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
	IL6001135	A. BUILDING: ______ B. WING ______	C 06/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST CITY REHAB & NRSG CTR	321 ARNOLD AVENUE ROCKFORD, IL 61108

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S 000	Initial Comments Complaint Investigation: 2214755/IL148099	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6 300.2210b)5 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. 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: 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 300.2210 Maintenance b) Each facility shall 5) Maintain all furniture and furnishings in a clean, attractive, and safely repaired condition. These Requirement was NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident wasn't too close to the side of the bed when providing incontinence care. This failure resulted in R1 being turned onto her side in bed next to a side rail that fell off the bed. R1 fell out of bed and sustained an orbital fracture. This applies to 1 of 3 residents (R1) reviewed for safety in the sample of 6.	S9999		

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The findings include:

The Nursing Progress notes for R1 showed, "On 5/31/22 at 4:30 PM, Writer was informed by the CNA (Certified Nursing Assistant) cleaning the resident that she fell out of the bed when she rolled over and the bed rail broke. Resident landed in a prone position. Writer assessed the resident and she was alert and oriented. Writer also noticed that there is a mild bleeding on the resident's right side of the face near her eye and her right nostril too. With the approval of the NP (Nurse Practitioner), resident was sent to the ER (emergency room) for further evaluation. At 10:38 PM, Writer called the ER and the ER nurse said R1 had an orbital floor fracture. Amoxicillin-Clavulanate 875-125 mg tab, twice a day for 5 days was prescribed. Resident is to be discharged (back to facility) awaiting transportation."

The hospital Emergency Department Physician's Note dated 5/31/22 for R1 showed, "Patient with a mechanical fall. Patient is on Norco and reports that her pain is not managed with that alone as she has been on Norco for a long time. She was subsequently given morphine and odanestron and removed reports of significant improvement. Patient is found to have a fracture of the inferior orbital floor, without any signs of entrapment both on physical exam or on CT (computerized tomography). Treatment plan is discussed with the patient and she is discharged back home to the nursing facility."

On 6/21/22 at 10:13 AM, V3 ADON (Assistant Director of Nursing) stated, "I was gone when that (R1 falling out of bed) happened. I heard about it. The CNA (Certified Nursing Assistant) was doing

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S9999	Continued From page 3 a bed change and the side rail on R1's bed broke. R1 fell out of bed. I am going to assume she fell because the side rail broke. I think we were going to see about a bigger bed. I don't believe they know why it broke." On 6/21/22 at 10:55 AM, V4 LPN (Licensed Practical Nurse) stated, "When I came in they said the CNA was rolling R1 and the side rail on R1's bed that was closest to the door came off. R1 fell out of bed onto the floor. R1 had a black eye and she fractured the orbital floor. R1 is alert and oriented. R1 is paranoid now about it." On 6/21/22 at 12:25 PM, V5 CNA stated, "I was changing R1 and she had two side rails on her bed that were already loose. I rolled R1 towards the wall. I rolled R1 so she could put her arm over the rail. R1 was near the side of the bed. I was changing her cloth pad and the side rail just fell off. R1 went face first onto the floor. R1 was really scared and is still scared when you turn her. R1 can tell you what happened. I talked to some other CNA's and they told me the railing had been broken and no one ever fixed it." On 6/21/22 at 12:59 PM, R1 was laying in bed and had a purple mark under her right eye. R1 had bilateral upper side rails on her bed. R1 stated, " V5 CNA was changing me and turned me towards the door. V5 had me close to the side of the bed and bam there I went. I fell on my face and front. I hit my face on the floor first. Since the fall, I am scared to death, I am afraid of falling again. It hurt like hell. The side rail came off, just like that. This side rail on the right side fell before too and they fixed it. I went to the hospital and they said I broke my cheek bone. They fixed the railing while I was at the hospital."	S9999		

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S9999	Continued From page 4 On 6/21/22 at 2:21 PM, V8 LPN stated, "I was starting my shift and was at the nurse's station. The CNA called me and I went to R1's room. R1 was laying on the floor. The CNA was in the room, said she was changing R1 and R1's whole body went into the bed rail. R1 cannot move her hands because of all of her neurological changes. R1 put her weight on the bed rail and it fell off. R1 was in a prone position on the floor. I told R1 not to move and I called 911. R1 was getting progressively worse before the fall and couldn't do anything herself anymore. R1 used to use the side rails for repositioning but couldn't anymore." On 6/21/22 at 2:30 PM, V9 CNA stated, "One time before R1's bed rail was loose on one side. I know they fixed a side rail before because it was loose and came off. R1 can't grab onto the side rails anymore or reposition herself. It takes two people to reposition R1 in bed and that was before this fall." On 6/22/22 at 9:56 AM, V16 CNA and V17 CNA were in R1's room to transfer her from her wheelchair to her bed and provide incontinence care. V3 ADON (Assistant Director of Nursing) was in the room to observe the transfer and care. R1 was transferred to her bed that had bilateral upper side rails. V17 turned R1 onto her left side near the side rail and side of her bed. R1 was not able to grab onto the side rail. V16 provided incontinence care and then turned R1 onto her right side. R1's body was pressed against the side rail and near the side of the bed. V3 stated, "We talked about getting R1 a bigger bed. R1 shouldn't be leaning into the side rails. They are not meant to prevent falls." V16 and V17 stated R1 needed a bigger bed because there was no room in her current bed to turn her without going near the side of the bed and into the railing. R1	S9999		

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stated she felt her body going into the railing and didn't like it.

The facility's Repositioning & Turning policy (6/21) showed, "A turning/repositioning program is used by the nursing staff. The MDS (Minimum Data Set) nurse or Wound Care Nurse is responsible for incorporating the plan, approaches and goal into the care plan. Positioning plans will be revised and approaches altered, on a timely basis, to address changes in the resident's condition. Prior to repositioning the resident the assignment for specific directions will be checked.

The MDS dated 5/3/22 for R1 showed for bed mobility, transfers, dressing, toilet use and personal hygiene the resident was totally dependent and required the assistance of two plus persons.

The Care Plan dated 5/25/22 for R1 showed, "R1 requires extensive assistance of 2 (people) with bed mobility, toileting, and transfer."

The Fall Risk Review dated 5/31/22 for R1 showed, "high fall risk."

On 6/22/22 at 10:19 AM, V17 CNA stated, "I know before R1 fell out of bed I had talked to V3 ADON about getting R1 a new bed. The one she has is too small. R1 was a 1 person assist at first and then she started gaining weight and declined. R1 is not able to grab the side rails anymore. R1 needs two people to do her care. R1's side rails should have been taken off. I noticed the side rails were bending out and were not straight up. It looked like they had weight against them. I wasn't in the room when it (R1's fall out of bed). V5 CNA was by herself when it happened. V5 came out to

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the nurse's station. I was at the nurse's station and we all went down there (R1's room). R1 was laying on her face. I asked the nurse if we could get R1 off her face and roll R1 onto her back. We stayed until the ambulance came."

The facility's Supervision and Safety policy (8/20) showed, "Safety risks and environmental hazards are identified on an ongoing basis through employee training conducted upon hire, annually and as needed. Resident supervision is the core component of resident safety. Staff to decrease safety risk factors as much as possible."

The facility's Fall Prevention Program policy (12/20) showed, "It is the policy of this facility to have a Fall Prevention Program to assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Care plan incorporates: identification of all risk/issue; preventative measures. All staff will be oriented and trained on fall prevention. Malfunctioning equipment will be immediately reported to maintenance for repair or removed from service, i.e. bed locks, side rails, and grab bars."

The Diagnosis Information dated 6/21/22 for R1 showed she has diagnoses including bipolar disorder, abnormalities of gait and mobility, diabetes mellitus, depression, insomnia, schizoaffective disorder, persistent mood disorder, anxiety disorder, hypertension and chronic kidney disease.

(B)

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