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
	IL6008056	A. BUILDING: ______ B. WING ______	C 06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCOLADE HC OF EAST PEORIA	500 CENTENNIAL DRIVE EAST PEORIA, IL 61611

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S 000	Initial Comments Complaint Investigation 2424364/IL173920	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. 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	S9999		

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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 interview, observation and record review, the facility failed to ensure a resident was properly positioned on a bed pan in bed to prevent a fall for one (R1) of three residents reviewed for falls in the sample of 5. This failure resulted in R1 sustaining a fall out of bed resulting in R1 suffering a painful left cheek laceration requiring stiches to the laceration, a closed head injury, and an abrasion to (R1's) left second toe requiring hospital treatment.

Findings include:

The facility's Fall Prevention Program policy dated 10/2023 documents, "Policy: To provide guidelines on preventing resident falls or injury. Procedure: Individualized Care Plan- 1. Identify problem or need."

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The facility's Positioning the Resident policy dated 7/2023 documents, "Purpose: To provide guidelines to staff for properly positioning residents while maintaining good body alignments and using proper body mechanics. Policy: Residents who are unable to reposition themselves assistance will be repositioned by staff to relieve pressure, prevent skin breakdown, relieve pain, and promote proper body alignment. Responsibility: It is the responsibility for all nursing staff to ensure that residents are frequently and properly repositioned."

R1's current Admission Record documents R1 was admitted on 8/30/2024. This same form documents R1 has the following, but not limited to, diagnoses: Chronic Obstructive Pulmonary Disease, Type Two Diabetes Mellitus with other specified complications, Rheumatoid Arthritis, Major Depressive Disorder, Post-Traumatic Stress Disorder, State Two Chronic Kidney Disease, Unspecified Osteoarthritis, Barrett's Esophagus without dysplasia, and Morbid (severe) Obesity with alveolar hypoventilation.

R1's Minimum Data Set dated 4/30/24 documents R1 is cognitively intact and was not coded for exhibiting any behaviors. This same form documents R1 is receiving Hospice services.

R1'S Care Plan dated 5/10/2024 documents, "(R1) has an ADL (activities of daily living)/mobility self-care performance related to weakness, pain, exertional dyspnea, and morbid obesity. Interventions: Bed mobility- (R1) can turn and reposition herself in bed every two hours and as necessary. Provide more assistance as needed due to anticipated decline with terminal prognosis. Toilet use- (R1) requires moderate

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assist 1-2 staff for toileting. Provide assistance as needed to due to anticipated decline with terminal prognosis." This same care plan documents R1 is at risk for falls related to weakness, unsteady balance, pain, and morbid obesity.

R1's ED (Emergency Department) Notes dated 5/19/2024 document, "Chief Complaint: Fall- (R1) a 57-year-old female with a history of chronic respiratory failure on four liters nasal cannula, Diabetes, Chronic Obstructive Pulmonary Disease, paroxysmal atrial fibrillation not on anticoagulation, presenting to the ED after fall out of bed. (R1) rolled out of bed and cut her left cheek on a nightstand, and then fell to the floor, landing on her face. Denied landing on her back or neck. No loss of consciousness. (R1) additionally hit her left second toe during the fall. Physical Exam: Skin- 5cm (centimeter) superficial linear laceration of the left cheek the maxilla. Hemostatic. 1cm superficial hemostatic skin tear on the dorsum of the left second toe. Clinical Impressions: Facial laceration, toe abrasion, ground-level fall, and closed head injury." This same note documents R1 received 7 sutures to R1's left cheek.

R1's Incident Report dated 5/18/2024 and signed by V3 (Former Registered Nurse) documents, "Nursing Description: This nurse was notified by the nurse assistant that (R1) was on the floor. Upon arrival in the (R1's) room, I observed (R1) laying on the floor next to her bed while bleeding from her left cheek. Call light was within reach. (R1) stated that she was in the process of using a bed pan and she ended up falling to the floor. (R1) is reporting hitting her head on the floor. (R1) has a 5.5cm deep skin cut to left of her cheek, around cut measuring 0.5cm on her left

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great toe.

R1's Progress Note dated 5/19/24 and signed by V9 (RN/Registered Nurse) documents, "R1 was observed on the floor approximately 11:00 PM, (R1) was lying on her left side with her head between the oxygen concentrator and the table beside her HOB (head of bed), bed pan lying on the floor somewhat under (R1's) buttock, large amount of bright red blood noted on the floor. (R1) stated she was bleeding from her face, small amount of bright red blood noted on the floor by (R1's) left foot."

R1's IDPH (Illinois Department of Public Health) Reportable (undated) documents, "Original Incident: On 5/18/2024 at 11:00 PM, (R1) was using the bed pan when she rolled out of bed resulting in a fall with a laceration to left cheek. Conclusion: (R1) has a complex and terminal medical condition which at times requires additional assistance of staff to position self in the middle of the bed. Continued staff education provided on safe bed positioning.

On 6/11/2024 at 10:41 AM R1 was in her room sitting in her wheelchair. A small scar was noted to R1's left cheek. R1 was dressed and groomed appropriately. R1's nasal cannula was in place. R1 was visibly upset and stated, "The night I fell out of bed (V4/Certified Nursing Assistant) and (V5/Certified Nursing Assistant) were just in my room prior to that and placed me on the bedpan. When (V4) was done positioning me on the bed pan, I told (V4) that I was too close to the side of the bed and that I felt like I was going to fall out and didn't feel safe. (V4) told me that I was not close to the edge of the bed and that I was fine. (V4) did not assist in repositioning me and I was unable to re-position myself. (V5) was brand new

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so she was just following everything (V4) said. When (V4) left the room, a few minutes later I felt myself sliding off the bed. I rolled off hitting my face on my bedside table and hurting my toe. I was in horrible pain and had to go to the ED. My left cheek still causes me pain."

On 6/11/2024 at 12:30 PM V2 (DON/Director of Nursing) stated, "If a resident requests for assistance the staff should provide it. If a resident is unable to reposition themselves in bed and requests for help, the staff should provide the assistance and ensure the resident feels safe."

On 6/13/2024 at 11:36 AM V10 (Hospice Registered Nurse) stated, "I have only worked with (R1) one time. I am not (R1's) main nurse, her main nurse is off for the week. When I worked with (R1), (R1) stated she was becoming weaker that's one of the reason's she was picked up for therapy because of her decline in her ADL (activities of daily living) status.

On 6/13/2024 at 2:48 PM V9/RN stated, "I have been (R1's) main nurse on night shift since (R1) admitted to (the facility). I have not known (R1) to make any false accusations. I do know that (R1) says that she has become weaker since she has received Hospice services and has been asking for more assistance. (R1) is a bigger lady so she has to be positioned just right in her bariatric bed."

(B)