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
	IL6014674	A. BUILDING: ______ B. WING ______	C 06/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALHOUN NURSING & REHAB CENTER	#1 MYRTLE LANE HARDIN, IL 62047

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S 000	Initial Comments Complaint 2244570/IL147883	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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. Restorative measures shall include, at a minimum, the following procedures:

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 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Regulations were not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide adequate supervision to 2 residents (R2, R11) reviewed for falls. This failure resulted in R2 having falls on two separate dates, both times requiring her to be

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sent to the emergency room and receiving 8 sutures to her head and a cervical fracture (C6) after the first fall on 2/17/22 and 12 sutures to her forehead on 6/11/22.

Findings include:

1. On 6/15/22 at 5:33 AM R2 was lying in her bed and was noted to have a gauze dressing covering her forehead. V14, Certified Nursing Assistant (CNA), and V15, CNA, were boosting R2 up in bed. V14 stated when R2 is up in her wheelchair (w/c) she is never left alone in her room because she will try to stand up without assist and has had multiple falls.

R2's Face Sheet documents her diagnoses to include Atherosclerotic Heart Disease, Pain, Unspecified Diastolic (Congestive) Heart Failure, Unspecified Osteoarthritis, Alzheimer's Disease, Type 2 Diabetes Mellitus, Generalized Anxiety, Unspecified Sequelae of Cerebral Infarction, and Insomnia.

R2's Minimum Data Set (MDS) dated 4/7/22 documents her Brief Interview for Mental Status score as 9, indicating she is moderately cognitively impaired. The MDS further documents R2 requires extensive assist of 2 persons for bed mobility, transfers, and toileting, and is dependent for locomotion on and off the unit. The assessment documents R2 had no functional limitations to her upper or lower extremities and her balance during surface-to-surface transfers is not steady and she is only able to stabilize with staff assistance. Per this assessment R2 is always incontinent of bowel and bladder.

R2's Care Plan dated 8/26/16 with the goal date of 7/12/22 documents, "Safety Notes: I would like

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S9999	Continued From page 3 to keep my alarms in place at this time. I am a fall risk due to my history of falls and diagnoses of Convulsions, s/p (status post) CVA (Cerebral Vascular Accident) and Osteoporosis. I do have alarms on my bed due to my poor safety awareness. I have tried to stand by myself before. I do have assist bars on my bed to help with bed mobility. Keep items that I frequently use within my reach but keep area free of clutter and safety hazards. Please offer me activities throughout the day. Please put on gripper socks on me while in bed as tolerated. 2/17/22 Please make sure my alarm is working as it has been replaced due to my fall. 6/11/22 Please assist me to a common area while up in (high backed) wheelchair. 6/11/22 Remind staff if I'm standing, attempting to stand up on my own to place me in a common area. 6/12/22 Observe my laceration to my forehead for s/s (signs/symptoms) of infection and pain. Notify MD (Medical Doctor) of my changes in condition-treatment as ordered-remove my 12 sutures in one week as ordered." R2's Care Plan further documents, under "Mobility/Transfers: I am an assist of 2 with a total lift for transfers. I have a history of a broken femur and had surgery for this fracture of pelvis. Brand name of chair (high back reclining wheel chair) for comfort." R2's Morse Fall Scale dated 6/11/22 documents her score as 90, indicating she is at high risk for falls. R2's Progress Note dated 2/17/22 at 4:51 PM documents, "CNAs called nurse into resident's room-lying on the floor with large pool of blood under her head. Large lacerations on both sides of head and forehead-had been sitting in chair (high back reclining wheelchair). Alarm in place but not sounding. Family, Medical Doctor (MD),	S9999		

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ambulance called. Blood noted on corner of bedside table."

R2's Progress Note dated 2/18/22 at 10:01 AM documents, "Resident remains on follow-up from fall on 2/17/22 with injuries noted to head, staples intact to three lacerations on head, pressure dressing in place, clean, dry, intact. Soft cervical collar in place due to C6 fracture (fx). No s/s of pain or distress noted. Neuro checks WNL (within normal limits). Family here at bedside."

R2's "Serious Injury Incident Report" dated 6/11/22 at 9:10 PM documents, "Incident Type: Fall; Type of Injury: Laceration-deep; Incident level: unwitnessed; Please see Nurses Notes, Large laceration to mid forehead with large amount of bleeding. Immediate Post Incident Action: Staff education to assist resident to a common area when trying to transfer or stand per self. Place in a common area when up in high backed chair as tolerated."

R2's Progress Note dated 6/12/22 at 4:00 AM documents, "Late entry for 6/11/22 at 9:10 PM: Staff member, (V19, Unit Aide) came and got writer from another resident's room, saying that resident was attempting to get up independently. As this writer ran to nurses station, heard a large thud and when rounding the corner, witnessed resident lying on the floor in front of her reclined high backed chair. Resident was lying on her right side and noted a large, deep laceration to mid forehead with a large amount of bleeding. Resident assisted onto her back and pressure dressing and ice applied to forehead. Second nurse called resident's daughter, at 9:13 PM and received consent to send resident to (local hospital). Neuro checks initiated and were WNL for this resident. V/S (vital signs) 170/100, 88, 20,

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S9999	Continued From page 5 98.0. AROM (Active Range of Motion) /PROM (Passive Range of Motion) to all 4 extremities without signs or symptoms of pain. Ambulance dispatched and arrived at facility at 9:20 PM. Resident placed in c-collar and transferred to stretcher per 4 assist. Resident enroute to (local hospital) at 9:27 PM with daughters to follow. MD made aware." R2's Radiology Report dated 6/11/22 documents, under Impression: "2. Small midline frontal scalp hematoma with associated laceration." On 6/16/22 at 8:36 AM, V19, Unit Assistant (UA), stated she was called into work on 6/11/22 because they were short on staff. V19 stated after dinner she was told to sit with R2, who was in her reclining wheel chair, in front of the nurses station to keep an eye on her. V19 stated she was not familiar with R2, and stated none of the other staff told her R2 tries to stand up by herself or that she is a fall risk. V19 stated any other time she had seen R2 in her chair, R2 was calm or sleeping. V19 stated the two Certified Nursing Assistants (CNAs) who were working that evening were down the hall in resident rooms, V20, Licensed Practical Nurse (LPN) was down the hall passing medications and V21, LPN was outside on the phone. V19 stated when she first approached R2, she could see R2 was wet and R2 smelled strongly of urine. V19 stated she let V6, CNA, know R2 was wet and V6 told her, "Well she's just going to have to wait." V19 stated R2 started pulling at her clothes and trying to stand up in front of her wheelchair (w/c), and V19 would tell her, "You need to sit down," and R2 would sit down for a minute, then try to get right back up. V19 stated R2 continued to pull at her pants like she was uncomfortable and hitting at V19 for trying to tell her to sit back down. V19 stated she	S9999		

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(V19) started yelling loudly, "I need help here." She stated she could see V20 down the hall and V20 pointed at her, but then V20 went into a resident's room. V19 stated nobody came and R2 continued to try to stand up, and was starting to try to hit V19, so she (V19) ran as fast as she could down to tell V20 that she needed help because R2 was trying to stand up, and they both ran back to where R2 had been sitting in her chair, but it was too late because R2 was already laying on the floor and her head was bleeding. V19 stated she has never worked in the health field until about two weeks ago when she was hired by the facility as a unit assistant. She stated her job duties include making beds, taking meal orders, assisting residents in wheelchairs to the dining room at breakfast, lunch and dinner, passing trays and picking up finished trays in the dining room. V19 stated she did not think about that she should push R2 in her w/c when she went to look for help, but just felt like she could hurry and get help and get right back to R2.

2. R11's Face Sheet documents her diagnoses to include Angina Pectoris, Major Depressive Disorder, Gastro-esophageal Reflux Disease, Age Related Osteoporosis, Unspecified Dementia with Behavioral Disturbance, and Generalized Anxiety Disorder.

R11's MDS dated 3/2/22 documents she is severely cognitively impaired and requires extensive assist with transfers and toileting. The MDS documents R11 is not steady when moving from seating to standing position, when walking, when turning around when walking, moving on and off toilet, and during surface-to-surface transfers and she is only able to stabilize her balance with staff assist. The MDS further

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S9999	Continued From page 7 documents R11 is occasionally incontinent of urine. R11's Care Plan dated 12/10/21 with the goal date of 6/8/22 documents: Safety Notes: 1/1 Please place non-skid footwear per my fall as tolerated. 1/14 Observe alarm for function. 1/16 Send to ER to evaluate. Please leave bathroom door cracked with light on as resident tolerates. I do have a history of falls prior to coming to this facility. Due to my dementia and impaired cognition I am at risk for falls. I do not call for assist with transfers or ambulation. I also take psychotropic medication daily increasing my risk for falls. Make sure I have nonskid socks or shoes on before transfers or walking. Keep items that I frequently use with in my reach but keep area freeze of clutter and safety hazards. 3/25/22 Due to my fall, please place me in staff's line of sight if awake as tolerated. 4/26/22 Please toilet me in the AM prior to taking me to assisted dining room for meal. R11's Care Plan further documents, under "Mobility: I am independent with bed mobility. I have grab assist bars on my bed. I can reposition myself when sitting up in a chair. I am 1 staff assist and gait belt with transfers and ambulation inside the facility." According to the facility's incident log dated 12/15/21 through 6/15/22, R11 has had falls on: 1/1/22 at 5:30 AM in her room. (Intervention-non-skid foot wear) 1/14/22 at 5:00 AM in her room. (Intervention-observe alarm for function) 1/16/22 at 9:45 PM in her room. (ER visit) (Intervention-leave bathroom light on and door cracked as tolerated by resident) 3/25/22 at 8:45 PM in her bathroom (Intervention-place me in staff's line of sight if awake as tolerated)	S9999		

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S9999	Continued From page 8 4/26/22 at 7:00 AM in her room (Intervention-please toilet me in AM prior to going to DR (dining room) V11's Morse Fall Scale dated 4/26/22 documents a score of 95 which indicates she is a high fall risk. On 6/16/22 at 8:36 AM, V19, Unit Assistant (UA), continued on stating she stayed late again last night (6/15/22) to help out and she was told to sit with R11 after dinner until they (CNAs) came to get them. V19 stated R11 had been done in the dining room for about 35 minutes and was asking to go back to her room. V19 stated R11 wanted to go to her room to go to bed and V19 told her she would have to wait a little bit until the CNAs were ready for her. V19 stated R11 started pulling her pants down and trying to take her clothes off while still in the dining room, so V19 called for help. V19 stated V6, CNA, came up to her and told her (V19), "You're going to have to fu***** wait because I can't help you right now. You obviously are not a good fit for a job in health care." and then walked away. V19 stated she knows R11 has a history of falls and she was afraid she would fall if she tried to get up because she had pulled her pants down to her knees. V19 stated she talked to V2, Director of Nursing (DON), this morning about what happened, and V2 told her she was sorry it happened to her. On 6/16/22 at 2:45 PM, V1, Administrator, stated she would expect staff to stay with a resident who was trying to stand, who was not safe to stand, until help came. She stated she would not want that staff to leave the resident if they were not safe. V1 also stated she would expect appropriate staff to meet a resident's needs in a timely manner, especially if that resident was	S9999		

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demonstrating unsafe behaviors. She stated she would have expected the CNA to take R11 to her room when she was asking to be taken to her room after dinner and CNAs should have provided incontinent care for R2 on 6/11/22 when V19 let them know R2 was wet.

On 6/17/22 at 3:10 PM in a phone interview initiated by V1, Administrator, V1 stated, "I have evidence I want to tell you about. I watched the video from the time (R2) fell on 6/11/22 and it showed on that night that (V19) only left (R2) alone for about 15 seconds to go report to the nurse that (R2) was trying to stand up by herself. (V19) was only away from (R2) for those 15 seconds and (R2) fell forward out of her chair onto the floor, striking her head and getting a laceration on her forehead. Hospitals use sitters who are not certified all the time; it was appropriate for (V19), a unit assistant, to be sitting with (R2)."

The facility's policy, "Interdisciplinary Fall Reduction/Injury Prevention Protocol" dated 7/12 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: Safety devices will be checked for placement and functioning by each shift and signed off as in place and functioning on the Flow/MAR (Medication Administration Record). The type of alarm and when it is to be applied should be clear. For example, pressure alarm on when resident in bed, or tabs alarm when resident up in wheelchair. "

The facility's "Job Description: Nursing Assistant (Non-Certified) effective 11/15/13 documents, "Performs non-direct care resident activities and

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S9999	Continued From page 10 services under the direction of the Supervisor. Skills: Must demonstrate knowledge of safety techniques." Experience: A minimum of three months of similar nursing assistant experience in long term care preferred." (A)	S9999		