted mildly depressed and left laterally deviated nasal bone fracture and comminuted nasal septal fracture., 2- fractures along the maxillary sinus walls inferolateral on the right side and far posterior on the left. This is probably extending through the left pterygoid plates and pterygoid palatine fossa area. 3- bilateral right greater than left maxillary sinus hemorrhage and fluid. Bilateral ethomoiditis. 4- soft tissue contusion and laceration overlying the nasal bone. Plastic Surgery Consultation note: 9-6-22, assessment- fractures of nasal bone, nasal septum, left maxillary sinus extending to left	S9999		

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S9999	Continued From page 6 pterygoid plate and left pterygoid palatine fossa. Recommendations: plan for reduction next week, will need medical clearance. History and Physical Information- patient has been immobile since having COVID last year, sometimes tries to get up and walk as she did last night and had a ground level fall sustaining the above listed injuries." R1's hospital post procedure notes document, "date of service 9-12-2022 Procedure: closed reduction nasal bone fracture repair. Procedure details: began by manual manipulation and reduction of nasal bones, I then used a "butterknife" to further reduce and set the nasal bones into position, the bones were very comminuted so perfect reduction was quite difficult. I then used a septal forcep to manipulate and bend the nasal septum into a better position. Nasal splints were then placed." The facility's policy, with a revision date of April 2019, titled "Fall Assessment and Management Policy" documents, "It is the policy of this facility to assess each resident's fall risk on admission, quarterly, and with each fall. This will help facilitate an interdisciplinary approach for care planning to appropriately monitor, assess and ultimately reduce injury risk. Procedure: Fall risk planning and assessment: C- The interdisciplinary care plan will be person centered to reflect the specific needs and risk factors of the resident." (B)	S9999		