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
	IL6008684	A. BUILDING: ____ B. WING ____	C 12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSHVILLE NURSING & REHAB CTR	135 SOUTH MORGAN STREET RUSHVILLE, IL 62681

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S 000	Initial Comments Complaint Investigtion #2229578/IL153903	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)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 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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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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. 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. These Requirements were not met evidenced by: Based on record review and interview, the facility failed to ensure a resident identified as a fall risk was wearing proper footwear and was provided adequate supervision, and failed to conduct a fall investigation according to facility policy, for one of three residents (R1) reviewed for falls in a sample of three. These failures resulted in R1 falling in her room on 11/04/22 and sustaining a Left Femoral Neck Fracture (Hip). Findings include: The facility policy, titled "Falls - Clinical Protocol (revised August 2008)" documents, "1. As part of	S9999		

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the initial assessment, the physician will help identify individuals with a history of falls and risk factors for subsequent falling." The policy indicates, "3. The staff will document risk factors for falling in the resident's record and discuss the resident's fall risk. a. Risk factors for subsequent falling include: lightheadedness or dizziness, multiple medications, musculoskeletal abnormalities, peripheral neuropathy, gait and balance disorders, cognitive impairment, weakness, environmental hazards, confusion, visual impairment and illness affecting the central nervous system and blood pressure." The policy advised that, "5. The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events, etc." The policy further documents, "1. For an individual who has fallen, staff will attempt to define possible causes within 24 hours of the fall. a. Causes refer to factors that are associated with or that directly result in a fall; for example, a balance problem caused by an old or recent stroke. b. Often, multiple factors in varying degrees contribute to a falling problem" and "3. The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or that finding a cause would not change the outcome or the management of falling and fall risk. 1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling."

The Electronic Medical Record documents R1 was admitted to the facility on 1/29/20 with Diagnoses of Unspecified Dementia without Behavioral Disturbance, Psychotic Disturbance,

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S9999	Continued From page 3 Mood Disturbance, Anxiety, Muscle Weakness, and Difficulty in Walking. A Minimum Data Set assessment, dated 10/13/22, documents R1 had significant cognitive impairment, utilized a wheeled walker or a wheelchair for mobility, required an extensive assist of one person to ambulate in her room and the extensive assistance of two staff to toilet. A Fall Risk Assessment, dated 10/11/22, determined R1 was at high risk for falling, due to confusion, the use of Anti-depressants and Anti-hypertensives, and impaired neuromuscular function. R1's Current Plan of Care (initiated on 1/11/2022) documents, "(R1) is at risk for falling (related to) Hallucinations, Unspecified Disorientation, Unspecified Muscle weakness (generalized) and Essential (primary) hypertension. (R1) is also receiving anti-hypertensive, antidepressant and diuretic medications which can increase (R1's) risk for falls, and instructs staff to "Keep (R1's) personal items and frequently used items within reach" and "Provide (R1) with proper, well-maintained footwear." Nursing Progress Notes document R1 was found on the floor of her room on 7/02/22, 7/10/22 and 9/05/22, and sustained no injury from those falls. A Fall Details Report, dated 11/04/22 by V6 (Licensed Practical Nurse), documents at 8:20 pm, "CNA (Certified Nursing Assistant) called writer to resident's room. Resident found sitting on floor with one slipper on and barefoot other foot. Resident was not using walker which was not near her. Resident sitting in lots of dried blood. Large hematoma noted to left side, back of head with dried blood. Resident lethargic and unable to get upright." The Fall Details Report documents, at the time of the fall R1's walker was not in use, she was wearing "slippers." The Follow Up (Occurrence) Report completed by V2	S9999		

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(Director of Nursing), documents "(R1) was observed sitting on the floor with one slipper on and barefoot on the other foot. (R1) was not using walker. (R1) noted to have a large hematoma to the left back of head. Upon assessment by nurse, resident lethargic and unable to sit upright. (R1) stated she was going to the bathroom. (R1) transferred to (Hospital) for evaluation. It appears that the resident got out of bed to go to the restroom without staff assistance. Resident was not using walker. Resident had one slipper on and barefoot on the other foot." Hospital Orthopedic Records, dated 11/05/22, document R1 was transferred to their hospital after sustaining a unwitnessed ground level fall in the Nursing Home trying to ambulate without her wheeled walker, that resulted in a Left Displaced Femoral Neck Fracture.

The Final Reportable Investigation regarding R1's 11/04/22 fall, dated 11/05/22 at 1:50 pm documents, "(R1) was found on floor in her room. Sent to (Emergency Room) for evaluation. Investigation Initiated. Alert and moderately cognitive female resident got up out of bed and self ambulated to use the restroom and fell in room. (R1) admitted to Hospital with diagnosis of Left Femur Fracture." The Final Reportable Investigation, Fall Details Report and Follow Up Report fail to document any additional information, including witness statement of the timeline of events.

On 12/07/22 at 1:42 pm, V5 (Certified Nursing Assistant) stated, on 11/04/22 she and V7 (Certified Nursing Assistant) were "putting residents to bed a little after 8:00 pm." V5 stated when they got to R1's room, the door was closed, which was unusual because "R1's door was usually open so she could be seen." V5 stated

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she opened the door and saw R1 on the sitting on the floor with a bloody head and blood on the floor next to her. V5 could not recall any other specific details regarding R1 at the time of the fall. V5 stated the the two nurses on duty "came pretty quick" and R1 was sent out by ambulance. V5 stated R1 was both continent and incontinent, and R1 would frequently take herself to the bathroom on her own. V5 stated R1 was "always up and down, up and down, so she needed to be watched closely." V5 stated no one from Administration questioned her regarding the circumstances surrounding R1's fall.

On 12/07/22 at 2:16 pm, R4 (R1's roommate) stated she was not in the room at the time of R1's 11/04/22 fall. R4 stated she was being taken to her room by V5 and V7, to be put to bed. R4 stated when they approached their room "the door was closed, and it's never closed." R4 explained that staff needed to watch R1, because she'd get up on her own, so the door was to be open. R4 stated staff opened the door and she saw R1 sitting on the floor, facing the wall that is to the right when you enter the room, with the bedside table near her. According to R4, R1 kept saying "I had an accident" over and over. R4 stated R1 had "dried blood on her head and there was dried blood on the floor, it looked like it had been there for a bit." R4 stated R1 would often take herself to the bathroom, even though she wasn't supposed to without help.

On 12/07/22 at 3:32 pm, V6 (Licensed Practical Nurse) stated she had started her shift on 11/4/22 at 6:00 pm, received report and started her evening medication pass. While passing medications, the CNAs (Certified Nursing Assistants) told her there was an emergency in R1's room. V6 stated when she entered R1's

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room, R1 was sitting on the floor facing towards her bed, as if she had been walking back from the bathroom. R1 had dried blood on her head and there was dried blood on the floor, which made her conclude that R1 had been sitting there for "awhile." V6 stated R1 was wearing one slipper, "the kind you slide your foot into, with no back", which had a non-skid bottom, and the other slipper had come off R1's foot. According to V6, R1's walker was at the foot board of her bed and not near her. V6 stated "staff were to keep her walker right next to her bed, because (R1) likes to get up on her own and use the bathroom, even though she is not supposed to." V6 stated R1 did not verbalized to her what she was doing when she fell, but was guarding her left side so she immediately called 911. V6 stated she was not questioned or interviewed regarding the details of R1's fall by V1 (Administrator) or any in Management, and she "just completed an occurrence report."

On 12/07/22 at 1:26 pm, V1 (Administrator) stated he was "pretty sure" he obtained witness statements when he did the investigation for R1's 11/04/22 fall, but does not know why those statements were not included in his final investigation details. Those statements were unable to be located.

On 12/07/22 at 1:20 pm, V3 (Regional Administrator) stated, in order to determine what actually occurred, all fall investigations are to include witness accounts of what occurred just prior to and at the time of the resident fall, "that's just part of your investigation."

On 12/08/22 at 10:23 am, V2 (Director of Nursing) stated she started interviewing staff "last night and this morning" regarding R1's 11/04/22

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S9999	Continued From page 7 fall. V2 stated it was determined after talking to Dietary Staff, R1 was observed in her bed in her room at approximately 7:00 - 7:30 pm on 11/04/22, and then was found on the floor at 8:20 pm. V2 stated that left approximately an hour to an hour and 20 minutes that the facility is unable to account for what R1 was actually doing. V2 stated "staff should have been checking in on her (R1)" as it was known that R1 frequently took herself to the bathroom independently, even though she required assistance. V2 concluded that a "slipper sock" or "some type of non-skid footwear that can't slide off the foot" would have been a safer option for R1 to have been wearing, rather than a traditional slipper. (A)	S9999		