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
	IL6001358	A. BUILDING: ______ B. WING ______	C 04/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLESTON REHAB & HEALTH CC	716 EIGHTEENTH STREET CHARLESTON, IL 61920

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S 000	Initial Comments Facility Reported Incidents of March 18, 2022 and March 24, 2022 IL145719	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 a) 300.1210 b) 300.1210 c) 300.1210 d)6) 300.1220 b)2) 300.1220 b)3) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. 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. 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: 2) Overseeing the comprehensive assessment of the residents' needs, which	S9999		

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include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

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.

These requirements are not met as evidenced by:

Based on record review, observation, and interview, the facility failed to develop and implement interventions to prevent falls, failed to complete fall risk assessments, and failed to ensure equipment was functioning correctly to prevent falls for three of four residents (R3, R2 and R4) reviewed for falls in the sample list of five residents. As a result of these failures, R3 fell and suffered an intraventricular (brain) hemorrhage and a femur fracture, R2 fell and suffered a laceration requiring sutures, and R4 fell and suffered a laceration requiring sutures.

Findings include:

1. R3's Physician Order Sheet (POS), dated April

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S9999	Continued From page 3 1-30, 2022, documents medical diagnoses of Subdural Hemorrhage Following Injury, Trauma, Traumatic Intracerebral Hemorrhage with Loss of Consciousness, Closed Displaced Fracture of Right Femoral Neck and history of Diabetes Mellitus, Unspecified Visual Loss, Paroxysmal Atrial Fibrillation and Encephalopathy. This same POS documents a Physician order of 'May have siderails on bed.' R3's Minimum Data Set (MDS), dated 3/19/22, documents a Brief Interview for Mental Status score of 4 out of 15 possible points, indicating R3 is severely cognitively impaired. This same MDS documents R3 as requiring extensive assistance of one person for bed mobility and total assistance for transfers. R3's Care Plan, dated 9/28/21, documents a fall intervention of, "Use body pillow at edge of bed to remind resident (R3) of boundaries." This same Care Plan has a separate fall intervention, dated 9/28/22, documenting, "When pillow is being washed, place other pillows at edge of bed." R3's Medical Record did not include a Fall Risk Assessment. R3's Final Incident Report to Illinois Department of Public Health (IDPH), dated 4/7/22, documents "Conclusion: (R3) was sent to the hospital and then transferred to another hospital on 4/3/22 for an unwitnessed fall in room. Computerized Tomography (CT) scan revealed Intraventricular Hemorrhage and Closed Displaced Fracture of Right Femoral Neck. (R3) admitted to hospital. Facility believes that the root cause of the alleged fall on 4/3/22 was a result of (R3) rolling out of bed due to restlessness."	S9999		

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R3's CT Brain Without Contrast results, dated 4/3/22, documents, "Impression: Acute hemorrhage has developed in the dependent portion of the occipital horn of the lateral ventricles. There are two small parenchymal hematomas in the genu of the corpus callosum on the left, each measuring less than seven millimeters (mm)."

R3's X Ray Report results, dated 4/3/22, document, "Impression: Subcapital Fracture Right Femur with mild impaction and dorsal cortical overlap. Non-displaced fracture through the Greater Trochanter also suggested."

On 4/16/22 at 4:40 AM, V13, Licensed Practical Nurse (LPN), stated, "(R3) was found laying on the floor next to bed, laying on back on floor mat. We (staff) think (R3) must have hit head on waste basket during fall. (R3) did not have a side rail on (R3) bed. (R3) used to have siderails, but (R3) hadn't had the side rails on since (R3) moved back into this room after having COVID-19. I (V13) do not think there was a body pillow in place. (R3) did not have it with (R3) on the floor, and it wasn't on the bed." V13, LPN, stated "(R3) used that body pillow when (R3) rolled over. (R3) would hug it and that is how (R3) knew to stop rolling. Since (R3) didn't have the pillow and siderails, (R3) just kept rolling and rolled out of bed."

On 4/16/22 at 5:40 AM, V15, Certified Nurse Assitant (CNA), stated, "I saw (R3) about 30 minutes prior to fall on 4/3/22. We (staff) heard the fall. (R3) must have fallen hard for how loud the crash was. (R3) was laying on the floor on and off the floor mat. (R3) had a knot on (R3) head. The nurse assessed and called for 911. We (staff) did not move him because of the

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injuries. You could tell (R3) was hurt bad. (R3) did not have the body pillow in (R3) room. (R3) did not have siderails on the bed. (R3) did have a regular pillow between (R3) knees, but there was no body pillow."

On 4/18/22 at 11:05 AM, V2, Director of Nursing, stated, "We (facility) are not able to find the Fall Risk Assessments for (R3). I (V2) have looked everywhere and cannot find them. The Fall Risk Assessments provide a score that relates to the resident level of risk for falls. This should be a part of the Care Plan. This should be a part of their care processes. The Fall Risk Assessment score determines what interventions should be placed on the Care Plan. It is very important and we (facility) either did not do them or we (facility) simply can't find them. Those assessments should be a part of the hard chart. They (staff) should be following the Physician orders. Since (R3) had the order for siderails, they should been in place. Between the body pillow and the siderails, those could have prevented this fall."

2. R2's undated Face Sheet documents medical diagnoses of Facial Laceration, Fall, Arthritis of Right Knee, Macular Degeneration, Cataract Left Eye, and Left Ureteral Stenosis.

R2's Minimum Data Set (MDS), dated 3/25/22, documents R2's Brief Interview for Mental Status score of 11 out of 15 possible points, indicating moderate cognitive impairment. This same MDS documents R2 as requiring one assist for transfers, walking in room, locomotion on unit, and toileting.

R2's Care Plan documents a fall intervention, dated 3/13/22, of "pressure alarm on bed."

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S9999	Continued From page 6 R2's Medical Record did not include a completed Fall Risk Assessment. R2's Final Incident Report to Illinois Department of Public Health (IDPH), dated 3/31/22, documents, "Conclusion: Facility believes that the alleged fall on 3/24/22 was a result of the resident (R2) getting up and walking to bathroom on his (R2) own. (R2) stated 'I fell while attempting to go to the bathroom.' (R2) returned same day from emergency room with seven sutures above Right Eye." This same report also documents, "(R2) entered room across the hall of his bedroom. (R2) was unaware that was not his room." R2's Hospital Records, dated 3/24/22, document (R2) diagnoses of Facial Laceration and Fall. This same record documents R2 received seven sutures to above Right Eye due to laceration received from fall. On 4/15/22 at 10:00 AM, R2's call light had been activated, and was making an intermittent buzzing sound. (R2) walked out of bathroom and sat on side of bed independently. Bed alarm was not sounding. At 10:04 AM, V6, Certified Nurse Assistant (CNA), entered room asking (R2) if R2 needed assistance to bathroom. (R2) responded, "I have already done that. You are too late." V6 assisted (R2) back in bed. V6, CNA, stated, 'Why isn't your bed alarm sounding? It should be going off right now and it is not." On 4/15/22 at 10:05 AM, V6, Certified Nurse Assistant (CNA), stated, "(R2) is a nice gentlemen and he (R2) forgets everything. (R2) is supposed to be one assist but sometimes (R2) just gets up on his (R2) own. Sometimes (R2) turns off the alarms on the bed or chair, but this	S9999		

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time the alarm just didn't sound on its own. It (alarm) was plugged in and set up ok, it just didn't sound. That alarm lets us (staff) know when (R2) is getting up on (R2) own. (R2) could fall and get hurt again if the alarm doesn't sound."

On 4/16/22 at 5:30 AM, V12, Housekeeper, stated, "I (V12) was the first one to find (R2) (on 3/24/22). I (V12) heard someone yelling so went to find out what was going on. (R2) was laying on the floor inside the room across the hall from (R2) room. The outside door was closed. (R2) had blood all over his face. (R2) is supposed to have a bed alarm but it was not sounding."

On 4/16/22 at 6:05 AM, V16, Certified Nurse Assistant (CNA), stated, "When I (V16) checked on (R2) early that morning before (R2) fall, (R2) was still in room with alarm on bed. (V16) don't know if it was working or not because I (V16) didn't check it then. These alarms don't work half the time."

On 4/16/22 at 10:00 AM, V1, Administrator, stated, "Alarms do not stop residents from falling. Alarms let the staff know when a high fall risk person is trying to get out of bed or chair. The staff can then go assist the resident before a fall happens. (R2) got up on his own and the alarm didn't sound so the staff couldn't have known that (R2) was up. (R2) ended up falling and receiving stitches over (R2) eye." V1, Administrator, confirmed R2's personal bed alarm was care planned prior to R2's fall on 3/24/22, and was not functioning properly at time of fall.

3. R4's undated Face Sheet documents an admission date of 1/18/22.

R4's Minimum Data Set (MDS), dated 1/25/22,

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S9999	Continued From page 8 documents R4's decision making ability as severely impaired. This same MDS documents R4 as requiring extensive assistance of one person to transfer. R4's Physician Order Sheet (POS), dated January 1-31, 2022, documents medical diagnoses of Dementia, History of Falls and Recent history of Blunt Head Injury, Facial Contusion, Intertrochanteric Left Femur Fracture and Fracture of Neck of Left Humerus. R4's Medical Record did not include a Baseline Care Plan. R4's Comprehensive Care Plan did not include fall focus area, goal, nor fall interventions prior to R4's 1/29/22 fall. R4's Medical Record did not include a Fall Risk Assessment. R4's Assess, Intercommunicate, and Manage Report, dated 1/29/22, documents, "(R4) found in room laying next to closet on Left side. Skin tear to Left Shoulder. Laceration to Left Ear. (R4) stated hit head. No signs of bruising or injury on top of head. Steri strips applied to skin tear. Bleeding stopped." R4's Final Incident Report to Illinois Department of Public Health (IDPH), dated 1/31/22, documents, "Summary: (R4) Alert and oriented x 1 and full assist had an unwitnessed fall hitting Left Shoulder and Left Ear on floor. Was sent to Emergency Room for evaluation. Laceration on inner Left Ear was sutured. (R4) had a previous Left Humerus Fracture prior to admission." R4's Hospital Record, dated 1/29/22, documents	S9999		

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a 1.5 centimeter (cm) laceration to Preauricular Area, 1.5 cm laceration to Concha area, 8 millimeter (mm) laceration to edge of Antihelix area and 6.0 cm x 4.0 cm skin tear to Left Upper Extremity. Four sutures were applied to Concha and Antihelix area.

On 4/18/22 at 11:15 AM, V2, DON, stated, "(R4) admitted with fractures from a fall in another facility. We (facility) should have been aware that (R4) was a high fall risk, (R4) fall history should have been on the baseline care plan and then on the comprehensive care plan and it wasn't. We (facility) can't find the Baseline Care Plan or the Fall Risk Assessment and the Comprehensive Care Plan does not include any information about falls until (R4)'s fall on 1/29/22. I (V2) have looked everywhere and cannot find them. The Fall Risk Assessments provide a score that relates to the resident level of risk for falls. This should be a part of the Care Plan. This should be a part of their care processes. The Fall Risk Assessment score determines what interventions should be placed on the Care Plan. It is very important and we (facility) either did not do them or we (facility) simply can't find them. Those assessments should be a part of the hard chart. The staff did not have any interventions in place to guide them in trying to prevent falls for (R4)."

On 4/18/22 at 2:35 PM, V19, Medical Director, stated, "The facility is responsible for determining the risk for someone to fall. This is the responsibility of the staff. The fall risk is determined and should be a part of the plan of care. When this facility did not complete the Fall Risk Assessments and Care Plan, they (facility) have not thoroughly reviewed the residents needs and therefore sets that resident up for injury from falls. They (facility) should have completed all of

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S9999	Continued From page 10 the assessments to provide thorough care and try to prevent falls." The facility policy titled 'Fall Prevention', revised 11/10/18, documents the following: "Policy: to provide for resident safety and to minimize injuries related to falls; decrease falls and still honor each resident's wishes/desires for maximum independence and mobility. Procedure: 1. Conduct fall assessments on the day of admission, quarterly and with a change in condition. 2. Identify on admission the resident's risk for falls. 3. Assessments of Fall Risk will be completed by the admission nurse at the time of admission. Appropriate interventions will be implemented for residents determined to be at high risk at the time of admission for up to 72 hours. 4. Assignment of the final risk category will be determined by the Interdisciplinary team (IDT) at their conferences based on: Fall Risk Score, History of Falls, Medical condition which directly impacts on equilibrium and/or ambulation. And Discussion of individual circumstances." The facility policy titled 'Baseline Care Planning', revised 11/1/17, documents the following: "A plan of care (Baseline Care Plan) shall be developed to include instructions needed to provide effective person-centered care to each resident, based on his/her initial assessment and the professional standards of quality of care, to serve as a functional guide in delivery of care until such time as a comprehensive plan is developed. The Baseline Care Plan shall be completed within 48 hours of admission by the admitting nurse or designee."	S9999		

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