llinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008205	A. BUILDING: ____ B. WING ____	C 06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN REHAB & HEALTH CARE	1403 9TH AVENUE SILVIS, IL 61282

(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 Investigation of Facility Reported Incident of 05-25-2022/IL147578	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210a) 300.1210b) 300.1210d)3)6) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008205	A. BUILDING: ____ B. WING ____	C 06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN REHAB & HEALTH CARE	1403 9TH AVENUE SILVIS, IL 61282

(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
S9999	Continued From page 1 and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. 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.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008205	A. BUILDING: ______ B. WING ______	C 06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN REHAB & HEALTH CARE	1403 9TH AVENUE SILVIS, IL 61282

(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
S9999	Continued From page 2	S9999		

These Regulations are not met as evidenced by:

Based on observation, interview and record review, the facility failed to assess and implement resident specific fall prevention interventions and evaluate current interventions following falls for one (R1) of three residents reviewed for falls. This failure resulted in R1 experiencing multiple falls with one fall resulting in a laceration to R1's head requiring evaluation at the local hospital for sutures.

Findings include:

Facility Fall Prevention Policy, revised 11/10/2018, documents: To provide safety and to minimize injuries related to falls, decrease falls and still honor each resident's wishes/desires for maximum independence and mobility; All staff must observe residents for safety. If residents with a high risk code are observed up or getting up, help must be summoned or assistance must be provided to the resident; appropriate interventions will be implemented for residents determined to be at high risk at the time of admission for up to 72 hours; Assignment of the fall risk category will be determined by the Interdisciplinary Team at their conferences based on fall risk score, history of falls and medical condition which directly impacts equilibrium and/or ambulation.

Facility Fall Analysis Log, dated 12/1/21 through 6/7/22, documents: R1's falls on 12/14/21 at 5:00 am, intervention of Hospice notified and resident education (wrapped self in oxygen tubing in room); 1/28/22 at 4:45 pm, intervention of 15 minute checks (fall in dining room); 2/8/22 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008205	A. BUILDING: ____ B. WING ____	C 06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN REHAB & HEALTH CARE	1403 9TH AVENUE SILVIS, IL 61282

(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
S9999	Continued From page 3 12:00 pm, no intervention documented (sat on buttock in room and was wrapped with oxygen tubing); 3/2/22 at 8:40 pm, intervention of 15 minute checks (fall in room with skin tear); 3/25/22 at 3:30 pm, intervention of 15 minute checks (fall in front of resident bathroom); 3/25/22 at 9:00 pm, intervention of neurological and 15 minute checks (fall in bathroom with laceration requiring hospitalization); 4/7/22 at 7:15 pm, intervention of requested a low bed from hospice (fall in resident room); 5/25/22 at 1:50 am, intervention of education on using call light and asking for assistance (fall in room); 5/25/22 at 1:30 pm, intervention of frequent verbal cues (fall in room with laceration); 5/25/22 at 7:00 pm, intervention of removal of mat on side of bed (fall in room with laceration requiring hospitalization). Facility Final Report to the Local State Agency, undated, documents R1's fall of 5/25/22 at 7:50 pm., wherein R1 "Ambulated self from bathroom to bed, turned her call light on and reported to staff that she was bleeding." The Report documents that R1 "Feels she stumbled over the mat." R1 received first aid, Emergency 911 was notified and R1 was transported to the local Emergency Department for evaluation and treatment. R1 received 12 sutures on R1's left forehead and returned to the facility at 11:42 pm. R1 was educated on the "Risks and benefits of pulling the call light and waiting for assistance," a fall mat was removed from R1's bedside and R1 remained on 15-minute checks. R1's Physician Order Sheet (POS), dated 6/1/22 through 6/30/22, documents that R1 was admitted to the facility on 6/3/2017, with diagnoses including Hospice Services, Osteoporosis, Borderline Personality Disorder, Abnormal Gait Mobility, Artificial Right Knee,	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008205	A. BUILDING: ______ B. WING ______	C 06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN REHAB & HEALTH CARE	1403 9TH AVENUE SILVIS, IL 61282

(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
S9999	Continued From page 4	S9999		

Anxiety Disorder, Major Depression Disorder, Sedative Hypnotic, Schizoaffective Disorder with Delusions and Psychotic Mood Disorder. R1's POS also documents that R1 has Physician Orders for a pain patch (Fentanyl), antidepressant (Cymbalta and Trazadone), antianxiety (Lorazepam), oral pain medication (Morphine) and an antipsychotic (Seroquel).

R1's Minimum Data Set/MDS assessment, dated 4/2/22, documents that R1 has a Brief Interview for Mental Status/BIMS score of 10/15 (moderate cognitive deficit). The MDS assessment also documents that R1 requires staff assistance with Activities of Daily Living (transfer, locomotion, dressing, eating, toileting, hygiene and bathing).

R1's AIM for Wellness, dated 3/2/22 at 11:00 pm, documents that R1 had an unwitnessed fall that resulted in a 0.5 centimeter/cm by 3.0 cm skin tear. The intervention related to this fall was for R1 to be placed on 15-minute checks.

R1's AIM for Wellness, dated 3/25/22 at 9:00 pm, documents that R1 had a fall at 3:00 pm, and R1 was placed on 15-minute checks. The AIM for Wellness also documents another fall at 9:00 pm on 3/25/22, and R1 sustained a hematoma above the right eye. The 3:00 pm fall does not document an intervention and the 9:00 pm fall documents an intervention of staff teaching R1 to ask for help and for the call light to be placed in reach at that time.

R1's AIM for Wellness, dated 4/7/22 at 7:55 pm, documents that R1 sustained a fall with no injuries. No additional fall interventions were documented.

R1's AIM for Wellness, dated 5/23/22 at 1:50 am,

llinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008205	A. BUILDING: ______ B. WING ______	C 06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN REHAB & HEALTH CARE	1403 9TH AVENUE SILVIS, IL 61282

(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
S9999	Continued From page 5 documents that R1 sustained a fall, with no injuries, on the floor mat next to R1's bed and R1 stated that R1 slipped off of the bed. No additional fall interventions were documented. R1's AIM for Wellness, dated 5/25/22, with no documented time, documents that R1 had an unwitnessed fall and sustained a 4.0 cm posterior head/scalp laceration that was cleansed, pressure applied and left open to air. No additional fall interventions were documented. R1's AIM for Wellness, dated 5/25/22 at 8:30 pm, documents that R1 sustained an unwitnessed fall in R1's room and that R1 was non-compliant with the use of the call light. R1 sustained a left side forehead 3.5 centimeter/cm by 0.5 cm laceration to R1's left side of forehead and R1's left eye was light blue in color. No additional fall interventions were documented. R1's Emergency Department Instructions, dated 5/25/22 at 11:25 pm, documents that R1 was evaluated for an accidental fall and forehead laceration. R1 was ordered an antibiotic (Keflex for ten days) and received stitches to the laceration, requiring a follow-up on 6/4/22 for removal of the stitches. R1's AIM For Wellness, dated 6/5/22 at 12:40 am, documents that R1 sustained a fall by the closet of R1's room. No additional fall interventions were documented. R1's current Care Plan documents that R1 is a risk for falls that require monitoring and intervention to reduce potential for self-injury; R1 is at risk for falls related to R1's use of antidepressants, antianxiety, antipsychotic and narcotics; Interdisciplinary Team/IDT will review	S9999		

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
	IL6008205	A. BUILDING: ____ B. WING ____	C 06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN REHAB & HEALTH CARE	1403 9TH AVENUE SILVIS, IL 61282

(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
S9999	Continued From page 6	S9999		

the changes and needs and discuss fall related information to review and revise the Care Plan; review quarterly and as needed during daily care and services of resident's plan for safety; IDT review of Activities of Daily Living status and fall potential with changes in condition or fall status; request Medical Director review of medications and conditions during nursing home visit especially after falls; and to remind resident to call for help. R1's Care Plan documents that R1 had four sutures above right eyebrow as a result of a fall that occurred on 3/25/22 and 12 sutures from a fall on 5/25/22. The Care Plan also documents fall interventions of educating resident on use of call light, asking for assistance and fifteen-minute checks. The Care Plan documents an intervention for the fall that occurred on 5/23/22 and 5/25/22 but does not document specific interventions for the remaining falls that occurred 12/1/21 through 6/5/22.

On 6/7/22 at 9:44 am, R1 could not recall any of the fall incidents and stated, "I fell a long time ago I think, I do not remember. I did not ever see a sign reminding me to ask for help, I do not know what you are talking about." A typed written sign that was a reminder for R1 to ask for staff assistance and to use the call light was hanging on R1's roommate's closet door and was not visible to R1's pathway to the bathroom door or exit door from R1's room. Multiple other signs were also hanging on both resident's closets and bathroom doors, making the sign intended for R1 to ask for staff assistance and use of the call light not visible to R1. R1 had a laceration above R1's left eye.

On 6/7/22 at 11:00 am, V3 (R1's Hospice Nurse Practitioner) stated, "(R1) has had quite a few falls. (R1) has significant confusion and a history

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
	IL6008205	A. BUILDING: ______ B. WING ______	C 06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN REHAB & HEALTH CARE	1403 9TH AVENUE SILVIS, IL 61282

(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
S9999	Continued From page 7	S9999		

of mental health issues. (R1) had a fall mat by her bed, and the other side of bed is up against the wall, but we removed the fall mats after the last fall because she said she tripped over it, but (R1's) cognition is impaired, and they were not quite sure exactly if (R1) tripped over the mat or not, but we did remove it."

On 6/7/22 at 9:17 am, V1 (Administrator/ADM) stated, "We implemented fifteen-minute checks for (R1's) falls and education on the use of (R1's) call light. (R1) would constantly get up in (R1's) room and walk around. We were already doing fifteen-minute checks on (R1) because of all of (R1's) previous falls and we educated (R1) again on the use of the call light. On the incident of 5/25/22, after (R1) got back from the hospital, (R1) stated that (R1) tripped over the floor mat next to (R1's) bed, so we removed the fall mat."

On 6/7/22 at 9:54 am, V2 (Director of Nursing/DON) stated, "(R1) is alert to (R1's) name and is confused a lot. From what I understand, (R1) ambulated self to the bathroom and tripped over a fall mat next to (R1's) bed and hit (R1's) head on the bathroom door. (R1) got in bed and put the call light on for help with the bleeding. (R1) is on Hospice and a few falls back we asked Hospice to reduce (R1's) Seroquel, and I am not sure that happened. I did not ever see a sign hanging in (R1's) room to remind (R1) to ask us for help."

On 6/7/22 at 10:32 am, V2 (DON) stated, "I went down and saw that reminder sign for (R1) to ask for help but it was hanging on the roommate's closet door. I moved it." V2 verified that the sign on R1's roommate's closet door was not viewable for R1 to see and that R1's fall interventions were not always updated and appropriate for R1's

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
	IL6008205	A. BUILDING: ______ B. WING ______	C 06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN REHAB & HEALTH CARE	1403 9TH AVENUE SILVIS, IL 61282

(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
S9999	Continued From page 8 cognitive status. On 6/7/22 at 11:10 am, V4 (Licensed Practical Nurse/LPN) stated, "I was the nurse when (R1) fell (on 5/25/22). We were already doing fifteen-minute checks on (R1) because of (R1's) other falls. When we were doing a fifteen-minute safety check, we found (R1) laying on her floor next to her bed trying to pick herself up, and she stated that she tripped over a mat next to her bed and hit her head on the door of the bathroom. (R1's) forehead was bleeding, so I called Emergency 911, and (R1) went to the Emergency Room and got twelve stitches and came back later that night. R1's call light was not on or sounding and (R1) had not quite made it to R1's bed. (R1) told me that (R1) was looking for (R1's) shoes." On 6/7/22 at 4:30 pm, V1 (ADM) stated, "My Director of Nursing (V2) does all of the fall review and interventions. If you can find me some nurses, it would be great, since I cannot find nurses. I do not think the pay is competitive enough, so my Director of Nursing (V2) has to work the floor a lot. Usually (V2) is working the floor, and it is medication pass time during our morning meetings and IDT meetings, so (V2) is not there to help with the fall reviews and I am not a nurse so she handles all of that when she is not working the floor, and she works the floor almost every day during the week and sometimes on the weekends." V1 verified that no other fall interventions were initiated for R1's falls, dated 3/2/22 through 6/5/22. (B)	S9999		