

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6001986</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/11/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GRANITE NURSING &amp; REHABILITATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3500 CENTURY DRIVE GRANITE CITY, IL 62040</b>
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(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  Annual License and Certification survey	S 000		
S9999	<p>Final Observations</p> <p>Statement of Licensure Violations (1 of 3):</p> <p>300.610a) 300.1210b) 300.1210d)5)</p> <p>Section 300.610 Resident Care Policies</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p> <p>d) Pursuant to subsection (a), general nursing</p>	S9999	<p style="text-align: center;"><b>Attachment A</b> <b>Statement of Licensure Violations</b></p>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.</p> <p>These requirements were not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to prevent pressure ulcers for 1 of 4 residents (R62) reviewed for pressure ulcers in a sample of 36. This failure resulted in R62 sustaining an pressure ulcer on his left BKA.</p> <p>Findings include:</p> <p>R62's Care Plan dated 4/1/2021 documents problem: at increased risk for skin issues related to impaired mobility diagnoses right AKA, left BKA (below the knee amputation), ESRD (end stage renal disease) with dialysis, diabetes (DM), CHF (chronic heart failure) with edema. Goal: no break in skin integrity through next review 12/2022. Approaches: observe skin daily with cares, perform weekly skin assessments, notify physician of any abnormal findings. Pressure relieving mattress on bed and cushion in w/c as tolerated. Staff to assist with repositioning,</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>perform a skin risk assessment quarterly and PRN, treatment as ordered. 5/2/2022 staff handwritten note treatment as ordered, prosthetic ortho looking at leg 5/9/2022. 6/20/2022 staff handwritten stage 3 pressure to left BK and left distal BKA admitted with from hospital. 6/20/2022 treatment as ordered; wound specialist ordered. 8/27/2022 handwritten left BKA Pressure wound stage 3.</p> <p>R62's Undated Face Sheet documents he was initially admitted to the facility on 1/18/2021.</p> <p>R62's Evaluation of Pressure Ulcer Risk, dated 4/8/2022 documents bed mobility problem: no. Bedfast: no. Bowel incontinence: no. Peripheral Vascular Disease (PVD): no. Previous ulcer: no. Skin desensitized to pain or pressure: no. Daily trunk restraint: no. It was determined R62 was not at risk of pressure ulcers.</p> <p>R62's Nursing Notes dated 5/2/2022 at 3:20 AM V6, Wound Nurse documented observed resident this shift, noted open area to left BKA related to ill-fitting prosthetic. Treatment applied as ordered. Prosthetic company coming 5/9/2022 to re-fill few new prosthetics. Physician and responsible representative aware of current situation. No assessment of the pressure ulcer was documented.</p> <p>R62's Physician's Order Sheet (POS) dated 5/2/2022 documents a physician's order dated 5/2/2022 cleanse left leg amputation site with wound cleanser, apply Medihoney, calcium alginate and cover with a dry dressing every day and PRN, (when necessary.) 5/31/2022 wound specialist consult and treat.</p> <p>R62's Medical Record dated 5/2022 no</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>documentation the prosthetic company assessed his left leg prosthetic.</p> <p>R62's quarterly Minimum Data Set, (MDS), dated 5/16/2022 documents he is alert, and needs is independent for bed mobility, transfers, locomotion on and off unit, eating and toilet use. Supervision with setup only for dressing and personal hygiene. Determination of pressure ulcer risk: resident has a pressure ulcer, formal assessment instrument tool and clinical assessment, resident at risk for developing pressure ulcers, 1 stage 2 pressure ulcer. Skin and ulcer treatments included pressure reducing device for chair and bed and pressure ulcer care. Mobility device: wheelchair.</p> <p>R62's Initial Wound Specialist Nurse Practitioner Note, dated 6/7/2022 HPI (history of present illness): initial consult of this 49-year-old male, who was noted on 5/2/2022 to have a pressure ulcer secondary to his prosthesis. Currently treating with Medihoney. He was noted today to have a new distal lateral area of his left BKA as well, awaiting orders. Patient has history of left BKA, DM and ESRD. Initial assessment of left BKA noted on 5/2/2022 stage 3 pressure ulcer with 100% granulation which measured 2.9 cm x 2.5 cm x 0.3 cm. Left BKA lateral distal noted 6/7/2022 stage 3 pressure ulcer with 100% granulation which measured 0.7 cm x 0.9 cm x 0.3 cm.</p> <p>R62's 6/2022 POS, dated 6/7/2022 documents discontinue current treatment to left BKA. Cleanse left BKA with wound cleanser apply skin prep to peri wound area apply alginate cover with foam dressing every day and PRN.</p> <p>R62's POS dated 6/10/2022 documents send</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>resident to hospital for evaluation.</p> <p>R62's POS, dated 6/16/2022 documents a physician's telephone order for new BKA prosthesis.</p> <p>R62's Evaluation of Pressure Ulcer Risk, dated 6/20/2022 documents bed mobility problem: no. Bedfast: no. Bowel incontinence: no. PVD: no. Previous ulcer: yes. Skin desensitized to pain or pressure: no. Daily trunk restraint: no. Staff circled diabetes on the form. It was determined R62 was at risk of pressure ulcers.</p> <p>R62's Medical Record documents no readmission skin assessment dated 6/20/2022.</p> <p>R62's POS, dated 6/21/2022 documents a physician's order cleanse left leg amputation site with wound cleanser apply Medihoney cover with dressing daily.</p> <p>R62's Wound Nurse Practitioner dated 6/21/2022 documents unstageable pressure ulcer on left BKA measured 3 cm x 2.5 cm x UTD (unable to determine.) Wound bed 10% granulation and 90% necrotic. Peri-wound area scarring dry and flakey. Moderate yellow drainage.</p> <p>R62's 7/2022 POS documents cleanse left BKA with wound cleanser, apply Medihoney, cover with dressing every day and PRN.</p> <p>R62's Wound Specialist Nurse Practitioner Note, dated 8/9/2022 HPI: 50-year-old male with a pressure ulcer of his left BKA secondary to his prosthesis. Currently treating with Medihoney and calcium alginate. He also has history of diabetes and ESRD. Assessment of Left BKA pressure ulcer stage 3 with 100% granulation which</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>measured 2 cm x 1.5 cm x 0.3 cm. Peri wound scarring dry, flakey with moderate yellow exudate.</p> <p>R62's POS dated 8/2022 documents a physician's order dated 4/7/2021 weekly skin checks, and cleanse left BKA with wound cleanser, apply Medihoney, calcium alginate, cover with dry dressing every day and PRN (when needed.)</p> <p>R62's Evaluation of Pressure Ulcer Risk, dated 8/27/2022 documents bed mobility problem: no. Bedfast: no. Bowel incontinence: no. PVD: yes. Previous ulcer: no. Skin desensitized to pain or pressure: no. Daily trunk restraint: no. Staff circled diabetes on the form. It was determined R62 was at risk of pressure ulcers.</p> <p>R62's POS dated 9/2022 documents a physician's order dated 9/23/2022 cleanse left BKA wound cleanser, apply Prizma and cover with dressing every day and PRN. Weekly skin checks.</p> <p>R62's quarterly MDS, dated 9/3/2022 documents he is alert, and needs extensive assistance of setup only for bed mobility, locomotion on and off unit, dressing, eating, and personal hygiene and extensive assistance with two-person physical assist for transfers and toilet use. Mobility device was a wheelchair and limb prosthesis. Determination of pressure ulcer risk: resident has a pressure ulcer, formal assessment instrument tool and clinical assessment, resident at risk for developing pressure ulcers, 1 stage 3 pressure ulcer. Skin and ulcer treatments included pressure reducing device for chair and bed and pressure ulcer care.</p> <p>On 10/4/2022 at 9:30 AM R62 was sitting in his</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>wheelchair in his room with a left leg prosthetic on.</p> <p>On 10/5/2022 at 9:00 AM, R62 was sitting in his wheelchair in his room with a left leg prosthetic on.</p> <p>Observation on 10/6/2022 at 8:15 am V6, Wound Nurse provided wound care to R62's left BKA. V6 washed her hands and donned gloves she removed a dressing dated 10/5/2022 removed gloves, washed hands and donned gloves and cleansed the pressure ulcer with dermal wound cleanser. V6 applied Prizma and cover the pressure ulcer with a dry dressing. The pressure ulcer wound bed was 80% granulation tissue and 20% red. It measured 0.7 cm x 0.4 cm. The peri wound area (area surrounding pressure ulcer) was dry and there was a small amount of serosanguineous drainage.</p> <p>On 10/6/2022 at 8:20 AM V6, Wound Nurse stated R62 in May 2022 staff notified her he had skin breakdown on his left BKA. She assessed it and documented a stage 3 pressure ulcer on this left BKA. R62 is alert and told her it was caused by his leg prosthetic rubbing against his skin. He was transferred to the hospital a few months ago and when he was readmitted the left BKA pressure ulcer was a lot bigger, so she documented it as a non-facility acquired pressure ulcer.</p> <p>On 10/6/2022 at 2:00 PM V16, Director of Therapy stated R62 was admitted to the facility years ago and he brought his left leg prosthetic with him upon admission. When residents are admitted to the facility with a prosthesis therapy staff evaluate to ensure it fits them properly. The prosthetic evaluation wouldn't be in therapy notes</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>because they document it on a template, and it is not printable.</p> <p>On 10/6/2022 at 1:00 PM V2, DON stated the pressure ulcer on R62's left BKA was assessed in May 2022 and the wound nurse practitioner assessed it weekly. R62 told V2 his left leg prosthetic was rubbing against his skin and caused it to open, it was a facility acquired pressure ulcer. She expected staff to assess and document resident's skin under a prosthesis every day and to document the assessment on the weekly skin assessment.</p> <p>R62's Weekly Skin Assessment, dated 4/2022 through 10/2022 no assessment of R62's skin under the prosthesis.</p> <p>On 10/6/2022 at 1:17 PM, V29 Wound Nurse Practitioner stated she initially assessed the pressure ulcer on R62's left BKA on 6/7/2022. Staff informed her the pressure ulcer was caused from an ill-fitting prosthesis on his left leg. V29 stated this was an avoidable pressure ulcer because staff should have been checking the prosthesis to ensure it fit R62's left BKA properly and assessing his skin under the prosthesis as well.</p> <p>On 10/6/2022 at 2:00 PM R62 was sitting in his room with his left prosthetic on. R62 stated they amputated his left leg about 5 years ago and his right leg 8/2022. He has a lot of health issues including diabetes, PVD and he's on dialysis. He got a wound on his left BKA because his leg prosthetic rubbed against his skin. The prosthetic company came to the facility a while ago and replaced a part on his prosthesis he didn't know when the prosthetic company came out.</p>	S9999		



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S9999	<p>Continued From page 8</p> <p>On 10/7/2022 at 7:30 AM V1, Administrator stated R62 wasn't compliant with wearing his left leg prosthetic.</p> <p>On 10/7/2022 at 8:00 AM, R62 was sitting in his wheelchair outside the dining room with his leg prosthesis.</p> <p>On 10/7/2022 at 9:43 AM, V28 Vascular Physician stated R62 had a left BKA years ago due to DM, ESRD and severe PVD. If a pressure ulcer developed from an ill-fitting prosthesis is an avoidable pressure ulcer. He expected the facility staff to follow their pressure ulcer and skin policies and assess the skin under the prosthesis per facility protocols.</p> <p>R62's Physician's Telephone Order dated 10/7/2022 documents a new physician's order stating R62 may wear the prosthesis to left BKA.</p> <p>The facility's Pressure Ulcer/Injury &amp; Skin Conditions Guide for Wound Evaluations Document Policy, dated 11/2017 policy: it is the practice of this facility to ensure residents with pressure ulcers receive necessary evaluation and treatment to promote healing, prevent infection and prevent new ulcers from developing. The assessment documentation includes length, width and depth measurements, tunneling/undermining, exudate (drainage), wound bed, peri-wound and pain, wound status: healing, no change, physician/family notifications, order changes and nutrition/hydration status. Upon identification of a pressure ulcer regardless, if developed in house or upon admission, the area is to be documented on the Wound Evaluation form or in electronic format. Contact physician, interdisciplinary team, family members, and significant others as indicated. Initiate appropriate treatment per</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>treatment protocol and physician order. Evaluate further interventions that may be indicated to promote healing and prevent infection. Documentation of wound status will occur at least once a week. this weekly evaluation will be documented electronically or on the Wound Evaluation Form/Skin Condition Form as appropriate. The physician is to be notified if there is no improvement in area, signs and symptoms of infection or signs of deterioration. The Unit Manager/Charge Nurse are responsible to ensure pressure ulcer treatment plan is addressed on the resident's plan of care. The Guide for Wound Evaluation and Documentation (above) can be utilized as a reference tool for licensed nurses when completing this documentation. This guide can be kept in the front with the treatment sheet for the month if completed manually. This is placed in the medical record. The Director or Nursing and/or designated licensed nurses will make pressure ulcer rounds on a weekly basis. Documentation of the area will be address. Resident progress or lack of progress will be evaluated. Directives may be given for further interventions and changes in plan of care. The resident's current care plan will also be reviewed. When a pressure ulcer heals, a preventative plan of care should have initiated.</p> <p>(B)</p> <p>Statement of Licensure Violations (2 of 3):</p> <p>300.610a) 300.1210b)2)</p> <p>Section 300.610 Resident Care Policies</p>	S9999		

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S9999	<p>Continued From page 10</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p> <p>Restorative measures shall include, at a minimum, the following procedures:</p> <p>2) All nursing personnel shall assist and encourage residents so that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. All nursing personnel shall assist and encourage residents so that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in</p>	S9999		

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S9999	<p>Continued From page 11</p> <p>range of motion.</p> <p>These requirements were not met as evidenced by:</p> <p>Based on observation, interviews, and record review the facility failed to provide restorative or licensed therapy to prevent the decline in Range of Motion, (ROM), for 1 of 3 residents, (R4) reviewed for restorative programs in the sample of 36. This failure resulted in (R4's) physical decline not able to use his left arm, limited ROM in his right arm.</p> <p>Findings include:</p> <p>R4's Minimum Data Set, (MDS), dated 09/21/2022, documents R4 is intact cognitive response for cognitive skills for decision making, requires extensive assistance with two person physical assist for bed mobility, requires extensive assistance with two person physical assist for transfers, requires extensive assistance with one person assist for dressing, requires extensive assistance extensive assistance with one person physical assist for eating, requires extensive assistance with one person physical assist for personal hygiene, special treatments, procedures, and Programs zero (0) documentation for physical therapy, speech therapy, occupational therapy, or restorative nursing programs.</p> <p>R4's Care Plan dated 06/21/2022, documents R4 is a short-term care resident to return home with family and home health services. Interventions dated 06/21/2022 encourage me to participate in all recommended therapies. Require assist with Activities of Daily Living (ADL's) r/t impaired</p>	S9999		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6001986</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/11/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GRANITE NURSING &amp; REHABILITATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3500 CENTURY DRIVE GRANITE CITY, IL 62040</b>
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(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	<p>Continued From page 12</p> <p>mobility impaired cognition will often refuse care, meds, and therapy. Transfers with 2 assist and Hoyer Lift - bedrest at this time per residents/family request, provide assist with any and all ADLs as needed.</p> <p>Medical Diagnoses dated October 2022 on the Physician Order Sheet (POS) unspecified sequelae of cerebral infarction, old myocardial infarction.</p> <p>On, 10/04/2022 at 11:58 AM, V18 R4's mother said, R4 tries to feed himself with finger foods. I bring in chicken tenders most of the time. Break the chicken tenders apart then hand him the chicken he will put it in his mouth using his right arm. V18 said she brings food in for him to eat because they serve him food he doesn't like and won't eat, and he likes the chicken tenders. He needs finger foods so he can use that right arm to feed himself. At times I will feed him, or the staff will feed him the foods that are not finger foods. V18 said he lost the ability to feed himself or do anything because he hasn't had any kind of exercises or therapy on him for a while now. V18 said R4 had a heart attack and stroke, and he needs therapy and exercises. I've told them he needs to be exercised but was told by staff that management said he couldn't have therapy. V18 said at times R4 can push the TV remote button, and call light at times with his good hand. V18 said R4 has not walked since February 2022. She said his legs and arms are sore most of the time and know it's because he does not get exercised. V18 said they don't get him up in a chair, or ever give him a shower. Would like to see him get up for just a bit, "I know he has sores on his bottom but would like him up for a little bit and have a shower, exercises, and some kind of therapy to help him."</p>	S9999		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6001986</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/11/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GRANITE NURSING &amp; REHABILITATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3500 CENTURY DRIVE GRANITE CITY, IL 62040</b>
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(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	<p>Continued From page 13</p> <p>10/04/2022 at 1:30 PM V7 Licensed Practical Nurse/Restorative Nurse (LPN/RN) said, R4 is not on any Restorative Programs, not sure why he isn't.</p> <p>10/04/ 2022 at 1:42 PM V2 Director of Nursing (DON) said, R4 was in Hospice and family revoked him being on Hospice, not interested in Hospice - family not on board. V2 said R4 came off Hospice 8/19/2022. Not sure why R4 wasn't placed on restorative program and screened for therapy.</p> <p>On, 10/05/2022 at 1:50PM, V20 R4's dad stated, "don't want Hospice again" they told us he wasn't eating and needed Hospice. The facility finally put him on a pill to help with his appetite. His appetite is better since on the pill. V20 said he told V6 Licensed Practical Nurse/Wound Care Nurse (LPN/WCN) they wanted him to get up to a chair, shower, and evening sit on side of the bed to soak his feet. V20 said, the WCN said they can't get him up in a chair because my boss said he couldn't get up. V20 said he is losing his ability to do anything by not getting therapy.</p> <p>On, 10/05/2022 at 2:03PM, R4 stated, "I haven't got up for a shower, no exercises, only a bed bath. I would like to have a shower and have some exercises."</p> <p>On, 10/05/2022 at 2:57PM, V23 Certified Nurse Aide (CNA) assisted V6 LPN/WCN with providing treatment to R4's wounds. R4 used his right hand and grabbed the handrail to help roll to his right side for treatment to be provided.</p> <p>On, 10/06/2022 at 10:35AM, V15 Occupational Therapists (OT) stated, "I evaluated R4 yesterday</p>	S9999		

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S9999	<p>Continued From page 14</p> <p>and we are picking him up for OT for self-feeding, grooming, hygiene, fine motor coordination, and positioning five times per week for eight weeks.</p> <p>On, 10/06/2022 at 10:45AM, V16 Occupational Therapists (OT) Director of Therapy Services said, anytime a resident comes off skilled therapy an email is sent to V7 Restorative Nurse and V1 Administrator cc'd for recommendations. R4 was discharged off skilled therapy because he went on Hospice. V16 said, when he was discharged from Hospice not sure what happened to why he wasn't screened after his Hospice discharge.</p> <p>On, 10/06/2022 at 12:25PM, V18 R4's mom at bedside visiting with R4. R4's head of bed elevated, and R4 has his right arm behind his head watching TV and talking to his mom.</p> <p>On, 10/06/2022 at 12:46AM, V16 (OT) stated we have no documentation that R4 was screened again after his discharge from Hospice.</p> <p>On, 10/07/2022 at 10:02AM, V24 Certified Occupational Therapy Assistant (COTA) stated it is possible if a resident comes off skilled therapy could decline if not recommended for Restorative Programs.</p> <p>On, 10/07/2022 at 10:06AM, V15 Occupational Therapists (OT) said, a Functional Maintenance Program (FMP) recommends the Restorative Program so any resident being discharged off skilled therapy and staying here in the facility is recommended a restorative program to help maintain, or decline.</p> <p>R4's Departmental Notes, dated 8/24/2022 at 4:00PM, documents, (R4) has chosen to discharge from hospice services as of</p>	S9999		

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NAME OF PROVIDER OR SUPPLIER  GRANITE NURSING & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 CENTURY DRIVE GRANITE CITY, IL 62040
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S9999	<p>Continued From page 15 09/19/2022.</p> <p>R4's Departmental Notes, dated 8/26/2022 at 2:51 PM, document, Interdisciplinary Department Team (IDT) meeting held (R4's) chart reviewed, wound care discussed, no new orders, no recommendations received, (R4) has been taken off hospice care, wound care specialists, registered dietician, director of nursing, responsible representative, medical director, aware of status.</p> <p>R4's Physical Therapy PT Discharge Summary dated 6/22/2022 - 6/29/2022, documents, discharge recommendations you are discharged from physical therapy on 6/29/2022 due to no longer requiring the skills of a therapist. You are discharge to this skilled nursing facility with hospice. You will require full time nursing care. You did not achieve your personal goal for wanting to get up in a wheelchair. Restorative program established/trained equals not indicated at this time. Functional maintenance program established/trained equals not at this time. Prognosis to maintain Current Level of Function (CLOF) equals N/A, Factors Impacting Prognosis Equal Risk for change in medical condition.</p> <p>R4's Occupation Therapy Treatment Encounter Notes dated 10/07/2022, documents, precautions/contraindications fall risk, foley catheter and rectal tube. Patient provided with Estim PENS UE triphasic to right forearm to facilitate wrist Range of Motion (ROM)/strength needed for self-feeding and hygiene/grooming. Patient provided with Active Range of Motion (AROM) to left upper extremity (LUE) and educated on SROM to increase ROM and strength to facilitate bilateral upper extremity (BUE) movement with washing face. Patient</p>	S9999		



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NAME OF PROVIDER OR SUPPLIER  <b>GRANITE NURSING &amp; REHABILITATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3500 CENTURY DRIVE GRANITE CITY, IL 62040</b>
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S9999	<p>Continued From page 16</p> <p>completed self-feeding with finger foods eating two sandwiches with SBA. Patient completed hygiene/grooming washing face with SBA</p> <p>Subject: Nursing Rehabilitation/ Restorative Care Policy dated 10/09 Rehabilitative or restorative care refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as is possible. Focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning. A restorative program should be started when a resident is admitted with restorative needs, but not a candidate for therapy, or when the need arises during a stay.</p> <p>(B)</p> <p>Statement of Licensure Violations (3 of 3):</p> <p>300.690a) 300.1210b) 300.1210d)6)</p> <p>Section 300.690 Incidents and Accidents</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p>	S9999		

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NAME OF PROVIDER OR SUPPLIER  <b>GRANITE NURSING &amp; REHABILITATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3500 CENTURY DRIVE GRANITE CITY, IL 62040</b>
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S9999	<p>Continued From page 17.</p> <p>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.</p> <p>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:</p> <p>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.</p> <p>These requirements were not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to document, assess, monitor and implement safety measures for 1 of 10 residents (R32) reviewed for falls in the sample of 36. This failure resulted R32 falling from his wheelchair and sustaining a focal hemorrhagic confusion of cerebrum (brain bleed) and being hospitalized and admitted to the trauma intensive care unit.</p> <p>Findings include:</p> <p>The Incident Log provided by the facility documents R32 had a fall on 1/5/2022 at 6:45 PM</p>	S9999		

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NAME OF PROVIDER OR SUPPLIER  GRANITE NURSING & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 CENTURY DRIVE GRANITE CITY, IL 62040
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S9999	<p>Continued From page 18</p> <p>and suffered an injury. The log also documents R32 fell in resident room on 6/30/2022 at 5:30 PM, R32 was found on floor. The Fall log does not document any other falls for R32.</p> <p>R32's Physician Order Sheet (POS) dated October 2022 documents a diagnosis of hemiplegia following cerebral infarction affecting right dominant side, epilepsy, other symptoms and signs with cognitive functions following non-traumatic intracranial hemorrhage. R32 also has an order for 50 milligrams (mg) of Zoloft by mouth daily.</p> <p>R32's Diagnosis History document a diagnosis of Aphasia following non-traumatic intracerebral hemorrhage dated 7/22/2022 and Aphasia following non-traumatic intracerebral hemorrhage dated 6/17/2022 and history of falling.</p> <p>R32's Fall Assessment dated 9/19/2022 document R32 was a high risk for falls.</p> <p>On 10/11/2022 at 9:49 AM, V30, Licensed Practical Nurse, (LPN), stated, "(R32) would have behaviors of screaming and yelling, but he was easily redirected. I did not have any issues with him personally. I know he was involved in one resident to resident altercation, and he got into it with another resident. Again, I did not have any issues with redirecting him."</p> <p>On 10/11/2022 at 10:03 AM, V31, Certified Nursing Assistant (CNA) stated, "(R32) has a history of screaming and yelling. It was usually started with another a resident. I did not have any issues with any issues with redirecting him. (R32) had a stroke a few months ago and he yells a lot now."</p>	S9999		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL6001986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  10/11/2022
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NAME OF PROVIDER OR SUPPLIER  GRANTE NURSING & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 CENTURY DRIVE GRANITE CITY, IL 62040
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S9999	<p>Continued From page 19</p> <p>On 10/11/2022 at 10:15 AM, V7 stated, "At times (R32) will yell out and if he is upset, he will cuss loudly. As long as he has his cigarettes, he is usually happy. I do not have any issues with redirecting him. (R32) had a stroke back in July and has issues with communicating things from his brain to his mouth. He yells out a lot."</p> <p>R32's Care Plan dated 10/2022 documents R32 requires assist with all activities of daily living related to impaired mobility, weakness, diagnosis CVA with right side hemiplegia. R32's Care Plan also documents he is at increased risk for falls related to impaired mobility/weakness, diagnosis of right-side hemiplegia, HTN, seizure disorder, depression with the use of psychotropic medication.</p> <p>R32's Progress Notes showed nothing documented in his medical records regarding his fall on 10/3/2022.</p> <p>R32's Progress Notes handwritten dated 10/4/2022 at 5:00 AM, written by V17, Licensed Practical Nurse shows, "Resident presented to this nurse by facility staff after having a behavior causing him to topple his wheelchair backward and hit the ground around 7:20 PM on 10/3/2022 in the hallway. This fall was witnessed and reported to this nurse as intentional. This nurse called (V2, Director of Nursing) at 7:33 PM to make her aware. Spoke with Nurse Practitioner (V25) at 7:35 PM and received orders to send the resident out for evaluation related to large knot that had formed on the back of his neck, continued behaviors and blown pupils slow to react. Emergency Medical Services was called to make a transfer of the resident from facility to (Hospital) around 7:40 PM. Report called into Emergency Department at this time. Emergency</p>	S9999		

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S9999	<p>Continued From page 20</p> <p>Medical Services (EMS) arrived and resident extremely confused and combative while responding inappropriately. EMS informed this nurse they would be taking the resident to a different hospital instead for better plan of care. This resident has no contacts listed."</p> <p>R32's Resident Incident Report dated 10/3/2022 at 7:20 PM, "Resident was noted to be yelling and rocking his wheelchair and tipped it backwards in the hallway. Nurse assessed resident. Range of Motion performed. Resident placed back in his wheelchair. DON and NP notified of fall. NP gave order to send to ER for evaluation. Knot/hematoma to back of head 2 x 2 centimeters. Additional Follow ups: Sent to Emergency Room for evaluation. Admitted to hospital with altered mental status, subarachnoid hemorrhage stroke, will place anti roll backs on resident wheelchair upon his return." The Incident Report was not reported to the state until 10/6/2022.</p> <p>R32's Initial Report dated 10/6/2022 documents, "(R32) fell at approximately 7:15 PM on 10/3/2022, (R34) was transferred to Emergency Room for a bump of his head. He was admitted to hospital with altered mental status and a subarachnoid hemorrhage per the Nurse on 10/5/2022 at approximately 5:30 PM. Final to follow. This report was not sent to the state until 10/6/2022.</p> <p>R32's Incident/Accident Report dated 10/3/2022 at 7:20 PM, documents, "resident started yelling and attempted to tip wheelchair. Large hematoma to back of head. Resident sent to Emergency Room.</p> <p>On 10/7/2022 at 1:45 PM, V26, Registered Nurse</p>	S9999		
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S9999	<p>Continued From page 21</p> <p>(RN) stated, "If a resident has a fall there is a neurological evaluation form in the drawer at the nurse's station that we are supposed to fill out and then place in the resident's chart."</p> <p>On 10/17/2022 at 2:22 PM, R32's chart was reviewed and does not have any Neurological Evaluation Flow Sheet present in his chart or Incident Report. No neuro checks were present in the R32's medical records.</p> <p>R32's Hospital Records dated 10/3/2022 at 808 PM, "(R35) us a 55-year-old male with past medical history significant for hypertension, hyperlipidemia, type 2 diabetes mellitus, right branch vein occlusion, and chronic left cerebellar stroke who present with AMS (altered mental status) and vomiting of S/P (Status post) fall from wheelchair. The fall occurred at an unknown time. There was unknown LOC (loss of consciousness). They did not arrive on a backboard and continued to remove the c-collar. The patient is altered and unable to provide a history due to mental status. On arrival, patient was reported to be alert and orientated x 2 but not on exam now, patient is non-verbal and lethargic."</p> <p>R32's Hospital Records dated 10/4/2022 document, "Admitted to the Intensive Care Unit (ICU) overnight. Worsening head bleed on CT (Computed tomography), follow up ordered. Platelet dysfunction addressed." R32's Assessment documents "focal hemorrhagic confusion of cerebrum."</p> <p>On 10/11/2022 at 10:33 AM, V1, Administrator stated, "I did not view the incident on the camera because it happened in the lounge area right in front of the area where residents go outside to</p>	S9999		

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S9999	<p>Continued From page 22</p> <p>smoke. The camera did not catch the fall."</p> <p>On 10/11/2022 at 10:41 AM, V17, LPN, Agency nurse stated, "I did not witness (R34's) fall. I do not what his behavior were occurring at the time because I was not there. I was told (R32) threw himself from his wheelchair and the CNA put him back into his wheelchair and brought him to me. The CNA had got him up and he was in his wheelchair when I saw him. I am agency so I cannot tell you who the CNA was. I had to run around trying to find his chart, and the physician's information. (R34's) pupils were blown and his pupils were large. I was scared he had a brain bleed. I did not document any neuro checks on him, but he was with me the whole time."</p> <p>On 10/11/2022 at 12:46 PM, V33, Medical Director stated, "Any resident with a fall I would expect staff to follow protocol and assess the residents, do neuro checks on the residents and send the resident out to the hospital. If a resident was yelling out, I would expect staff to try and find out why they were yelling and what was going on with them."</p> <p>On 10/11/2022 at 11:42 AM V32, R32's hospital nurse stated (R32's) CAT scan (CT) documents, R32 has an acute subdural hemorrhage, an acute subarachnoid hemorrhage, and an acute intraventricular hemorrhage. V32 stated these are all documented as acute, so the head injuries were caused from R32 falling and hitting his head.</p> <p>The Interdisciplinary Fall Reduction/ Injury Prevention Protocol with a revision dated of 7/12 documents, "An interdisciplinary approach at reducing falls, preventing injury and increasing</p>	S9999		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL6001986	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  10/11/2022
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NAME OF PROVIDER OR SUPPLIER  GRANITE NURSING & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 CENTURY DRIVE GRANITE CITY, IL 62040
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(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 23  safety awareness ultimately resulting in improved quality of care for our residents. Witnessed statements are to be obtained as soon as possible post fall, by all staff members working on that unit."  (B)	S9999		