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
	IL6004840	A. BUILDING: _____ B. WING _____	C 11/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSONVILLE SKLD NUR & REHAB	1517 WEST WALNUT STREET JACKSONVILLE, IL 62650

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S 000	Initial Comments Complaint# 1948515/IL117659 Statement of licensure violations	S 000		
S9999	Final Observations 300.610a) 300.1210b)5) 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 resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:	S9999	Attachment A Statement of Licensure Violations	

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5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning

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 provide adequate supervision and assistive devices to prevent falls for 2 of 4 residents (R2, R3) reviewed for falls in the sample of 5.
This failure resulted in R3's fall from the toilet sustaining a left femur fracture.

Findings include:

1. R3's Physician Order Sheet (POS) documents that R3 was admitted on 6/25/19 with the diagnosis of Altered Mental State; Nondisplaced Commuted Fracture of the Left Femur, Left Humerus Fracture in part.

R3's Minimum Data Set (MDS), dated 7/8/19, documents that R3 had moderately impaired cognition, required extensive assistance of two persons with transfers and toilet use, balance

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was unsteady with only an ability to stabilize with staff assistance when moving on and off the toilet.

R3's care plan, dated 7/14/19, documents that R3 is dependant on staff with toileting needs due to fractures and requires an assistance of two persons with toileting needs. R3's fall care plan, dated 6/27/19, documents that R3 is at risk for falls related to cognitive impairment, history of falls, poor safety awareness, unsteady gait and weakness, with an intervention to keep the call light in reach. There is no assessment of R3's ability to use the call light or what level of supervision and how R3 would be adequately supervised to prevent falls due to her impaired cognition, unsteady gait and poor safety awareness.

R3's Fall Risk Assessment, dated 6/25/19, documents R3 as being at high risk for falls.

R3's Fall report, dated 7/15/19 at 6:50 AM by V5, Licensed Practical Nurse (LPN), documents R3 had an unwitnessed fall during a self transfer from the toilet. The report further documents R3 required assistance with this task. Possible contributing factors identified as acute illness and resident did not use assistive device. R3 was unable to communicate what occurred, was alert to person, and orientation level was normal for resident. R3's Left hip was deformed / misaligned, Pain level of 8; Grimacing with pain; movement and sensation intact to right arm & right leg; No movement or sensation in the left arm and left leg; Unable to complete range of motion to the left arm due to history of fracture and unable to complete on the left hip due to pain with rotation noted.

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The facility investigation report to the Illinois Department of Public Health, dated 7/19/19 by V3, Director of Nurses (DON), documents that R3 had an unwitnessed fall on 7/15/19 at 6:50 AM which resulted in a left femur fracture and R3 was subsequently admitted to the hospital for further treatment. The investigation report further documents that R3 requested to use the bathroom at 6:40 AM and V6 and V7, Certified Nursing Assistants (CNAs), wheeled R3 to her room and placed R3 on the toilet using a gait belt. V6 remained in the room with R3, but then left the room to assist another resident leaving R3 alone in the bathroom by herself. R3 agreed to put the call light on when finished. At approximately 6:50 AM, V8 responded to R3's call light and observed R3 on the bathroom floor. V5, LPN was notified and observed R3 lying on the floor with her head near the sink and her feet at the toilet. R3's left hip was "misshapen" and she was left in place and EMS (Emergency Medical Services) was activated. R3's physician & family were notified. On 7/15/19, V5, LPN confirmed with the hospital that R3 was admitted with a left femur fracture. In the investigation summary, it states that the facility was unable to determine if the fall caused the fracture or if the fracture caused the fall and the facility would train on the toileting of residents.

R3's hospital X-Ray report for the left femur, dated 7/15/19 at 7:50 AM, documents a displaced obliquely oriented fracture distal to the femoral hardware.

R3's death certificate documents R3 expired on 8/23/19 with the cause of death listed as cardiac arrest and fractured femur.

On 10/20/19 at 11:30 AM, V1, Administrator, stated that R3 was admitted to the facility on

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6/25/19 after sustaining a fall at home which resulted in several fractures. V1 stated that R3 did have a fall at the facility and fractured her femur. V1 stated R3 was admitted to the hospital and did not return to the facility.

On 10/20/19 at 11:40 AM, V7, CNA, stated that R3 requested to use the bathroom and she and V6, CNA, transferred R3 to toilet with a gait belt. V7 stated that she left the room to help another resident and V6 remained in the room with R3. V7 states that V8, CNA, later found R3 on the floor. V7 stated V6 had left the room leaving R3 unattended on the toilet. V7 stated that R3 required assistance of two staff members with a gait belt for transfers. V7 stated she was unaware of what R3's care plan stated in regards to her transfer status, however, on each resident's door is a card that states what their transfer status is. V7 stated that she was unaware of R3's cognitive status, but stated that R3 didn't like to do things or get up. V7 stated that R3 didn't try to get up on her own normally and R3 would use her call light or yell out if she needed help or assistance.

On 11/21/19 at 8:35 AM, V6, CNA, stated that R3 was in the common area and had requested to use the bathroom. V6, CNA, stated that R3 required an assistance of two with a a gait belt for transfers. V6 stated she and V7, CNA, assisted R3 with a gait belt to the toilet. V6 stated after R3 was placed on the toilet, she removed the gait belt from R3 and pushed the wheelchair out of the bathroom. V6 stated that R3 said that she needed to have a bowel movement and requested privacy. V6 stated that she stepped out of the room to help another resident. V6 stated that R3 put the call light on while she was out of

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the room. V6 denied witnessing R3's fall. V6 stated that R3 had not tried to get up before without assistance that she was aware of. V6 stated R3 wasn't "super confused", R3 knew her name and other's names. V6 stated that there are codes on the doors that state what the resident's transfer status is and if there is a change, they are notified during change of shift report. V6 stated, after R3's fall, she was educated to stay with residents in the bathroom if assistance is needed .

On 11/21/19 at 10:45 AM, V13, LPN, stated she was unaware of how the facility assessed R3's ability to use the call light due to R3 having impaired cognition and poor safety awareness. V13 stated R3's bowel and bladder care plan addresses R3's transfer status for toilet use. V13 stated she was unaware why that information was not included on the fall prevention care plan. When asked how the facility would provide adequate supervision to prevent falls for a resident that has impaired cognition, poor safety awareness and unsteady gait, V13 stated interventions would be put in place like keep them busy or engaged and those interventions would be placed on different parts of the care plan. When asked why R3 did not have interventions on the care plan for supervision related to fall prevention, V13 stated she was unaware why those interventions were not included on the care plan.

V14's, R3's Physician, written response to questions regarding R3's fall, dated 11/26/19, documents that the standard of practice would have been to provide supervision during toileting due to R3's history of falls, high fall risk, unsteady gait, poor safety awareness and moderate cognitive impairment.

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The facility's undated Fall Management policy & procedure, documents the purpose is to evaluate risk factors and provide interventions to minimize risk, injury, and occurrences by evaluating risk factors for sustaining falls and initiating a fall prevention care plan with strategies to minimize risk and potential for injuries. The care plan should identify the fall risk, document goals for minimizing falls and outline fall prevention strategies and approaches.

2. The MDS, dated 8/14/19, identifies R2 as having severe cognitive impairment and requires extensive assist of one staff for transfer. The MDS also documents R2 required extensive assist of one staff to ambulate in/out of her room and in all aspects of balance is documented as "not steady, only able to stabilize with staff assistance."

The Care Plan, dated 5/15/19 revised 8/14/19, identifies R2 to be at high risk for falls due to use of Cardiovascular, Pain and Other Medications, cognitive impairment, history (HX) of falls, poor safety awareness, unsteady gait, and weakness. The goal is to decrease risk of fall and/or minimize injuries from falls in the next 90 days with interventions being as follows: Assess toileting needs, Attach bag to wheel chair to hold newspaper, Encourage use of call light Date Initiated: 05/19/2019, keep call light and personal belongings within reach.

The Fall Log documents R2 to have had three recent falls, on 7/21/19, 8/21/19 and 9/9/19.

The facility's Investigation documents R2 had a witnessed fall on 7/21/19 and that V4, CNA, assisted her to the bathroom the morning of the

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fall. The investigation documents as R2 was "coming out of the bathroom, she stooped down to retrieve something from the floor and lost her balance." The report documents V4 was unable to intervene quick enough to prevent the fall and x-rays obtained on 7/22/19 were negative for fracture. The report documents that no assistive device (her walker) was being used at the time. The report documents R2 continued to complain of pain and a CT (Computed tomography scan) was done on 8/9/19 which revealed a transverse process fracture at the L1 level, a deformity of T12 and a second CT scan was ordered and completed on 8/16/19. This CT scan revealed age-discriminate compression fracture deformities of the T11 and T12 vertebral bodies and defuse demineralization. The Investigation does not identify a root cause of the fall.

The care plan, revised to reflect the fall on 7/21/19, documents, The resident has had an actual fall with the goal being "the resident will resume usual activities without further incident through the review date." Only one intervention was added which was "Monitor/document /report PRN (as needed) x 72h (hours) to MD (medical doctor) for s/sx (signs/symptoms): Pain, bruises, Change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation." No interventions were added to prevent further falls based on the root cause analysis of the fall. There is nothing in the care plan interventions addressing R2's poor safety awareness, her getting up unassisted, her need for increased supervision and her lack of using the walker when ambulating in her room.

The SBAR (Situation, Background, Assessment, Recommendation) form, dated 8/21/19, documents R2 had a fall on 8/21/19 at 4:13 AM.

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The report documents R2 was found on the floor near her bathroom, didn't use assistive device and her call light was not activated. The report documents R2 "overestimates limitations" but there is no root cause analysis of the fall. The report documents R2 complained of "the same pain she had before."

The care plan, revised on 8/21/19, adds the following interventions: Low Bed, Mat at bedside when in bed, OT (occupational therapy) evaluation and treat if indicated, and bed alarm. There is no explanation as to why these particular interventions were implemented when she didn't fall out of bed, but rather got up unattended. The facility did not identify R2's need for increased supervision, getting up unassisted, and/or take into consideration her toileting needs since this was her goal in getting up.

The Physician's Order Sheet (POS) documents an order, dated 8/26/2019, "may place bed and chair alarm related to repeated falls and poor safety awareness" .

The SBAR form, dated 9/9/19, documents R2 was again found on the floor. The description of the fall documented "Resident found at foot of bed. Alarm sounding. Resident stated 'I slid right off the foot of bed, I was trying to go to the bathroom'. Residents bed was lowered all the way down and call light was within reach." The report documents R2's alarm was sounding and the call light was not activated. The report documents R2 was "reeducated on the use of the call light." The section "Fall Care Plan Reviewed & Current Interventions effective" was blank as was the further comments with no revisions to the care plan documented following this fall. Again, the facility failed did not identify the root cause of

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the fall and take into consideration her cognitive impairment or ability to appropriately use a call light and her need for increased supervision given that she got up unassisted again.

On 11/20/19 at 11:30 AM, V9, LPN, stated R2 is alert, but confused and she'd never seen her use her call light appropriately.

On 11/20/19 at 11:36 AM, V10, CNA, stated R2 is a one person transfer and walk with assistance with a gait belt. V10 stated R2 does use her call light at times especially since she got the alarm. V10 stated R2 does try to transfer herself to and from the toilet unassisted, but not very often. V10 stated the alarm is a reminder for her to call or holler for help if she needs something.

On 11/20/19 at 11:55 AM, R2 was in her wheelchair wheeling herself to the dining room for lunch. R2 stated she felt fine and was hungry. R2 had an alarm on the back of her chair. R2's room was noted to be at the furthest end of the hall from the nurses station and would require someone to go into the room in order to see into the bathroom. R2 had floor mats bilaterally beside her bed.

On 11/21/19 at 1:00 PM, V13, Care Plan/MDS Coordinator, stated they have placed many interventions in R2's falls prevention, but acknowledged that increased supervision was not one of them. V13 confirmed that R2's room was at the end of the hallway, but stated that she is at activities a good portion of the time. V13 was unable to state whether R2 could consistently and appropriately use her call light to ask for assistance, but stated R2 could demonstrate it's use if asked to. V13 stated they initiated a "reacher" as an intervention with the first fall on

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7/21/19 even though the report clearly documents there was nothing on the floor to pick up.

On 11/21/19 at 1:33 PM, V1, Administrator, and V3, DON, stated they had considered moving R2 closer to the nurses station for increased visibility, but her son refused to have the room change done. V1 stated they meet and discuss falls after they occur, but haven't looked into how many times R2 uses her call light appropriately and/or if she uses it consistently. V1 stated they also do not know how many times her alarm goes off and staff respond appropriately in an effort to determine how effective the alarms are.

On 11/21/19 at 3:00 PM, R2 was at bedside in her wheelchair and was attempting to stand when her alarm went off as V15, CNA, entered her room. R2 stated she needed to use the restroom. A gait belt was applied and R2 was assisted to the toilet. R2 stated she appreciated the help, but didn't really need it. R2's stance was unsteady and she assisted herself by grabbing the bars beside the toilet. There was no walker in R2's room and V15 stated R2 does not use one that she's aware of.

On 11/21/19 at 3:20 PM, V4, CNA, stated on 8/21/19, she found R2 on the toilet and thought she'd gotten herself there from the bed. V4 stated she told her to stay on the toilet and she'd be right back. V4 stated R2 must have gotten up and followed her out of the bathroom because when she turned around, R2 was falling to the floor. V4 stated she did not see R2 reaching for anything on the ground as the investigation stated adding that she "just went down." V4 stated she did not see R2's walker in the bathroom and explained that she had a regular walker and one with a seat on it. V4 stated R2's alarm does not go off very often during the night shift when she

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S9999	Continued From page 11 works, but she has caught her trying to get up to go to the bathroom without assistance and/or her walker. V4 stated R2 no longer is walking with her walker. V4 stated R2 also removes her alarm at times (B)	S9999		