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
	IL6014260	A. BUILDING: ______ B. WING ______	C 09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THOMAS HERBSTRITT HOUSE	4003 N RTES 1 & 17, P.O. BOX 260 MOMENCE, IL 60954

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Z 000	COMMENTS Investigation of Facility Reported Incident of 7-18-21/IL136347	Z 000		
Z9999	FINDINGS Statement of Licensure Violations 350.620a) 350.700a) 350.1210b) 350.1230e) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.700 Incidents and Accidents 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. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health.	Z9999	**Attachment A** **Statement of Licensure Violations**	

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Z9999	Continued From page 1 These services include, but are not limited to, the following: b) Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent. Section 350.1230 Nursing Services e) Sufficient, appropriately qualified nursing staff shall be available, which may include licensed practical nurses and other supporting personnel, to carry out the various nursing service activities. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These regulations were not met as evidence by: Based on observation, interview and record review the facility failed to: 1) Ensure injury reports for resident injuries were reviewed by Quality Assurance Review Committee for origin, trend, patterns and resolution. 2) Ensure Individual Habilitation Team developed safety measures to prevent continuous injuries to R1. 3) Ensure nursing services assessed fall risks and developed safety measures to prevent falls with injuries for R1, R2, R3 and R4. 4) Ensure thorough investigations were conducted for unwitnessed and serious injuries to R1, R2, R3 and R4. 5) Ensure sufficient staff to provide service needs	Z9999		

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of residents who fall, were at risk for falls and who obtained injuries for falls.

These failures affected 4 of 4 (R1, R2, R3 and R4) residents. R1 experienced multiple witnessed and unwitnessed falls resulting in Subdural Hematoma, Intensive Care Unit admission and surgery, R2 obtained multiple unwitnessed falls resulting in injuries, R3 obtained a closed fracture of right rib, and R4 sustained trauma to the elbow after a fall. These failures have the potential to affect all other residents living in the facility (R5 - R11).

Findings include:

Facility Policy Section 425 "Qualified Assurance Review" dated 7/31/15 states, "(name of facility) has an established Quality Assurance Review Process and Committee which meets quarterly to review the following: 1. Examine all significant events including injuries, 2. Identify patterns and trends based on location, time of day, staff involved, participants involved." Section 426 "Policies and Procedures on Outcome Quality Assurance" states 5. Recommendations, as appropriate, will be made as to how programs can be better meet the needs of persons served on a regular basis."

Facility Policy Manual was reviewed and failed to include policies for investigated injuries of unknown source or for investigating incidents for signs of neglect.

On 9/14/21 starting at 11am observations were made of R1, R2, R3 and R4 in the day training program and during the lunch meal.

On 9/14/21 at 11:15am R1 was in his classroom

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Z9999	Continued From page 3 sitting in a recliner chair. R1 was observed as a thin man, responded to surveyor's greeting and questions with a smile. There was a 5 centimeter (cm) in length and approximately 2cm in width healed scar to the front left lateral scalp where hair is absent from this area. Staff in the classroom assisted R1 to transfer from the chair to a wheelchair. The manual wheelchair was too small for R1. R1 was observed moving at a fast speed and ate lunch independently then started to cry audibly and moving all extremities in the wheelchair. Observations were also made of R1's bedroom and the bathroom he uses on 9/14/21 at 3:30pm. The floor was tile and of a hard surface. There was 25 feet to the bathroom (across the hall) from R1's bed, and the second bathroom that R1 uses is 38 feet from his bed. R1 was currently not at the facility but at a local long term care facility. R1 was present today as a visit from the local skilled facility for assessment to determine if R1 could return to this facility. On 9/14/21 from 11:15 TO 11:45am R2 was observed sitting in a wheelchair, right arm in a soft cast with ace wrap and his right foot was elevated on the wheelchair footrest with a pillow. R2 had a blue transport device cloth that he was sitting on while eating lunch. R3 was observed ambulating with a walker R4 was observed with helmet on, unsteady gait while ambulating. Review of resident's records, hospital records, incident report and nursing progress notes document the following: 1. 5/13/21 - nurses note dated 5/13/21 written by E3 (Director of Nurses/DON) states, "R1 fell on	Z9999		

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floor while trying to sit at the table for lunch. No apparent injuries seen. R1 went to local hospital Emergency Department for evaluation."

2. 5/20/21 - nurse note written by (nurse signature illegible) states, "R1 fell to buttocks, no injuries;" "lungs wheezing;" "pursed lip breathing while ambulating resident sent to (local hospital)."

3. 5/25/21 - nurse note written by E3 (DON) states, R2 "seen by Z8 primary physician for follow up on ED visit for fall on 4/30/21."

4. 5/24/21 - R1's Individual Habilitation Plan (IHP) has an amendment on 5/24/21 which states "Emergency consent was received for use of a bed and chair alarm, gait belt and crash mat. Concern for recent fall. Discussion recommends bed alarm and chair alarm to alert staff when resident is getting out of bed and/or chair." R1 is 76 years old and has lived at the facility for 26 years, has a limited vocabulary, several diagnoses including Seizure Disorder and Right parietal craniotomy with removal of angioblastic meningioma.

5. 6/1/21 - R2's nurse's note written E18 (RN) states, "staff reported that resident was sitting on buttocks in the floor of the bathroom. No sign of injury at this time sent to (local hospital) ED via ambulance for evaluation."

6. 6/3/21 - R1's Hospital Emergency Department (ED) records written by Z5 (RN) at 11:58am document, "patient (Pt) presents to the ED" "after a fall while walking" "patient has abrasions noted to bilateral knees."

According to R1's Individual Habilitation Plan dated 8/14/21 R1 has limited vocabulary,

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Z9999	Continued From page 5 Intelligent Quotient (IQ) of 17 and mental age equivalent of 3 years and 7 months. Email dated 5/21/21 from E3 (DON) to E2 (President), E5 (Case Manager), E6 (Case Manager) and E1 (Director of Clinical Services) includes, "R1 also makes frequent back and forth bathroom trips at all hours of the day and night. He might need a bed alarm; he is nearly impossible to prompt or redirect when he walks around." 7. 6/29/21 - R1's Hospital ED records written by Z6 (ED Physician) at 7:46pm document, "patient to ED via emergency medical service (EMS) from (facility) for fall. Per EMS fall unwitnessed, staff found patient sitting on floor." "patient fell yesterday also." "Discharged back to facility with fall precautions." 8. 7/7/21 - Injury Report dated 7/7/21 at 5:45am written by E16 (DSP) states, "as I was walking down the hall I seen R3 on the floor with blood everywhere. He was aware of everything but was very shaky." "number of clients 10 number of staff 2". R3's hospital records written by Z14 (ED Physician) at 7:50am document, "the patient is a 64 year old male who presents to the ED for evaluation of fall and facial injury. The patient normally ambulates with a walker. He had just gotten up was wearing socks and was not ambulating with a walker lost his footing and fell face first onto the floor. He has no loss of consciousness; he does have some bruising to the area above his eye and to his nose with mild epistaxis." "He has a facial Computerized Tomography (CT) which shows Closed Nasal Bone Fracture. He has some epistaxis that was currently under control. Pt will be discharged back to (name of facility) he will be given an	Z9999		

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Z9999	Continued From page 6 ambulatory referral to follow up with ENT (Ears, Nose and Throat)." 9. 7/9/21 - R1's Hospital Emergency Department (ED) records written by Z9 (ED Physician) at 9:39pm, "Per chart review, was found on the bathroom floor and thus had a unwitnessed fall. Patient has been having numerous falls recently with multiple subsequent Emergency Room evaluations;" "unclear timing of bleed as he has had multiple falls recently." Z10 (ED Physician) states at 6:03pm "Fall impact surface: hard floor." "Spoke to Z7 (Neurosurgeon). Reviewed the patient's imaging with him as well as the patient's lab work. He asked to go ahead and admit patient for the Subdural Hematoma, keep the patient NPO (nothing by mouth) after midnight and he did ask that the patient have a chest xray and twelve lead electrocardiogram (EKG) performed should he need to take the patient to surgery sooner." On 7/11/21 at 10:02am Z11 (ED Physician) states, "Patient remains at his neurological baseline throughout the course of admission;" "neurosurgeon recommended follow up as outpatient in 4 weeks." Inservice given by E7 (Qualified Intellectual Disability Professional/QIDP) on 7/11/21 states, "1. R1 is to be assisted at all times while ambulating with his gait belt around him. 2. He is not to be left alone in his room or bathroom during wake hours. 3. Staff must absolutely ensure R1's seat alarm is on at all times when he is in the chair or in bed. If R1 removes the alarm staff must immediately place it back on. 4. R1 is at increasing risk for falling and further creating more serious injuries to himself; it is imperative that we do all we can to provide him with a safe environment. 5. Please make sure you are aware of R1's whereabouts at all times."	Z9999		

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10. 7/15/21 - nurse's notes written by E18 (Registered Nurse/RN) untimed states, R1 "resident tipped wheelchair backwards sent to (local hospital) ER for evaluation via 911." "returned from ER follow up CT brain. Follow fall precaution and currently in place." Review of R1's record failed to include a supervision level for staff to follow after identified Subdural Hematoma head injury after falls requiring hospitalization and admission to Intensive Care Unit.

11. 7/17/21 injury report written by E4 (Direct Support Person/DSP) at 10:54pm states, "E15, Direct Support Person (DSP) and I were changing R7, we heard a noise in hall. I found R1 on his knees in front of bathroom door. He stood up before we could stop him so we had him sit in a chair" "number of clients 12 number staff on duty 2."

12. 7/18/21 nurses note written by E18 (RN) states "overnight supervisor sent resident (R1) to emergency room for fall. resident sent to (name of hospital) for worsening Subdural Hematoma."

8/9/21 nursing note states "R1 is in nursing home."

13. 8/16/21 - Hospital records document R4 was admitted to the local hospital Emergency Department (ED) on 8/16/21 at 10:55am. Z4 (ED Physician) states, "Patient had a witnessed fall and fell backwards hitting his back." "Trauma to torso and back. Impact surface hard floor." "xray revealed possible right fourth rib fracture."

14. 8/20/21 - R3's hospital ED notes dated 8/20/21 at 1:59pm state, "Patient to ED from (name of facility). Per Emergency Medical

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Z9999	Continued From page 8 Service (EMS), patient had a fall in the bathroom. Patient states that he tripped and fell, per ems report staff found pt face down on the floor. Pt is alert to name and place. Small abrasion noted to right knee." 15. 8/25/21 - R2's nurse's note states, "R2 fell out of bed overnight to (local hospital) for evaluation" E5 (Case Manager) documents on 8/25/21 "Initial and Final Report of Incident ER visit, At approximately 1:15pm R2 was transported to (local hospital) ER via ambulance due to an unwitnessed fall." "staff heard a bang and ran to check on him" 16. 9/2/21 - Injury report dated 9/1/21 at 9:54pm written by E8 (DSP) states, "R2 fell out of his bed at 9:52pm which caused a bleeding scratch on his right arm by the elbow." R2 nurse's note written by E18 (RN) on 9/2/21 states, "returned from (local hospital) ED overnight seen for a fall. Abrasion to left elbow." "Instruction sheets for abrasion and head injury to the house." 17. 9/21/21 - R4's hospital ED notes dated 9/21/21 at 1:44pm written by Z4 (ED Physician) state, R4 "presents with chief complaints of fall. Patient stays at (name of facility). He tripped over someone's foot and fell onto his right side, patient right elbow. He was wincing and pain in his right elbow and right knee. Patient was able to ambulate at his baseline. It was a witnessed fall. Patient did not hit his head." "xrays negative." Facility Policy "Medical Concerns Procedures" Section 372, #11 states, "11. All serious incidents with significant effect on the health, safety and welfare of the individual, including any who become ill or had an injury and sent to the hospital and expires at the hospital shall be	Z9999		

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investigated."

During interview on 9/14/21 at 12:40pm, E1 (Director of Clinical Services) was asked for investigations regarding multiple falls and injuries for R1 and for unwitnessed resident falls. E1 stated, "Investigations are not required if we know why it happened and what caused it."

During interview on 9/14/21 at 1:40pm. E1 (Director of Clinical Services) was asked for Quality Assurance meeting notes and if the IHP team had met regarding R1 to discuss multiple falls with outcomes and if R1's service needs can continue to be met at the facility. E1 did not have evidence that a Quality Assurance Committee existed or meeting minutes or report. E1 stated the case manager, physician and herself have discussed R1's debilitating condition, the meetings are not in writing and it was not discussed if R1 is a candidate for living at the facility.

Review of functioning level and service needs per E6 (Case Manager) on 9/14/21 at 2pm and again with Z16 (Direct Support Person/DSP) documents:

R1 - needs assistance with ambulation, putting clothes on and taking a shower. Can require 1:1 assistance at times
R2 - needs assistance with shower, will not use soap unless staff is there. R2 is 192 pounds and 6 feet tall according to office visit with orthopedic surgeon on 9/14/21.
R3 - Needs assistance with hygiene.
R4 - Full assistance with all needs. Can require 1:1 assistance at times.
R5 - Utilizes walker for ambulation, requires standby assistance with showers.

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Z9999	Continued From page 10 R6 - Needs assistance with shower. R7 - Needs assistance with hygiene, elopes and is hard to get back at times, behaviors of slapping, self-hitting self with fist and history of staff verbal and physical abuse. R8 - Needs full assistance, needs to be fed and utilizes wheelchair. Can require 1:1 assistance at times. R9 - Needs assistance with shower. R10 - Independent. R11 - Required full assistance with hygiene, putting on clothes and required 1:1 assistance with ambulation. On 9/14/21 at 12:15pm during interview, E6 (Case Manager) stated, "The facility has 2 to 3 staff on the second shift and 2 staff on nights." Review of the staff schedule from April to September 2021 lists two staff for day shift 8a to 4pm, two to three staff on 2nd shift 4pm to 12pm (varies per days of the week), and two staff on night shift 12pm to 8am. On 9/23/21 during interview, Z16 (DSP) stated, "R7 elopes and the staff have to chase him. Even if we get 3 staff scheduled, most of the time one will get pulled to another house. It is difficult loading the guys on the bus in the morning with 2 people, because we can't leave them in the house alone. We do call for help from the SOD (Supervisor on Duty) and the Q, but we hear we will send someone over or someone is on their way, and they do come but it is never right away. Loading the guys on the bus we need 3 people. We need more staff help at lunch because we need more than 4 or 5 people to help the residents with lunch. One of the staff that you are telling me about on your schedule no longer even works here. It is so hard to transfer R2 because	Z9999		

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Z9999	Continued From page 11 he is heavy, even with 2 staff it is overwhelming. R2 could use a hospital bed with rails or something. I'm not sure; it's just overwhelming. There is also a staff on the schedule that has restrictions that staff cannot lift, transfer, have restrictions to the back and cannot do showers, cannot do meds, and probably shouldn't be counted as a second staff." On 9/23/21 during interview, Z17 (DSP) stated, "R7 runs out the door on many occasions. He is close to being deaf and you have to go out there to get him. But it is difficult for him to even hear. A lot of time R7 goes to his behaviors; he hits himself, yells. It is hard to redirect him." (A)	Z9999		