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
	IL6007181	A. BUILDING: _____ B. WING _____	12/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN REHAB & HCC	304 MAPLE AVENUE AUBURN, IL 62615

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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b)5) 300.1210c) 300.1210d)6) 300.1450 300.3240a) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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includes measurable objectives and timetables to 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.

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.

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

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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 300.1450 Language Assistance Services

A facility shall provide language assistance services in accordance with the Language Assistance Services Act [210 ILCS 87] and the Language Assistance Services Code (77 Ill. Adm. Code 940).

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These regulations are not met as evidenced by:

Based on interview and record review the facility failed to implement effective interventions and provide supervision to prevent falls for 2 of 4 residents (R39, R304) reviewed for falls in the sample of 27. This failure resulted in R39 falling twice and obtaining rib fractures, a pneumothorax, and laceration to her forehead and R304 falling and obtaining a right hip fracture.

Findings include:

1. R39's Medical Record documents diagnosis, Alzheimer's, Transient Ischemic Attack, Cerebral Infarction, Cognitive Communication Deficit, Major Depressive Disorder, Dementia, Schizoaffective Disorder, Bipolar Type.

R39's Minimum Data Set (MDS) dated 09/09/19,

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documents R39 has a severe cognitive impairment. Functional Status Needs extensive assist of 2 persons for transfers.

R39's Care Plan documents
"Focus: Resident is at risk for falls related to Gait/Balance problems. History of falls.
Interventions-Anticipate and meet (R39's) needs (initiated 5/23/15).
Eliminate potential hazards such as uneven surfaces, debris or clutter, spills or water on floor (initiated 3/14/16).
Ensure (R39) has on appropriate shoes for ambulation and that they are in good condition. To wear soft soled, diabetic, non-skid slipper. May replace if worn per family (initiated 8/23/16).
(R39) uses a merry walker to enhance her ability in a safe environment. Restraint release tasked for CNA's every 2 hours (initiated 1/17/17).
(R39) needs to be in high traffic areas while up in merry walker, due to unaware of safety needs. Re-educated caregivers (initiated 6/23/17).
When (R39) is in dining room chair, continuous supervision is needed (initiated 1/04/18).
When toileting (R39), staff must remain in the bathroom with her (initiated 7/07/18)."
Be sure (R39's) call light is within reach and encourage the resident to use it for assistance as needed (initiated 5/23/19).
(R39) is to be at a table where Certified Nurse Aide (CNA) is assisting others to monitor while in dining room chair (initiated 10/19/19).
(R39) will eat all meals in her merry walker at a supervised table (initiated 11/21/19)."

R39's Fall Investigation/Intervention Final Report dated 10/24/19 for fall on 10/19/19 documents, "On 10/19/19 resident was sitting at dining room

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table during dinner. She stood up and attempted to ambulate without assistance, lost her balance and fell backwards hitting the radiator. Nurse assessed resident and noted complaints of pain on the right side. Medical Doctor (MD) notified and obtained order to send to ER (emergency room) for evaluation and treatment. X-rays done in ER revealed right rib fractures and small pneumothorax, (collapsed lung), Resident admitted for pain control."

R39's Hospital records dated 10/19/19, document, "Computerized Tomography (CT) scan dated 10/19/19 documents CT of abdomen and pelvis with intravenous (IV) contrast. Findings: There are moderately displaced fractures identified involving the lateral aspect of the ninth and tenth ribs. There are mildly displaced fractures involving the lateral aspect of the right seventh and eighth ribs. There is associated focal pleural thickening involving the inferior and lateral aspect of the right hemithorax adjacent to the fractures. There is a tiny right basilar pneumothorax."

R39's Fall Investigation/Intervention Final Report dated 11/27/19 for fall on 11/21/19 documents "Resident has diagnosis of dementia and impulsive behavior. She was seated in dining room chair eating lunch. Once she finished eating, she stood and started to ambulate away from the table. She lost her balance and bumped her forehead on the table. Resident was taken to ER for evaluation and treatment. She received 5 sutures to her right forehead."

On 12/17/19 at 4:14 PM, V10 Certified Nurse Aide (CNA) stated, "I don't remember the name of the housekeeper, maybe it was (V11). On 10/19/19, I heard her tell (R39) to sit down and

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then I heard a loud smack sound and turned around and (R39) was on the floor. I wasn't sitting next to (R39) in the dining room, I was maybe 3 or 4 tables away from her."

On 12/18/19 at 10:00 AM, V11 Housekeeper stated, "On 10/19/19, (R39) was at the dining room table near the kitchen door, she got up and lost her balance and fell. No staff were sitting with her, they were in the back of the room feeding other residents."

On 12/18/19 at 1:45 PM, R14 (R39's roommate) stated, "On 11/21/19, I saw (R39) get up by herself and fall, no staff were with her."

On, 12/18/19 at 3:27 PM, V2 Director of Nurses, (DON), stated, "Staff should have been supervising (R39) in the dining room."

The facility Policy and Procedure for Fall Prevention dated 2001, revised February 2014, documents in part "DEFINITION: The S.A.F.E. program promotes Safety Assessment, Fall prevention and Education of both staff and residents. Program: #3. Following any falls, the facility staff completes an Occurrence Report. Details of the fall will be reported will be reported and potential causal factors identified and investigated. Interventions will be immediately implemented following each fall and added to the resident's plan of care. The staff will review the resident's Fall Risk Data Collection. An update or change to the data collection form would be made only if the resident the resident had previously been identified as low risk. 4. All Occurrences Reports are reviewed at the daily QA (quality assurance) meeting to ensure that an intervention was immediately implemented, added to the plan of care and that the current intervention is

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appropriate. #5. Occurrences will also be reviewed weekly at the facility Care Management Meeting to ensure, the occurrence report is completely finished and closed, that interventions were implemented timely and to evaluate the outcome of the interventions. Revisions to the plan of care will be done if indicated. Patterns and trends will also be reviewed at that time to enhance the success of the program.

2.R304's Care Plan, date 11/09/19, documents (R304) is at risk for falls gait/balance problems, unaware of safety needs. Interventions to anticipate and meet (R304's) needs. Be sure (R304's) call light is within reach and encourage her to use it for assistance as needed. Requires (2) staff participation with transfers.

R304's MDS, dated 11/12/19, documents resident is rarely/never understood with short and long-term memory problems and some difficulty in new situations. Totally dependent on 2 staff for transfers.

R304's Fall Risk Data Collection, dated 11/08/19, documents high risk for falls. Fall in the last 90 days. Unable to independently come to a standing position. Decrease in muscle coordination. Confined to a chair and disoriented.

R304's Progress Note, dated 12/4/19 04:10, Behavior Note Text: Resident was assisted to bed early last eve, approximately 2100, was found out of bed and sitting on the edge of her recliner at start of this shift. Later was found standing in the middle of her room and assisted to recliner. Resident laughs at staff and says "no" at each attempt to get her to lie down tonight. Was given crackers, peanut butter, a banana, and a slice of cinnamon raisin bread, as she was able to

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communicate that she wanted "dinner". After eating, still refused bed. The progress note does not document any attempts to toilet R304.

R304's Fall Risk Data Collection, dated 12/05/19, documents high risk for falls. Exhibits loss of balance while standing. Strays off the straight path of walking. Requires hands-on assistance to move from place to place. Uses short discontinuous steps and/or shuffling steps. Uses an assistive device, cane, walker, et cetera.

R304's Progress Note, dated 12/5/19 at 1:07 AM, documents R304 was in recliner with feet up, sitting on the "feet" of the recliner, sideways, facing her bed. Found by writer, walking by her room. Assisted resident to bed. Refused CPAP (continuous positive airway pressure, eventually allowed NC (nasal cannula) to stay on. Now, sleeping quietly. The progress note does not document any attempts to toilet R304.

R304's Progress Notes, dated 12/5/19 at 5:15 AM, documents the resident is experiencing a change in condition. The change in condition the resident is currently experiencing is "Resident found sitting upright, leaned against the wall in front of her toilet."

R304's Progress Notes, dated 12/5/19, documents "Resident complained of right hip pain and decreased ambulation. New order for hip x-ray. X-ray results showed partially impacted, intertrochanteric fracture. R304 was transferred to the hospital and admitted with diagnosis of right hip fracture."

R304's Emergency report information dated 12/05/2019 at 3:58 PM documents admission reason right hip fracture. Chief Complaint "Patient

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arrives by emergency medical service from Facility. Patient had a fall around 5:00 AM, had right hip X-ray with diagnosis of right hip fracture."

On 12/18/19 at 1:15 PM, V22, R304's son, stated, I had spoken with them about interventions when she first came here. She was at home with us forever. She never used a call light. She would yell out "Hey" and we would come and help her. I told them with the language barrier and her not understanding how to use the call was there anything else that could be done, an alarm, something. They said they don't have those. She had a blood transfusion that morning and she had energy."

On 12/18/19 at 2:00 PM V22 stated "My mom told me what happened. She says she got up and needed help to go to the bathroom. The staff came in and couldn't understand her and put her to bed. She then took herself and when she stood from the toilet she lost her balance and fell to the floor and laid there for about 2 hours before the staff came and found her."

On 12/18/19 at 3:15 PM, V2 stated, when she first came here she never tried to get up. She had a blood transfusion and I guess decided to get up and get moving. I know she can't really understand us. She has a low cognitive because she doesn't understand the words. Maybe if we used words she understands then it (score) would be better."

(A)