STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6011613	A. BUILDING: _____ B. WING _____	C 04/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENRY REHAB AND NURSING	1650 INDIAN TOWN ROAD HENRY, IL 61537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: 2122425/IL132603	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 d)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 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure resident safety during wheelchair positioning for one resident of three residents (R3) reviewed for accidents in a sample of five. This failure resulted in R3 sustaining a fall from R3's wheelchair leading to a subsequent subdural hematoma and death. Findings include: The facility's Falls Practice Guide, dated 2011, documents "Purpose: The purpose of the Falls Practice Guide is to describe the process steps for identification of patient fall risk factors and interventions and systems that may be used to manage falls. Fall management focuses on minimizing fall risk factors and fall related injuries while continuing to promote the patient's quality of life." This guide continues with "Overview: Falls among elderly patients are a common source of both high injury severity and mortality, much more so than in younger patients. Of the elderly who fall, 20 to 30 percent suffer moderate to severe injuries such as hip fractures or head traumas that reduce mobility and independence and increase the risk of premature death." R3's Progress Note, dated 3-14-21 at 3:30am by V9 (Registered Nurse/RN), documents "This writer was in (Room number) changing a wound (vacuum) dressing, upon exiting room, heard a loud noise and then heard CNA (Certified Nursing Assistant) yelling out for help. Observed Patient (R3) on ground with knees bent upwards towards the midline in a sitting position with wheelchair underneath resident and CNA kneeling next to resident. CNA states that she was assisting with increasing comfort and elevated bilateral lower	S9999		

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S9999	Continued From page 2	S9999		

extremities onto a chair and the wheelchair had then fallen backwards. Clothes and shoes properly fitted and on. Resident had just been toileted prior to event. CNA states that resident had shown signs of increased anxiety, restlessness, and was attempting to get out of bed per self and CNA had made decision to assist resident to nurses' station for closer observation." This same Progress note continues to state that R3 was transferred to a hospital of R3's family's request.

R3's Progress Note, dated 3-14-21, documents the hospital called and reported R3 had a "head bleed".

R3's Annual Minimum Data Set/MDS assessment, dated 1-28-21 documents R3 is severely cognitively impaired; has diagnoses of Dementia with Behavioral Disturbance and Anxiety; needs extensive assist with two staff members for bed mobility and transfers; is only able to stabilize with staff assistance for all type of transfers including surface to surface transfers, due to R3's imbalance during transitions and walking; and has a functional limitation in range of motion with impairment to bilateral lower extremities.

On 4-15-21 at 12:15pm, V1 (Administrator) stated "On 3-14-21, (R3) was restless, so for better comfort V7 CNA brought (R3) to the nurse's station and raised (R3's) legs up to put them on a chair. (R3's) wheelchair had an anti-sling device on the bottom and a cushion for comfort and skin which brought (R3) up further and raised (R3's) point of gravity. The back of the chair came to (R3's) mid back so (R3) was top heavy. (R3's) center of gravity was too high."

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S9999	Continued From page 3 On 4-15-21 at 12:18pm, V2 (Director of Nursing/DON) stated "It didn't matter if the wheelchair was locked or unlocked - the problem was (R3's) center of gravity." On 4-15-21, at 2:20pm, V8 (Physical Therapist) stated that R3's wheelchair had not been assessed; R3 was mostly ambulatory but was receiving therapy for a decline. V8 stated that to position R3 for comfort "I would have used leg rests and would not have propped his legs up on a chair." On 4-15-21 at 2:49pm, V7 (CNA) stated the following: "(R3) was restless and attempting to get out of bed so I brought (R3) to the nurse's station to keep an eye on (R3). I wanted to raise (R3's) feet up to make (R3) more comfortable so I lifted both of (R3's) feet at the same time to place them on a chair and (R3) fell right over backwards and hit (R3's) head on the floor. I did not lock (R3's) brakes and I thought that maybe if I had it may not have tipped. (R3) is a stiff sitter. I didn't tell (R3) to lean back and I'm not sure if (R3) did because it all happened so fast. (R3) sits high in the wheelchair and has a wedge (anti-sling) and a cushion under (R3) for comfort. There were no witnesses. I should have put the brakes on. It all happened so fast but when we did the re-enactment, I recalled that I had not (put the brakes on). Normally I would brake a wheelchair when a resident is placed out by the nurse's station to be watched. (R3) was very restless and I brought (R3) out to the nurse's station so (R3) wouldn't fall out of bed and then I caused (R3's) fall." R3's Fall investigation, dated 3-14-21, documents by V2 (DON) that "(R3's) wheelchair was used for re-enactment. It was observed that when (R3's)	S9999		

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S9999	Continued From page 4 legs were raised for repositioning that if (R3) reclined or leaned back that the wheelchair tipped backward very easily. Current wheelchair does not have anti-tip device on it. Wheelchair back from top of cushion to top of wheelchair back measures leaving approximately 8-10 inches of resident's upper body not supported by wheelchair back. In an attempt to make (R3) more comfortable by elevating (R3's) legs, unfortunately changed (R3's) center of gravity and when (R3) leaned as to recline the wheelchair tipped causing the fall." On 4-19-21 at 8:05am, V10 (R3's Physician) stated that the injuries R3 sustained from the fall on 3-14-21 "would have increased (R3's) risk of death." R3's State of Illinois Certificate of Death Worksheet documents R3's date of death as 3-21-21 with the following causes of death "a. Acute Hypoxic Respiratory Failure due to b. Subdural Hemorrhage due to c. Ground level fall." (A)	S9999		