

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008494	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/20/2022
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NAME OF PROVIDER OR SUPPLIER STONEBRIDGE NURSING & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 902 SOUTH MCLEANSBORO BENTON, IL 62812
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(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 Certification and Licensure Survey	S 000		
S9999	<p>Final Observations</p> <p>Statement of Licensure Violations:</p> <p>300.610a) 300.1210b) 300.1210d)6)</p> <p>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.</p> <p>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.</p> <p>Section 300.1210 General Requirements for</p>	S9999	<p style="text-align: center;">Attachment A Statement of Licensure Violations</p>	

ILLINOIS DEPARTMENT OF PUBLIC HEALTH LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>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.</p> <p>Regulations were not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to lock the wheels on a resident's bed and failed to provide the required level of assistance with bed mobility for 1 of 8 residents (R55) reviewed for falls in the sample of 55. This failure resulted in R55 falling out of bed, suffering a fractured left femur, and subsequently being admitted to the hospital for surgical intervention.</p> <p>Findings Include:</p> <p>R55's facility document titled, "Face Sheet" documents R55 was admitted to the facility on 1/22/2019 with an admitting diagnosis of heart failure, muscle weakness, polyneuropathy, and type 2 diabetes mellitus. R55's Minimum Data Set (MDS), dated 4/08/2022, documents a Brief Interview for Mental Status (BIMS) score of 15, indicating R55 is cognitively intact. This same MDS documents R55's Functional Status as requiring extensive assistance x 2 person physical assist with bed mobility.</p> <p>On 10/17/2022, at 8:50 a.m., R55 stated that on 6/27/2022, V23 (Registered Nurse/RN) came into her room to do her treatment on her bottom. R55</p>	S9999		

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S9999

stated that V23 assisted in rolling her on her right side toward the wall. R55 stated she and V23 were the only ones in the room. R55 stated V23 turned away from her to get her treatment supplies and at that time, R55 stated the bed started to move away from the wall and before she could tell V23, she had fallen out of the bed onto the floor face-first between the wall and the bed. R55 stated that she started to have severe pain in her left leg and hit her head on the floor. R55 stated that V23 ran out of the room and V7 (Licensed Practical Nurse/LPN) came back into the room and looked her over. R55 stated she was sent out to the hospital and was told she had a broken leg and said she had a golf ball size bruise to the middle of her forehead. R55 stated that she had surgery on her left leg. R55 stated that at that time before she had her fall, she had one bed rail (1/2) on the upper left side of the bed. R55 stated she did not know why V23 rolled her to the other side that did not have a bed rail to hold onto.

On 10/20/2022, at 10:00 a.m., V7 (LPN) stated that on 6/27/2022, 12:00 p.m., she was standing by the bathroom door outside of R55's room and heard a loud bang and then saw V23 (RN) come out of the room. V7 stated that she and V23 entered R55's room and rotated her onto her back and waited for the ambulance to arrive. V7 stated that there were no other people in the room when she entered to help V23 with R55. V7 stated that R55 was located between the bed and the wall when she and V23 repositioned R55 on her back.

R55's medical records documents on 6/27/2022, at 4:20 p.m., local hospital history and physical, under section, "Patient's Chief Complaint: Fall ...Patient presented to local hospital emergency

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S9999	<p>Continued From page 3</p> <p>department due to fall. She states she has chronic wounds on her sacrum in dependent areas for which she was attempting to get wound care today. She states that she was rolled over and that the bed was not locked and slid away from the wall causing her to fall between the bed and the wall. Further x-rays and computed tomography (CT) revealed left distal femur comminuted fracture. Ortho was consulted and she will be admitted for further workup and treatment". Signed by V24 (local physician).</p> <p>R55's medical records, titled "After Visit Summary" dated 6/29/2022, under section, "Surgical/Procedural Cases on This Admission," "Open Reduction and Internal Fixation (ORIF), fracture, femur using intramedullary implant and interlocking screw" by V26 (local surgeon). R55 returned back to the facility on 7/06/2022.</p> <p>R55's facility document titled, "Resident Incident Report" dated 6/27/2022, documents "Resident side lying on right side during treatment. Bed raised approximately 3 feet, bed locked on bottom, checked with R55 to see if she was ok lying on her side. V23 (RN) turned around to get treatment supplies and R55 rolled out of the side of the bed landing on her stomach. R55 reported she hit her left leg and her head. R55 had a golf ball sized raised area on her head in the front middle area and reported pain in her left leg. Order obtained for transport to hospital to evaluate and treat." R55's facility document titled, "Incident Investigation" dated 6/27/2022, documents "Full Investigation has been completed on this investigation. It was found that R55 was lying in bed and V23 (Registered Nurse) entered the room to do R55's treatment. R55 is independent with bed mobility and went to roll over so V23 could complete treatment and rolled</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>off the side of the bed onto the floor. Interdisciplinary team (IDT) determined the root cause of this incident is R55's poor bed mobility and poor safety awareness." By V6, (Regional Administrator).</p> <p>On 10/18/2022 at 11:25 a.m., V20 (Director of Therapy) stated that R55 was evaluated for physical therapy on 7/19/2022 and R55's previous level of functioning was maximum assistance x 2 with rolling left to right with bed mobility.</p> <p>On 10/18/2022 at 1:55 p.m., V21 (Minimum Data Set/MDS Coordinator) stated that extensive assistance is 2 person physical assistance with bed mobility, transfer, walking, dressing, eating, toileting, and personal hygiene.</p> <p>At the time of this survey V23 was unable to be interviewed due to no longer being employed at the facility.</p> <p>(A)</p>	S9999		