STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009559	A. BUILDING: _____ B. WING _____	07/22/2022

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EFFINGHAM REHAB & HEALTH C CTR	1610 NORTH LAKEWOOD DRIVE EFFINGHAM, IL 62401

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S 000	Initial Comments Annual Licensure/Certification Facility Reported Incident of 5/6/22/IL149018 Complaint Investigation: 2255510/IL148999 Complaint Investigation: 2255636/IL149184 Complaint Investigation: 2255638/IL149186	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These requirements are not met as evidenced by: A. Based on interview, record review, and observation, the facility failed to notify a resident's physician of a change in condition for 2 residents	S9999		

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S9999	Continued From page 2 of 24 residents (R4, R17) reviewed for physician notification in the sample of 24. This failure resulted in R4 becoming hospitalized on 7/18/22 for being lethargic, having poor skin turgor. R4 was diagnosed with pneumonia and continued to remain hospitalized as of 7/22/22. This failure also resulted in R17 not being promptly transferred to the hospital for evaluation where R17 was diagnosed with a fractured right humerus. B. Based on observation, record review, and interview, the facility failed to assess a resident after two falls and failed to report and investigate these falls for 1 resident of 3 residents (R17) reviewed for falls in the sample of 24. This failure resulted in R17 not being promptly transferred to the hospital for evaluation where R17 was diagnosed with a fractured right humerus. Findings include: 1. On 07/19/22 at 10:07am, V8, Emergency Medical Technician, stated he responded to a call from the facility on 07/18/22 about R4. V8 stated R4 was very lethargic with poor skin turgor. V8 stated facility staff told him that R4 had not eaten or drank in about three days. V8 stated it was his professional opinion that R4 should have been sent to the hospital sooner than she was. On 07/20/22 at 08:20 am,V9, Emergency Room (ER) Registered Nurse, stated R4 was brought into the ER on 07/18/22, lethargic and dehydrated. V9 stated when she called the facility to get report, V10, Licensed Practical Nurse (LPN) stated that, "(V1, Administrator) wanted (R4) sent out a couple of days ago, but for whatever reason, I guess it didn't happen." V9 stated it was her professional opinion R4 should	S9999		

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S9999	Continued From page 3	S9999		

have been sent to the hospital sooner than she was.

An Emergency Department Hospital Admission report dated 07/18/22 documented,"(R4) is an 88 year old female with a history of Asthma, Dementia, Diabetes, Hyperlipidemia, Disease of the Thyroid Gland, Osteoporosis, and (a history of) Pneumonia (on 03/09/20). The nursing home states the patient has not ate or drank for four days ....(patient) Endorses being thirsty. When offered water, she drank with no coughing or difficulty. Physical Exam: Oropharynx is VERY (caps, bold) dry with peeling skin on the lips. Assessment: Pneumonia: (Patient (diagnosed) with Covid on 07/03/22), (and) Acute Kidney Injury on Chronic Kidney Disease Stage 3."

On 07/20/22 at 10:20am,V10 stated she worked with R4 on 07/18/22 from 8am to 6pm. V10 stated R4 was recovering from Covid and was refusing to eat or drink, and V10 was told in report she had been that way for a couple of days, and that she had stopped having urine output. V10 stated she felt R4 needed to be sent to the ER, and discussed it with V1, who agreed and stated, "She thought the resident had needed to go out a couple of days ago but for whatever reason, she didn't." V10 stated she sent R4 to the ER around 7:15pm, but she probably should have sent her out earlier in the shift.

On 7/20/22 at 1:59pm, V11 LPN, stated she worked with R4 on the 6am to 6pm shift on 07/17/22, the day before she was sent to ER. V11 stated she was told in report that morning that R4 had been refusing food and fluids. V11 stated when the evening shift Certified Nursing Assistants (CNAs) came in at 2pm, they reported when they worked the previous evening, R4 had

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S9999	Continued From page 4	S9999		

no urine output. V11 stated this was not relayed during morning report. V11 stated she confirmed with the day shift CNAs she had not had output during the shift, and they had not reported it to V11. V11 stated she immediately assessed R4, and her vital signs were within normal limits, her lungs were clear, but she did have a slight non-productive cough. V11 stated her skin turgor was good. V11 said she did not contact the physician about R4 as she did not feel it was necessary. V11 stated she was however concerned about the lack of output and had decided to send R4 out when the CNAs reported R4 had soaked her adult brief. V11 stated she conferred with V1, who advised for R4 not to be sent out but to be closely monitored during the night. V11 stated she passed this along in shift change report.

On 07/21/22 at 12:26 pm, V1 stated she was called on 07/17/22 between 5 and 6pm by V11, who stated R4 was not eating or drinking and had no urine output. V1 stated she told V11 to send R4 to the hospital. V1 stated V11 then called right back and stated R4 had a soaked adult brief. V1 stated she told V11 to call the doctor, encourage fluids and to monitor R4 closely. V1 stated she worked on 07/18/22, she saw R4 around noon and she looked sick, and staff stated she was no better. V1 stated she told V10 to send R4 to the hospital. V1 stated she worked late into the afternoon that day, and around 7 pm she noticed that R4 was still in her room. V1 stated she instructed V11 to immediately send R4 out.

A July 2022 Food and Fluid Intake Sheet documented the following daily totals: 07/14/22: Food intake for the day was 25% of her lunch. Fluids: 100 cc(cubic centimeters).
07/15/22: No food intake, 260cc of fluid. 7/16/22:

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S9999	Continued From page 5 Food-25% of supper, 440cc of fluid. 07/17/22: 25% of lunch, 565cc of fluid. 07/18/22: No food or fluid intake. R4's July 2022 Nurses Notes contained no documentation about R4's lack of food and fluid intake nor lack of urine output. An Admission Nutritional Assessment dated 03/17/22 documented that R4 required 1423 calories per day to maintain her admission weight of 111.8 pounds, and a daily total of 1524 cc of fluids. R4's Weight Record documented the following: May 2022: 94.6 pounds, June 2022: 98 pounds, July 2022: 99 pounds. On 07/21/22 at 10:40 AM, V16, Hospital Registered Nurse, stated R4's was still in the hospital and status was about the same as when she was admitted, but her daughter is now at the bedside, and she had perked up a bit and had started to eat a little. On 07/21/22 at 1:45pm, V7 (Physician/Medical Director) stated the facility called her on the evening of 07/18/22 to report R4 had not been eating or drinking and had no urine output and she told them to send her out. V7 stated that was the first time she was made aware that R4 had been in this condition for several days. V7 stated she has reiterated to the nursing staff previously that fluid intake is crucial in supportive care for resident recovering from Covid and they should have called her much sooner. V7 stated the facility should have notified her when R4 began refusing food and fluids and had no urine output. V7 stated, "I have standing orders that any of my residents can be sent to ER at any time if they	S9999		

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S9999	Continued From page 6 can't get hold of me." 2. On 07/19/22 at 10:04am, R17 was observed in his room. R17 was sitting in a high backed wheelchair wearing a safety helmet and a sling to the right arm. R17 was alert but did not answer the surveyors' questions. R17 would occasionally grunt or squeal. R17's Minimum Data Set dated 04/05/22 documented that R17 requires limited assistance from at least one staff member for transfers. R17's Care Plan with a revision date of 07/06/22 documented a problem area, "Falls-Resident has risk factors that require monitoring and intervention to reduce potential for self injury." A Final Report submitted to the Illinois Department of Public Health dated 05/11/22 documented, "(On 05/05/22) Resident (R17) was being assisted in ADL (Activities of Daily Living) when a staff member noted redness under the arm along with swelling, alerting her to follow up with the nurse on duty. The nurse then collected the residents' vital signs, and his temperature was elevated to 101.8 (degrees Fahrenheit) and (she) assessed the area where she noted redness and swelling of the right shoulder area. This occurred at 1930(7:30pm). This change of condition alerted the nurse to contact the physician at 1945 (7:45pm). The physician then informed the nurse to send this resident out (to the emergency room) for further evaluation, based off the assessment and vitals stating it may be a possible infection. The resident returned with (diagnoses) of fever and right humerus fracture. At the time of the alleged incident the following was completed: The Administrator was notified, the DON (Director of Nurses) was notified, the Physician was notified, (staff) statements were	S9999		

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obtained, the family was notified, IDPH was notified, and an investigation was initiated." Report further documents, Staff Interviews: (V12): Certified Nursing Assistant (CNA) "(On 05/05/22 at 11:45am) I was serving lunch trays and when I walked out of the kitchen with food trays, I saw (R17) begin to lose his balance. As he began to fall, I caught him ...catching his right arm to ease him to the floor with (V13, CNA) who came to assist." (V13):"(On 05/05/22 at 11:45am), When I was serving dining room trays, (R17) was walking toward the kitchen. I was holding a tray..and I was helping guide (R17) back to his seat to begin eating his meal. When (R17) turned around to go toward his seat, he lost his balance and started to fall. (V12) was coming out of the kitchen and helped me lower him to the floor." (V6), Registered Nurse: "(On 05/05/22)Two CNAs came to me and said (R17) 'almost fell'." After this set of interviews, this writer (V1) then interviewed staff members on the (5/5/22) evening (shift). The following was noted: (V14) CNA: 'I was walking down the hallway (on 05/05/22 on the 2pm to 10pm shift) checking on residents when I found (R17) on the floor next to his bed, laying on his fall mat. I had (V15, CNA) help me get him up. No abnormal reactions were had by this resident." V15: "V14 asked for help in assisting (R17) up from his fall mat where he was laying. His head was toward the wall (nearest the bathroom) laying on his right side. We rolled him onto his back...together we assisted in standing him up. We then walked (R17) until he was steady." The report further documents, "Conclusion of Investigation: In conclusion, the facility has determined that the causation could have been either occurrence from the day and/or a combination of both, and/or anytime the resident was crawling (on his fall mat.) It is important to note that the resident has a

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S9999	Continued From page 8 diagnosis of intellectual disabilities, and his Care Plan states, "He has the mentality of a three year old" ...Based on this incident, the QAC (Quality Assessment Committee) team has put in place that anytime (R17) is found crawling on the floor, nursing staff have to alert a nurse and they are to do a full assessment on him to ensure he has not obtained any injury. All staff have been educated that even if a fall was assisted to what they believe his safety, we will do best practice and ensure no injury took place in the assisting of the fall by having the on duty nurse fully assess the resident before standing him back up ..." There was no documentation in the nursing progress notes about staff assisting R17 to the floor nor of staff finding R17 on his fall mat. A Hospital Emergency Room Summary dated 05/05/22 documented, "Exam: Right shoulder X-Ray. Trauma to the shoulder, and pain. Findings: There is a displaced fracture of the proximal humerus." On 07/20/22 at 1:05pm, V1 (Administrator) stated the facility's Fall Investigations represent Quality Assurance documentation and are only available to facility staff. V1 confirmed the above documented incidents as stated in the report. V1 confirmed R17 did not receive nursing assessment after either of the above referenced incidents, and neither were immediately investigated. V1 stated she had to re-educate staff that both of these incidents represented falls and should be reported and investigated as such. On 07/21/22 at 1:30pm, V7, R17's (Physician/Medical Director), stated she was contacted by facility staff at 7:45pm on 05/05/22 stating they thought perhaps R17 had cellulitis of	S9999		

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S9999	Continued From page 9	S9999		

the shoulder. V7 stated staff forwarded her a photo of the shoulder, which showed an obvious bone deformity. V7 stated she instructed staff to immediately send R17 to the emergency room. V7 stated controlled falls where a resident is lowered to the ground and unwitnessed falls wherein a resident is found lying on a fall mat should both be reported to a physician and investigated as falls. V7 confirmed the facility did not notify her immediately after the resident was lowered to the ground nor after the resident was observed on his fall mat.

A Notification for Change in Resident Condition or Status Policy dated 12/7/17 documented, "The nurse supervisor/charge nurse will notify the residents attending physician or on call physician when there has been an accident or incident involving the resident."

A Fall Prevention Policy dated 11/10/18 documented, "Immediately after any resident fall, the unit nurse will assess the resident and provide any care or treatment needed...The unit nurse will place documentation of the circumstances of the fall in the nurses' notes."

(A)

2 of 2

300.1210b)
300.1210d)2)
300.1210d)3)

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary

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S9999	Continued From page 10 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. 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: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These requirements are not met as evidenced by: Based on interview, record review, and observation, the facility failed to provide wound care per physician's orders for 1 residents of 24 residents (R133) reviewed for quality of care in the sample of 24. Findings include: On 07/19/22 at 9:53am, R133 was alert and oriented to person, place, time, and purpose. R133 was observed to have a bandaged right foot. R133 stated she had to be admitted to the hospital on 07/12/22 due to complications of Covid. R133 stated she is diabetic and has an	S9999		

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S9999	Continued From page 11 arterial ulcer on the top of her foot. R133 stated the wound was debrided during the hospital stay. R133 stated the facility is supposed to be treating the wound daily, "but they aren't consistently." R133 stated in spite of this, the wound has improved and is healing. On 07/19/22 at 3:04pm, V6, Registered Nurse, was observed providing wound care for R133. V6 stated to R133, "The current order says to use Dakin's Solution, but I know before you went to the hospital, we had been using Medihoney. Which one do you want me to use now?" R133 replied she preferred the Medihoney, so V6 proceeded with the wound care using this treatment. A Physicians Order Sheet for July 2022 documented an order for "Right top foot wound: Clean with wound cleanser apply Dakin's (solution) wet to dry (dressing). Change daily." On the July 2022 Treatment Administration Record and in the Nursing Progress Notes, there was no documentation to indicate the treatment was done on 07/16/22, 07/17/22, and 07/18/22. On 07/21/22 at 8:38am, V1, Administrator, acknowledged she had been made aware that the wound was not being treated as ordered. V1 stated she had had to write up some of the nursing staff for this. On 07/21/22 at 1:35pm, V7, Physician/Medical Director, stated the current July 2022 wound care treatment orders should be followed. V7 stated staff asking the resident how they want the wound to be treated is not acceptable practice. V7 stated the wound is healing adequately.	S9999		

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S9999	Continued From page 12 (B)	S9999		