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
	IL6001986	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE NURSING & REHABILITATION	3500 CENTURY DRIVE GRANITE CITY, IL 62040

(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 Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b)5) 300.1210d)4)6) 300.1810c) 300.1810f)1) 300.1820c)3)4) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: 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: 4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following: 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. Section 300.1810 Resident Record Requirements c) Record entries shall meet the following requirements: f) An ongoing resident record including progression toward and regression from established resident goals shall be maintained. 1) The progress record shall indicate significant changes in the resident's condition.	S9999		

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S9999	Continued From page 2 Any significant change shall be recorded upon occurrence by the staff person observing the change. Section 300.1820 Content of Medical Records c) In addition to the information that is specified above, each resident's medical record shall contain the following: 3) Nurse's notes that describe the nursing care provided, observations and assessment of symptoms, reactions to treatments and medications, progression toward or regression from each resident's established goals, and changes in the resident's physical or emotional condition. 4) An ongoing record of notations describing significant observations or developments regarding each resident's condition and response to treatments and programs. These Regulations are not met as evidenced by: Based on observation, interview and record review the Facility failed to document falls, assess and monitor and implement safety measures for 3 of 10 residents (R26, R28, R165) reviewed for falls/incidents in the sample of 40. This failure resulted in R165's fall sustaining a fracture to left humerus, left shoulder humerus fracture and compression fractures of T1, T3 and T4. Findings include: 1. On 11/2/2021 at 9:35 AM, when entering R165's room he was lying on his bed. The sheet around R165's head was stained in a brown ring	S9999		

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the size of a football circling his head. The Peripherally inserted central catheter (PICC) line machine was beeping and V2, Director of Nursing (DON), entered the room and shut off the machine and left the room.

On 11/2/2021 at 9:39 AM, V2 stated, "I am not sure what is happening with (R165) or what is going on with the brown staining around his head. I will have a look. He has sutures to that area it looks like the area is wet, I will go and get the Wound Nurse."

On 11/4/2021 at 2:21 PM, V7, Wound Nurse stated, "(R165) was admitted with a cranioplasty and multiple sutures to his head. (R165) had about 35 sutures in his head when he came here from the hospital. This area here is wet and stated there was drainage coming from an area on R165's head sutures. I will contact the doctor."

The Incident Log provided by the Facility on 11/2/2021 document R165 had a fall on 9/24/2021 at 6:40 PM, 9/29/2021 at 10:30 AM, and 9/29/2021 at 10:31 AM.

R165's Face sheet documents he was admitted to the facility on 9/24/2021.

R165's Nurses Notes dated 9/27/2021 at 9:35 PM, document, "New admit charting day 3. Resident is high risk for falls. Resident incontinent of bowel and bladder with good peri care given with each incontinent episode. Resident is assist of 2 with use of gait belt for transfers. Resident is assist for 2 for Activities of Daily Living related to resident becoming combative with personal care. Resident has no injuries noted related to incident. Resident has canoe mattress and safety floor mat on left side

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S9999	Continued From page 4 of bed. No complaints of pain or discomfort voiced. Call light in easy reach." R165's Physician Order Sheet for September 2021 documents a diagnosis of hemiplegia following cerebral infarction affecting left non-dominant side. Eliquis (apixabin-a blood thinner) 5mg (milligrams), take 1 tablet by mouth 2 times a day. Heparin (a blood thinner) 5000 unit/milliliter inject 1 milliliter subcutaneously every 12 hours. R165's Interim Care Plan dated 9/24/2021 documents, "Cognition confuse, alert and orientated times one. Bowel and Bladder, risk for incontinence, urinary retention, incontinent of bowel and bladder, History of Falls, high low bed related to craniotomy." R165's Nurses' Notes dated 9/24/2021 at 6:00 PM, documents, "Resident transferred to room. Resident oriented to new facility and staff, Resident is confused, does not understand where he is or that the people in the room are nursing staff. Resident talking to right side of bed not to a person. Residents' states, 'he needs to go to work with Dave,' Resident is somewhat aggressive with nurses and while trying to reposition him in bed. Attempts made to de-escalate resident with some success. Resident has slight left side facial droop, left arm is flaccid, left leg very weak, right arm leg strong and able to grip with right hand, right leg strong, lung sounds clean, respirations even and unlabored, bowels sound positive, abdomen soft and non-distended, condom catheter patent and draining dark yellow urine, incision to right side of resident head well approximated, moisture or staples open to air. Resident denies pain, call light given to patient, use of call light education	S9999		

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S9999	Continued From page 5 done with patient, will continue to monitor." R165's Nurses Notes dated 9/24/2021, documents, "At approximately 6:40 PM, resident's call light was (on), Certified Nursing Assistant went to answer the light when he came down to the nurse's station to get nurse because resident was sitting on the floor on his buttocks, legs folded 'Indian style'. When asked what happened resident stated, 'I went to stand up fell straight to the floor.' Resident roommate alert and orientated x 3-4 (person, place, time and situation) stated he turned the call light on when he fell on the floor. He did not hit his head." Range of Motion (ROM) pain and body assessment completed. No injury noted at this time. Resident very agitated, PRN (as needed) order for 2.5 mg of haloperidol by mouth, Resident's medication not in the facility yet. This nurse checked Emergency kit to find (IM) intramuscular. Contacted Nurse Practitioner and informed her of fall, gave 1 time order for 2.5 milligrams of Haldol (haloperidol) Intramuscularly (IM). Resident brought up to nurse's station related to keep trying to get up. Resident verbal/physical combative with staff, Will continue to monitor." R165's Resident Incident Report dated 9/24/2021 at 6:40 PM, documents, "Resident attempted to out without assistance and fell to the floor. Resident was very agitated at time of occurrence. No injury." R165's Incident Follow Up dated 9/24/2021 at 6:40 PM, documents, "Resident attempted get up without assistance and fell to the floor. Resident was very agitated at time of occurrence. Incident Recorded in Progress Notes 9/24/2021. Addressed in Care Plan."	S9999		

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S9999	Continued From page 6 R165's Nurses Notes dated 9/29/2021 at 12:57 PM, documents, "Resident noted on the floor in resident bathroom, appeared that resident was transferring from chair to toilet unassisted, when asked what happen resident stated, 'I have to poop' resident noted skin tears to both right and left elbows, area cleaned with wc (wet cloth), pat dry, bacitracin and covered with dry dressing, resident alert and oriented, able to make needs known to staff, verbal complaint about pain to left shoulder area placed to Medical Doctor to report incident and make aware of pain to left shoulder." R165's Nurses Notes dated 9/29/2021 at 7:38 PM, documents, "Call placed to ambulance for transport at around 7 PM and they arrived at 7:37 PM, Resident assisted by 2 assist and ambulance. Report called to emergency room but got no answer. Will try again." On 11/3/2021 at 9:30 AM, R165's Incident Reports for falls was requested for 9/24/2021 at 6:40 PM, 9/29/2021 at 10:30 AM, and 9/29/2021 at 10:31 AM. No Resident Incident Report was provided by the Facility for the two falls on 9/29/2021. R165's Nurses Notes dated 9/29/2021 at 7:04 PM, documents, "Call placed to (V23) Physician, related to x-ray result to left shoulder that shows fracture to left humerus. Received new order to send to Emergency Room." On 11/3/2021 at 9:01 AM, all nurses notes and Fall reports were requested from 9/24/2021 t0 9/29/2021 for R165. All the nurses' notes were reviewed for R165 and there was no documentation regarding R165 having 2 falls on 9/29/2021. There was no Fall	S9999		

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S9999	Continued From page 7 Report provided documenting what fall interventions were put into place for R165 for his first fall on 9/29/2021 or the second fall. There were no nurses' notes documenting R165 was being monitored or any interdisciplinary approaches the facility was doing for R166 for his fall on 9/29/2021. On 11/5/2021 at 3:00 PM, V1, Administrator, stated "We have given you everything for (R165's) falls." An undated report prepared by V2, Director of Nursing, stated, "On 9/29/2021 at approximately 11:00 am, (R165) had a fall and complained of left shoulder pain. Medical Doctor notified with new order for x-ray to left shoulder. RR (resident representative) notified. X-ray results show fracture to the left humerus. Medical Doctor notified with orders to send to the emergency room (ER) for evaluation and treatment. Resident R (representative) notified. Director of Nursing notified and started investigation. The following was reviewed. Face sheets and diagnosis, Care Plans, Nurses' Notes, Physician Orders, Labs, Assessments, Medical Doctor and Resident Representative notified, Hospital Report and EZ move reviewed. In conclusion through interviews and chart review, (R165) had 2 falls on 9/29/2021. The first fall occurring at 10:30 in his room. The second fall occurring at 11:00AM in his resident bathroom. On 9/24/2021 (R165) was identified upon admission as a fall risk. (R165) was placed in a low bed with a canoe mattress, fall mat placed on floor next to bed upon admission. On 9/29/2021 around 10:30 AM, (R165) attempted to get out of bed without assist to go to the bathroom. (R165) was found on his left side on the floor on left flaccid arm. (R165) was checked and changed due to incontinent of	S9999		

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urine around 9:30 AM, prior to the first fall. At approximately 11:00 AM, (R165) was found on the floor in his bathroom. (R165) attempted to put himself back on the toilet around 10:40 AM and fell and then complained about left shoulder pain. Staff had just placed (R165) on the toilet around 10:40 AM so that he could have a bowel movement and was assisted back to his wheelchair. Medical Doctor was notified. New orders received for an x-ray that was positive for a fracture to the left shoulder. Orders received to send to Emergency Room. Resident Representative and Stage was notified. (R165) was admitted to the (local hospital) and remains at the hospital at this time. (R165) is impulsive and did not call or wait for assistance and has osteoarthritis which could be a contributing factor that caused the fracture to the left shoulder. (R165) recently had a craniotomy prior to admission to the facility."

On 11/4/2021 at 3:30 PM, the facility only provided the Incident Report for falls for R165 for 9/24/2021 at 6:40 PM. No Resident Incident Report requested was provided for the 2 falls on 9/29/2021.

R165's Nurses' Notes do not document a fall on 9/29/2021 at 10:30 AM and/or 11:00 AM. R165's nurses' notes do not document anything regarding R165 falling in his room. R165's nurses' notes do not document R165 was toileted before his fall in the bathroom.

R165's medical records do not document on 9/29/2021 multiple falls for R165. R165's medical records do not document R165 was being monitored, assessed or any neuro checks were being provided.

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R165's Care Plan with a Problem Onset 10/18/2021, documents "(R165) I am increased risk for falls related to my impaired mobility hemiplegia diagnosis, Cerebrovascular Accident (CVA), impaired cognition, communication impulsive behaviors/impaired safety awareness, decompressive cranioplasty related to CVA, incontinence, Diagnosis of osteoarthritis, Afib, High Blood pressure, use of psychotropic medication, history T3, T4 fractures and fracture of left humerus status post fall."

On 11/4/2021 at 2:21 PM, V2, Director of Nursing (DON,) stated, "He (R165) was admitted with cranioplasty and multiple sutures. (R165) had 3 falls while he was here in the Facility. He was being assessed after his second fall on 9/29/2021 and was complaining of pain, we got x-rays and he had a fracture and was sent out to the local hospital. From the local hospital he was sent out to another hospital and then another hospital. His cranioplasty had to be redone. (R165) did have some compression fractures but I am not sure he got them while he was at our facility. The hospital had to send him out again because they had to redo his cranioplasty because he had some edema, and they could see some hardware. I would expect this to be charted in his nurse's notes."

R165's Hospital Records dated 9/29/2021 document, "Traumatic subdural hemorrhage with loss of consciousness of unspecified duration sequela-traumatic acute subdural hematoma initial encounter." Patient coming from (Facility) and rehab patient had an unwitnessed fall today at approximately 12:00 PM, Patient has complaint of left shoulder pain. (Facility) did outpatient x-ray that shows an acute fracture of the surgical neck humerus with mild displacement. Mechanism of

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S9999	Continued From page 10 injury: Fall. Patient fell from his wheelchair at approximately 12:30 PM. Patient was complaining of left arm pain so the nursing did x-ray and found he had a humerus fracture. Nursing home sent patient over at approximately 8 PM, upon arrival patient is alert and oriented times one." R165's Hospital 2 notes documents "(R165) is a 68-year-old with past medical history of atrial fibrillation, prostate cancer, hepatitis B, and RMCA stroke and a documented past psychiatric history, major depressive disorder who was admitted on 9/29/2021 for Level 2 Trauma after falling in a nursing home with resulting left humerus fracture and compressed fracture of T1, T3 and T4." R165's Hospital Records dated 10/7/2021 document, (R165) is a 68-year-old male, was brought to (hospital) by EMS (emergency medical systems) on 9/29/2021 following a fall at skilled nursing facility. Workup showed subdural fluid collection consistent with post-operative changes and age indeterminate T3 and T4 compression fracture. R165's Hospital Records from his second hospital dated 9/30/2021 document, "(R165) is a 68-year-old male who presents as a level 2 trauma transferred from (former hospital) fall at 1:00 PM. He lives in a nursing home and fell while transferring from wheelchair to commode. There was unknown Level OC (of consciousness). They arrived on a backboard and without a c-collar in place. Workup at (hospital) revealed left humerus fracture and a right shoulder displaced humerus (SDH). Patient is on eliquis and did not receive kcentra before transport. Injuries: SDH, right humerus fracture	S9999		

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S9999	Continued From page 11 and age indeterminate T3 and T4 compression fractures. Patient was admitted to the Intensive Care Unit (ICU)." The Interdisciplinary Fall Reduction/Injury Prevention Protocol Policy dated 7/2021 documents, "An interdisciplinary approach at reducing falls, preventing injury and increasing safety awareness ultimately resulting in improved quality of care for our residents. Assess the resident for adverse reactions/side effects/ vital signs, left and right arm blood pressure and, when applicable, a neurological check. Monitor the resident's condition until stable or according to physician's orders. A detailed account of the incident must be recorded in the medical record. Such documentation should include but is not limited to: time and date of incident, the name and strength of medication, condition of the residents, treatment administered, time the physician was notified and his/her instructions, time, time the resident and or legal representative was notified." On 11/10/2021 V23, Physician stated "I expect all residents to be monitored and assessed after falls, vital signs taken, and any neurological checks if there is a suspected head injury. This should be documented in the resident's file. (R165) had a history of falls and was at high risk I would expect him to be watched and monitored." 2. On 11/2/21 at 1:04PM, R28 was observed with 5 burn holes on his lap blanket. R28 stated they are from cigarette ashes dropping on it. On 11/4/21 at 9:12AM, R28 was observed with a burn hole in the upper left side of his pants. R28 states it is from his cigarette ashes dropping on it.	S9999		

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S9999	Continued From page 12 R28's Face Sheet, undated, documents a diagnosis of Dementia. R28's MDS, dated 8/9/21, documents R28 is cognitively intact. R28's Care Plan, dated 9/9/16, documents R28 is a smoker with the following interventions: staff to remind me of designated areas for smoking, provide education to my family and friends regarding smoking policy, perform a smoking risk assessment quarterly, supervised smoking and cigarette and lighter is to be kept at the nurse's station. R28's Smoking Safety Evaluation, dated 8/9/21, documents R28 is able to manage ashes, has no history of smoking related incidents, smokes safely with minimal supervision and is to be supervised smoking by staff. On 11/4/21 at 9AM, V1, Administrator, states R28 will not wear a smoker's apron and the burn holes in his blanket are from a long time ago. The "Smoking" policy, dated 6/2021, documents all resident's will be subject to modified smoking limitations. Limitations may include, but are not limited to: facility storage of tobacco products and/or fire materials, designated smoking times, assistance with lighting tobacco products, assistance to hold cigarette, supervised smoking by staff and/or other protective/safety measures as determined appropriate by the individualized plan of care based on the smoking evaluation. 3. R26's quarterly MDS, dated 7/29/21, documents R26 as severely cognitively impaired, requires supervision for bed mobility and eating; Extensive assistance of one person for walk in	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001986	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE NURSING & REHABILITATION	3500 CENTURY DRIVE GRANITE CITY, IL 62040

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S9999	Continued From page 13 room, walk in corridor, locomotion on unit, locomotion off unit, personal hygiene, bathing, toileting, dressing, transfers. R26's balance during transitions and walking: Steady at times when moving from seated to standing position, surface to surface transfer and moving on and off toilet; walking and turning around: not steady, only able to stabilize with staff assistance. Mobility devices: walker and wheelchair. R26 has had no falls since admission. R26's Morse fall scale, dated 7/29/21, documents the resident was high risk for falls and to implement high risk fall prevention interventions. R26's Care plan undated documents, "Problem: I am at increased risk for falls related to my impaired mobility, impaired cognition/safety awareness. -Goal: My falls/injuries will be minimized through management of my risk factors through next review. -Target date: 11/2021. -Approaches: perform a fall risk assessment on me quarterly and PRN (as needed), provide me a safe environment, place my call light and frequently used items within safe reach, give me verbal reminders not to ambulate or transfer without assistance, I transfer with 1 assist and gait belt, keep my bed in lowest position, refer me to therapy/restorative nursing as needed, encourage me to change positions slowly to avoid dizziness, I have a canoe mattress on my bed. 10/16/21 encourage use of gripper socks." R26's nurse's note dated, 10/17/21 at 3:30 AM, documents, resident found sitting on her bathroom floor by CNA. Res states she was attempting to sit in wheelchair after using the bathroom and slid down to the floor. No apparent	S9999		

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S9999	Continued From page 14 injuries. Resident denies pain. She was transferred from the floor by 2 staff and assisted to bed. Res (Resident) educated on the use of her call light and encouraged to wait for assistance before transferring self. R26's incident/accident report, dated 10/17/21, documents res was found on her bathroom floor sitting on her bottom. No apparent injury noted. Resident's states she was attempting to sit in wheelchair and missed chair. Steps taken to prevent recurrence: educate resident to wait for assistance. No injuries sustained. The incident witness statement was blank. R26's Morse fall scale, dated 10/17/21, documents the resident was high risk for falls and to implement high risk fall prevention interventions. R26's medical record showed no new approaches added to her medical record or care plan after she fell on 10/17/21. On 11/5/21 at 3:50 PM, V2, Director of Nurse's (DON) stated when a resident fall she expects staff to update the resident's care plan the same day with an intervention that is not already listed on the care plan and for staff to follow the facility's fall policy. The facility's policy, "Interdisciplinary Fall Reduction/Injury Protocol" dated 7/2012 documents, "Intent: An interdisciplinary approach at reducing falls, preventing injury and increasing safety awareness ultimately resulting in improved quality of care for our residents. Recommendations: Nursing to complete a fall risk evaluation upon admission, re-admission, quarterly and with significant change. If the total	S9999		

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S9999	Continued From page 15 score places the resident at risk, determine appropriate interventions. Once selected, implement the intervention and then add to the resident's plan of care and pocket care guide (PCG). All new admissions/readmissions will be monitored for approximately 72 hours of their stay." (A)	S9999		