STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001663	A. BUILDING: _____ B. WING _____	C 03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HEALTH CARE CENTER	1450 26TH STREET HIGHLAND, IL 62249

(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 2242053/IL144657	S 000		
S9999	Final Observations Statement of Licensure Violations: (Findings 1 of 2) 300.610a) 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 300.1210 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 were not met as evidenced by: Based on interview and record review the facility failed to assess and monitor for injury related to pain after a fall for 1 of 3 residents (R2) reviewed for quality of care in the sample of 9. This delay in treatment resulted in R2 having a decline in activities of daily living, not being assessed for pain and unable to follow orthopedic orders and complete physical therapy. Findings include: R2's Social Service Notes dated 12/17/2021 document, "The resident was admitted to (Facility) from (local Hospital) following treatment for hypotension and fall. The resident is understood when speaking, however does have dementia."	S9999		

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S9999	Continued From page 2	S9999		

R2's Admission Assessment with an effective date of 12/19/2022 at 6:01 PM, documents R2 was at the facility for therapy, with the goal of returning to prior level of care, he has no contractures, was full weight bearing, with no impairments on the upper or lower extremities.

R2's Fall Risk Assessment dated 12/19/2021 at 6:00 PM, document R2 was "High Risk" for falls and had no falls in the past three months.

R2's Minimum Data Set (MDS) dated 12/24/2021 document R2 was moderately impaired for cognition, requires extensive assist with one staff for bed mobility and toileting, extensive assist with 2 staff members for transfer, uses a walker, and has no impairment for range of motion.

R2's Progress Notes dated 12/31/2021 at 6:22 PM, "This writer heard resident call out, 'can someone help me.' Entered Room and noted him lying on the floor, on his back, partially under his bed with head at the end of the bed. Wheelchair sitting beside bed with brakes locked. Socks with no shoes on, bed was not locked. Resident stated he was trying to get into bed and the bed moved. Neuros and range of motion within normal limits. Assisted to standing and into bed by 2 staff with gait belt."

R2's Order Date of 1/13/2022 by V10 (Physician) documents, "Obtain CT (computerized tomography) scan of bilateral hips/pelvis due to pain and decline in mobility since fall."

R2's medical records document he had 3 falls while at the facility, 12/18/2022, 12/31/2021 and 1/3/2022.

R2's Physician Order Sheets for the month of

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S9999	Continued From page 3 January and February of 2022 have no orders for any nonsteroidal anti-inflammatory pain relievers. R2's December 2021 Medication Administration Record (MAR) documents R2 pain level as zero (no pain). Tylenol was the only pain reliever documented for the use of pain. R2's January 2022 MAR documents on 1/3/2022 R2 was having pain (level of 5 on scale of 1 to 10) and 2 tablets 325 Milligrams (MG) of Tylenol was given. The January 2022 MAR documented pain level as zeros for the rest of the month with the exception of Tylenol which administrated on 1/7/2022 (pain level of 4) and 1/10/2022 (pain level of 5). R2's MAR does not document any non-drug approach was attempted for R2's pain. On 3/17/2022 at 12:45 PM, V8 (Family of R2) stated, "I would go into the home every day and visit my husband. At the end of December when I went to visit him, I could tell he was in a lot of pain. I asked him are you hurting and in pain and he said yes, he had fallen. When R2 came in the nursing home, he was walking with a walker. After his fall, I took him to (Outside Orthopedic Center) and they took an x-ray and told me R2 had a hip fracture. No wonder he was in so much pain. R2 did not have any surgery because they said the fracture was 6 weeks old, I believe, so they wanted him to have physical therapy. R2 told me he fell because he was trying to get into bed and the bed moved and he fell. It just does not make sense to me." R2's Progress notes dated 1/17/22 at 12:27 PM documents, "Note Text: MD (physician) ordered CT of leg and pelvis, unable to schedule until written order received. Request for written order sent to MD, waiting response. Order: 1/13/2022 at 10:07 AM Obtain CT Scan of bilateral	S9999		

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S9999	Continued From page 4	S9999		

hips/pelvis due to pain and decline in mobility since fall." (4-day delay in order).

R2's CT image report, dated 1/27/2022 (14 days later), documents R2 was positive for hip pain, stress fracture and mildly distracted fracture of the right greater trochanter (hip).

On 3/18/2022 at 12:15 PM, V2 (Director of Nursing) stated, "It looked like V10 (Physician) came and saw R2 on 1/13/2022 and ordered the CT and when they went to schedule it the hospital needed a written order that was put in on 1/17/2022. I have no idea why there was a gap between those dates. I wonder if therapy may have contacted V10 regarding pain, but I really don't know for sure."

R2's Physical Therapy (PT) Note, dated 1/4/202, documents, "Patient has fallen, unwitnessed, since onset of therapy. Patient overall has responded to therapy program with positive outcomes. Skilled training and reinforcement continues to be indicated to maximize patient's independence and safety. Balance and strength continue to be less than optimal. Prognosis for Further Progress: Good due to patient, demonstrates physical potential to be mod I, unfortunately safety and independence are contingent on cognitive status which fluctuates widely."

R2's PT daily treatment note dated 1/10/22 (no time listed): PT complained of right hip pain with increased weight bearing through RLE (Right Lower Extremity). Patient requires mod (moderate) assist when weight bearing through RLE to advance LLE (Lower Left Extremity). Patient has increased difficulty staying on task. Nursing made aware of hip pain."

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S9999	Continued From page 5 R2's PT daily treatment note from 1/13/2022: "Patient ambulated 6 feet with w/w (wheeled walker) and mod assist with weight shifting to RLE and bearing weight to advance LLE. Patient complained of increased right hip pain with increased weight bearing through RLE." R2's PT daily treatment note from 1/18/2022: Patient ambulated 6 feet with w/w and modified assist with weight shifting to RLE and bearing weight to advance LLE. Patient complained increased right hip pain with increased weight bearing through RLE." R2's MAR does not document any pain medication was given to R2 on 1/13/2022 and 1/18/2022. R2's PT Note, dated 1/17/2022, documents "Patient demonstrated a decline in functional abilities last reporting period with pain with use of right lower extremity in any position. At this time patient has pain in Right hip during straining activities and stance phase on R (right). MD has put in orders for a CT scan. Patient is a high risk for falls on his feet requiring need for skilled training, overall functional abilities have declined since onset of Right hip pain. Prognosis for Further Progress: Fair due to patient's progress has been limited by R hip pain. X-rays are (-). Pending CT scan of hips." R2's Progress Notes and Physical Therapy Notes do not document the Physician was notified for any pain medication and there was no order for any pain Management for R2. R2's PT Note dated 2/3/2022 documents, "Picture of Right hip came back positive for fracture of	S9999		

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S9999	Continued From page 6 right greater trochanter, no fracture of femoral neck or head of femur demonstrated. Pain has limited patient's participation and progress in therapy. Fracture is not in a location of concern for negative response to weight bearing. Continued standing, attempts to ambulate are not contraindicated." R2's Orthopedic Report dated 2/14/2022 documents, "Patient is here today in regards to a right hip fracture. X-ray today shows 81 year old male with a history of fall in a nursing home about '6-7 weeks ago' according to the patient's wife. The patient was found on the floor by the nursing staff. According to the wife, the staff ordered an x-ray 'weeks later', followed by a CT weeks after that. Non-displaced fracture of the right greater trochanter. This will be managed conservatively. This will consist of protective weight bearing, NSAIDS, Nonsteroidal anti-inflammatory drug and pain control. The patient verbalizes understanding. Weight bearing as tolerated (WBAT) with 2 hands on walker at all times. Physical Therapy evaluation and treatment three times per week for 6 weeks. Strength Training and Gait Training." (R2 was never started on any NSAIDS). On 3/18/2022 at 1:10 PM, V10 (Physician) stated he was aware of the R2's fall and recalled ordering CT scan, but is unable to remember the exact details. Reports general hesitation to give older adults NSAIDs due to renal function and narcotics due to potential for instability or fall. States he was out of work for 10 days around that time frame and is unable to remember further details." On 3/18/22 at 1:30 PM, V14 (Physical Therapist) stated, "The first day I saw R2 he talked with me.	S9999		

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Stood up walked with me hand-held and walked to the shower. R2 was cognitively loosely and sharp. R2 had severe dementia and his performance fluctuates with his mental status. R2's first assessment was on 12/20/2021, he walked about 150 feet that day. His wife said he was walking in the house before that. His course of therapy was all over the place. Not a steady course. He dealt with pain and we put him on therapy. He had a history of falls at home. Lives with his spouse. I was aware that they found him on the floor. He had no safety awareness. He voiced pain on occasion, so somedays he was not able to sit up and would say his hip hurt and he would say he could not move it. We talk to the nurses I do not know in the case. There was a fall, there was a report nothing in urgency stood out. He would move and then he would have pain, it was hard to say. He voiced pain and it was hindering his abilities. He tried to work through the pain. The best day he had was the first day he was here. He had some behavior issues too. We let the R2's nurse know that he has pain. He was already being seen by PT. He was already seeing therapy. We were not making any progress with him the goal was to go home with the wife. R2 was declining and was not improving with therapy. With his dementia and decline we stopped therapy because we felt he was not able to improve. It had nothing to do with money, or days he was just declining."

The facility's "Management of Pain" policy with revision date of 9/16/2020 documents, "Our mission is to facilitate resident independence, promote resident comfort and preserve resident dignity. We will achieve these goals through promptly and accurately assessing and diagnosing pain, aggressively assessing pain in non-verbal and cognitively impaired residents,

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S9999	Continued From page 8 monitoring treatment efficacy and side effects, and preventing and minimizing anticipated pain when possible. Pain will be assessed and managed in a timely fashion, especially if it is of recent onset. The physician will be notified of resident's complaint of pain when not relieved by medication as ordered by physician. Thorough communication with the physician will ensure an appropriate pain management plan. When new pain or an exacerbation of pain is suspected, the comprehensive Pain Assessment will be completed. Drug therapy will be reviewed on a regular basis by the physician and pharmacist following the guidelines of the World Health Organizations Three Step Analgesic Ladder and the American Geriatric Society. Initiate an interdisciplinary plan of care based on the initial assessment, the choice of a pain rating scale, and the development of pain-relieving strategies. Document interventions and responses in the medical record as appropriate (i.e. medication administration record, treatment record, nursing progress notes, etc.)" (A) (Findings 2 of 2) 300.610a) 300.1210b) 300.1210c) 300.1210d)3) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the	S9999		

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S9999	Continued From page 9 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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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	S9999		

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S9999	Continued From page 10 resident's medical record. 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. These requirements were not met as evidenced by: Based on interview and record review the Facility failed ensure bed in locked position, failed to assess, monitor and provide supervision, and implement safety measures for fall prevention for 2 of 3 residents (R2, R4) reviewed for falls in the sample of 9. This failure resulted in R2's fall sustaining a right hip fracture. Findings include: 1. R2's December 2021 Physician Order Sheet (POS) documents a diagnosis of Dementia in other disease, difficulty in walking. R2's Face sheet document R2 was admitted to the Facility on 12/17/2021. R2's Physical Therapy Notes, dated 12/20/2022, document, "Patient has a history of fall at home and had 3 falls in succession leading up to hospitalization." R2's Admission Assessment with an effective date of 12/19/2022 at 6:01 PM, documents R2 was at the facility for therapy, with the goal of returning to prior level of care, he has no contractures, was full weight bearing, with no impairments on the upper or lower extremities.	S9999		

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R2's Fall Risk Assessment dated 12/19/2021 at 6:00 PM, documents R2 was "High Risk" for falls and had no falls in the past three months.

R2's Minimum Data Set (MDS) dated 12/24/2021 documents R2 was moderately impaired for cognition, requires extensive assist with one staff for bed mobility and toileting, extensive assist with 2 staff members for transfer, uses a walker, and has no impairment for Range of Motion.

R2's Social Service Notes dated 12/17/2021 document, "The resident was admitted to (Facility) from (local Hospital) following treatment for hypotension and fall. The resident is understood when speaking, however does have dementia."

R2's Progress Notes dated 12/31/2021 at 6:22 PM, "This writer heard resident call out, 'can someone help me." Entered Room and noted him lying on the floor, on his back, partially under his bed with head at the end of the bed. Wheelchair sitting beside bed with brakes locked. Socks with no shoes on, Bed was not locked. Resident stated he was trying to get into bed and the bed moved. Neuros and Range of motion within normal limits. Assisted to standing and into bed by 2 staff with gait belt."

R2's Incident Report dated 12/31/2021 at 6:10PM, documents the incident description as per the Progress Note. It also documents, R2 stated, "I was trying to get into bed, the bed moved and I fell." Immediate Action Taken, "Neuros and Range of Motion assessed and within normal limits. Assisted to standing by 2 staff members with a gait belt, Skin assessment completed with no injuries. Bed locked." The

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S9999	Continued From page 12 intervention does not document anything else regarding the safety of the bed being locked. On 3/17/2022 at 12:45 PM, V8, Family of R2 stated, "I would go into the home every day and visit my husband. At the end of December when I went to visit him, I could tell he was in a lot of pain. I asked him are you hurting and in pain and he said yes, he had fallen. When R2 came in the nursing home, he was walking with a walker. After his fall, I took him to (Outside Orthopedic Center) and they took an x-ray and told me R2 had a hip fracture. No wonder he was in so much pain. R2 did not have any surgery because they said the fracture was 6 weeks old, I believe, so they wanted him to have physical therapy. R2 told me he fell because he was trying to get into bed and the bed moved and he fell. It just does not make sense to me." On 3/17/2022 at 2:40 PM, V11 (Licensed Practical Nurse/LPN), stated, "R2 was confused, alert to self, impulsive, and very stubborn. I remember when R2 fell. He did not have his bed locked and was trying to get back in bed. I don't know why the bed was unlocked. R2's bed had to be all the way down to lock it. What could have happened is when they got him up, they had to lift the bed in order to transfer him. It could happen again if the bed was left up to eventually put someone back in. R2 had no injury and no complaint of pain at that time. Much later R2 complained of pain, so an x-ray was ordered. After that, he kept complaining during therapy, so the CT (computerized tomography scan) was ordered. I am not sure what happened after that. (R2) was transferring before he went home, but not walking with a walker. I think he had a fracture."	S9999		

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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
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R2's Progress notes dated 2/14/2022 at 11:02 AM, documents, "Resident came back from his appointment Resident has right greater trochanter fracture status post 6 weeks ago."

On 3/17/2022 at 3:52 PM, V9 (Director of Transportation) stated, "I took R2 for a CT scan at the hospital on 1/27/2022. Then on 2/14/2022, I took R2 to the (Outside Orthopedic Center). When he came back from the second appointment, I know he had a hip fracture. I may have told his wife."

On 3/17/2022 at 9:24 AM, V13 (Medical Assistant for the Orthopedic Physician) stated, "R2 is a patient here he had a fall at the nursing home and had a minimal displaced fracture of his right hip. The wife said they had taken an x-ray at the nursing home and it was negative and he was complaining of pain and not wanting to get out of bed and a few weeks later they took a CT scan and it showed a fracture. We took an x-ray when he was here and confirmed he had a fracture and it was an old fracture that appeared to be about 6 weeks old."

R2's CT image report dated 1/27/2022 at 3:31 PM, documents R2 was positive for a hip pain, stress fracture and mildly distracted fracture of the right greater trochanter (right hip).

R2's Orthopedic Report dated 2/14/2022 document, "Patient is here today in regards to a right hip fracture. X-ray today shows 81-year old male with a history of fall in a nursing home about '6-7 weeks ago' according to the patient's wife. The patient was found on the floor by the nursing staff. According to the wife, the staff ordered an x-ray 'weeks later, followed by a CT weeks after that. Non displaced fracture of the right greater

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	IL6001663	A. BUILDING: _____ B. WING _____	C 03/18/2022

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trochanter. This will be managed conservatively. This will consist of protective weight bearing, NSAIDS, Nonsteroidal anti-inflammatory drug and pain control. The patient verbalizes understanding. Weight bearing as tolerated (WBAT) with 2 hands on walker at all times. Physical Therapy evaluation and treatment three times per week for 6 weeks. Strength Training and Gait Training."

On 1/17/2022, Physical Therapy notes document R2 was demonstrating a decline in function and has pain in right hip with standing activities.

R2's Progress Notes dated 1/17/2022 at 12:27 PM, documents, "Note text; Medical Doctor (MD) ordered CT of leg and pelvis, unable to schedule until written order received. Request for written order sent to MD awaiting response." Written order date 1/13/2022 (before Progress Note).

2. R4's March 2022 POS documents R4 has a diagnosis of dementia, morbid obesity, Parkinson's disease, and cerebral infarction.

R4's MDS dated 2/24/2022 documents R4 was moderately impaired, cognitively. Required one staff person for supervision for bed mobility, was independent with transfers, required limited one person assistance with dressing and toileting, and had no impairment in range of motion.

R4's Care Plan Care Plan dated 3/4/2022 documents, "This resident has a behavior of placing blankets on the floor to make a "pallet" to sleep on related dementia/confusion. The resident has impaired cognitive function/dementia or impaired thought processes related to dementia, impaired decision making, and short-term memory loss. Date initiated:

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S9999	Continued From page 15 2/28/2022. The resident has delirium or an acute confusion episode related acute disease process (dementia). Date initiated: 2/21/2022. At risk for falls related to medications. Date initiated: 2/17/2022. 3/11/2022 Medication adjustment, brightly colored reminders left in room to remind R4 to wait for assistance. Date initiated: 3/11/2022. Do not leave resident unattended when awake. Resident is at risk for falls and injuries." R4's Incident Report dated 3/11/2022 at 6:18 AM documents, "R4 was heard yelling out for help. Entered the room to observe R4 on the floor laying on his left side with his blanket and sheet at the foot of the bed, unassisted, and did not use his call light for assistance. The bed was in the low position, the night light in place and functioning properly. The resident sensor alarm did not sound. Tested sensor alarm and functions properly. The sensor was not in reach of resident's movements. Unknown if resident moved alarm. Resident states he got up to make his bed, I don't understand." Immediate Action: "Resident was immediately assessed for injury, he was observed with ROM (range of motion) x4 extremities. He was table to actively perform ROM with no pain and active movement. New intervention: 1. Resident brought to the nurses' station for close observation, 2. Recommended room to be moved closer to the nurses station. His blankets and sheet were on the floor at the foot of his bed and the way it was positioned it appears as though he may have tripped over the bed linens turned around and fell. The resident stated, 'I don't know why but everything was going well and next thing you know I'm on the floor.' Medication review completed dosage reduction done, reminders place in room to call for help."	S9999		

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S9999	Continued From page 16 On 3/15/2022 at 11:26 AM, R4's door to his room was closed. Upon opening the door, R4 was sitting in a chair with his walker next to him. There was no other staff in the room. (This does not follow the intervention for his previous fall on 3/11/22). On 3/15/2022 at 11:38 AM, V6 (Certified Nursing Assistant/CNA), entered the room and told R4 she needed to get his vital signs. Vitals were taken, blood pressure slightly elevated 162/86 all other vitals WNL (within normal limits). V6 did not alert any staff or tell staff R4 was sitting in his room alone. On 3/16/2022 at 11:41 AM, V6 (CNA) stated, "R4 gets confused really easy and we have to constantly remind him to use his walker. He does not like activities and he forgets to ask for help. He has good days and bad days but he can be forgetful at times and confused." On 3/16/2022 at 11:48 AM, V7 (Registered Nurse/RN), stated, "R4 needs constant reminding as he can become easily confused and forgetful. He has good days and bad days. He usually does not do activities. He is not supposed to be alone in his room but he is across the hall from the activities today." The facility's "Fall Prevention Program" policy dated 09/15/2019 documents, "Complete the fall assessment initially on admission, quarterly, and with a change of status. Provide ongoing risk reducing interventions. Provide ongoing evaluation of resident response to interventions. New or changes in current interventions will be discussed by the interdisciplinary team and the care plan will be updated accordingly."	S9999		

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S9999	Continued From page 17 (No violation)	S9999		