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
	IL6009294	A. BUILDING: _____ B. WING _____	C 01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE SKILLED NUR & REHAB	333 SOUTH WRIGHTSMAN STREET VIRDEN, IL 62690

(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: 2241015/IL154555	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210d)6 300.1220)b3 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. 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 300.1220 Supervision of Nursing Services	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These Requirements were NOT MET as evidenced by: Based on observation, interview and record review the facility failed to provide adequate supervision, and implement progressive interventions to prevent further falls for 1 of 3 residents (R2) reviewed for accidents in the sample of 4. This failure resulted in multiple falls, 2 of which required Emergency Medical Services for evaluation for head injury with multiple bruises and lacerations to her face and head. Findings include: R2's Undated Face Sheet documents she was admitted to the facility on 7/26/2022 Diagnoses included Alzheimer disease, anxiety disorder, rheumatoid arthritis, cerebral infarction, and urinary tract infection.	S9999		

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S9999	Continued From page 2 R2's Admission Fall Risk Assessment, dated 7/26/2022 documents she was a low risk for falls. R2's Minimum Data Set (MDS), dated 11/2/22 documents she has severely impaired cognition, requires extensive assistance of two for Transfers, Locomotion on unit, Toileting. R2's Balance during Transitions and Walking not steady only stable with staff assistance, and has history of falls. R2's Fall Incident Reports document dates of falls: 10/13/2022 no injury, 10/22/2022 no injury but sent to local hospital Emergency Room (ER) related to R2 hitting her head, 11/14/2022 no injuries, 11/28/2022 hematoma to back of head, hematoma to left side of face, laceration to face, 12/2/2022 no injuries, 12/7/2022 no injuries, 12/14/2022 bruise to right front of shoulder, 12/19/2022 no injuries, 12/20/2022 hematoma to back of head, 12/21/2022 unable to determine injury to face, 12/25/2022 bleeding hematoma to face, and 12/30/2022 no injuries. R2's Care Plan, dated 11/15/2022 documents no progressive fall interventions for the falls on 11/14/2022, 12/2/2022, 12/14/2022, 12/19/2022, 12/20/2022, 12/21/2022, and 12/25/2022. R2's Care Plan dated 12/2/2022 documents R2 has severely impaired cognition and /or wandering behavior related to diagnosis to Dementia. Interventions dated 10/13/2022 include provide ensure resident transfers into dining room chair for meals, Put sign above bed "(R2's) bed" so she knows which bed is hers, keep call light within reach, keep environment clutter free, PT (Physical Therapy), OT (Occupational Therapy), ST (Speech Therapy) to eval (evaluate) and treat.	S9999		

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S9999	Continued From page 3 R2's Progress Note, dated 10/13/2022 at 11:41 AM, documents resident had a fall and was on the floor. Upon entering the Dining room resident was observed sitting on her butt, back leaning against the wall with her leg stretched out in front of her. The floor was dry, she had gripper socks on feet, there was a empty wheelchair at the table and she was sitting on a soft collapsible floor sign. R2's Incident Report, dated 10/22/2022 at 6:50 AM, documents resident fell in another residents room and was on her left side. Incident report states Certified Nurse Aide (CNA) thinks resident hit her head. Order received to send resident to local Emergency Department (ED) for evaluation and treatment for fall. R2's Progress Note, dated 10/22/2022 2:32 PM, documents call received from local ER (Emergency Room) stating resident was ready to return to facility. Resident has Urinary Tract Infection (UTI) and was given IV (intravenous) antibiotic in the ER and will return to facility with orders for Cefelexin (oral antibiotic). R2's Incident Report, dated 11/14/2022 at 9:59 AM, documents resident sitting on her buttocks in front of dining room chair in activity room on the special care unit. R2's Fall Incident Report, dated 11/28/2022 at 7:34 PM, documents resident was sitting on the floor in front of the toilet leaning on her arm. Another resident was leaving the dining room and stated I think someone needs help. 911 was called. Hematoma to face, hematoma to back of head, laceration on her face. Resident was transferred to local ED.	S9999		

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S9999	Continued From page 4 R2's Progress Note, dated 11/28/2022 at 11:50 PM, documents resident returned to facility via stretcher per Ambulance. Resident incontinent of urine. Hematoma to left side of head and bruising around left eye. Multiple small lacerations to left forehead and nasal area. R2's Fall Incident Report, dated 12/2/2022 at 12:15 PM, documents resident was sitting on her buttocks with legs stretched out in front of her asking staff to help her up. Resident was in the door way to the activity room with the door to her left side and facing the dining area. The food cart was directly behind resident in the doorway. Staff member was standing at the tables gathering up dishes and when the staff turned to take the dirty dishes to the food cart resident was standing directly behind the staff. That staff person bumped into resident and resident lost her balance and fell into the door. Resident hit her head on the door and slid to the floor. R2's Fall Incident Report, dated 12/7/2022 at 11:30 AM, documents resident was sitting on her buttocks on the floor in the dining room. Agency CNA witnessed the fall and stated she R2 hit her head on the right side. R2's Fall Incident Report, dated 12/14/2022 at 2:10 PM, documents resident was sitting on her butt next to the air conditioner in the activity room scooting towards the doorway. Resident was bleeding on the left side of her face. 911 was called for an ambulance. Bruise was forming on the top of her left shoulder. Previous hematoma had re-opened and was bleeding. R2's Fall Incident Report, dated 12/19/2022 at 6:00 PM, documents resident was on her left side on the hallway floor. There was blood on the floor next to resident. Resident had a bloody nose, and	S9999		

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S9999	Continued From page 5 an old skin tear above the eye had re-opened. R2's Fall Incident Report, dated 12/20/2022 at 5:30 PM, documents resident was found lying on her back in another resident's room and she has a bump on the back of her head. R2's Fall Incident Report, dated 12/21/2022 at 8:33 PM, documents resident was on the floor sitting upright. Unable to determine injury to her face. R2's Fall Incident Report, dated 12/25/2022 at 1:30 PM, documents resident was observed lying flat in a prone position with her left arm under her head and right arm out in front of her body. Legs were straight. She was lying with her back against the bathroom door, head towards the hall door in another residents room. Resident did have visible blood coming from a previous hematoma on her forehead. Bleeding from hematoma from previous hematoma to her forehead. R2's Fall Incident Report, dated 12/30/2022 at 6:32 AM, documents resident was sitting on another resident's floor mat next to her bed. Her feet went towards the door, bottom on the floor. No injuries observed at time of incident. On 12/27/2022 at 12:04 PM, V4, MDS/Care Plan Coordinator, stated they talk about new interventions for falls in morning meetings that they typically have Monday thru Friday. V2, Director of Nursing (DON), and V5, Assistant Director of Nursing (ADON), does the investigations and sometimes has the root cause for the fall before the meeting, Sometimes the nurse on the floor making the fall report will document new interventions (progressive interventions) V4 stated she does not put a new	S9999		

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intervention in place until its discussed in the meeting. Sometimes root cause analysis is discussed in morning meeting, sometimes not.

On 12/27/22 at 12:43PM, V8, Special Care Coordinator/CNA, stated they have falls back there on the unit and have to redirect constantly. V8 stated R2 is constantly getting up and walking by herself. They try to redirect as much as they can. They are working with her on medications, with ativan she doesn't sleep well at night and she wanders, paces, and then she gets tired from pacing the hallway and will fall, she wanders in other residents' rooms too.

On 12/27/22 at 1:03 PM, V8 was walking R2 in the hallway without a gait belt and holding R2's hand. R2 walked with tiny steps, shuffling gait, and wobbly at times, gait unsteady. V8 stated she wasn't really sure about the policy of using a gait belt.

On 12/27/22 at 1:37 PM, V11, CNA, stated, "We have (R2) that falls a lot and wants to walk the hallways and she paces at a fast walk. Those bruises on her face is from one of her falls and when she falls she seems to fall on her face. I try my best to keep an eye on her but she is so fast at getting up. We do not get any new interventions for (R2) to keep her from falling again. Nurse gives us report when resident falls but no report of any new interventions for falls."

On, 12/27/2022 at 1:54 PM, V12, Licensed Practical Nurse (LPN), stated R2 has advanced dementia and has had frequent falls where she has gotten bruises, lacerations, and abrasions on her face. She has a history of exit seeking, and aggression with other residents. She is just so exhausted from up pacing the halls and going in

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S9999	Continued From page 7 and out of residents rooms. V12 stated he is at his wits end she falls, falls, falls. Don't know what to do with her and her falls. V12 stated, "We can't strap her down. As far as interventions, the management team tells us if any new interventions, but we haven't been told of any new interventions with (R2) with her falls." On 12/27/22 1:57 PM, V1, Administrator, stated not really sure of R2's root cause of her falls. V1 stated, "We sent her to psych (psychiatric) hospital for medication adjustment, she came back zonked, she was sleeping all the time. We called her MD (medical doctor) and weaned her back off the medications." V1 stated that R2 does not require assistance, she is independent with her walking. On 12/27/22 2:05 PM, V2, DON, stated, she agreed with V1's statement except V2 stated R2 requires extensive assistance and is not independent. On 12/27/22 at 3:34 PM, R2 was sitting in her recliner trying to get up. Her recliner was near her bed. V13, CNA, and V14, CNA, applied gait belt around resident's waist to transfer from her recliner to ambulate her to the bathroom. Both CNA's had their hands on the gait belt during ambulation. R2 had an unsteady gait, wobbling, she walked with tiny steps and shuffling gait. On 12/28/22 at 8:00 AM, R2 was up ambulating by herself in the hallway carrying a glass of juice in her left hand (hand is noted to be shaking) R2's gait was unsteady, wobbly, and walks with tiny steps and shuffling gait. Two CNA's were in the dining room assisting other residents while R2 was walking the hallway unassisted. Another resident was in her wheelchair and this resident	S9999		

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pushed her feet making her wheelchair roll backwards to the point it almost hit R2 while walking in the hallway alone. V16, CNA, saw what was happening and ran over to stop the other resident from running over R2. V12, LPN, was standing at the med cart passing medications and did not see what happened.

On 12/28/22 at 8:09 AM, V17, CNA, took R2 by the hand and walked R2 down the hallway without a gait belt. Placed R2 in her recliner, V17 CNA lifted R2 underneath her arms to scoot resident back in the recliner. R2's gait is unsteady gait, wobbly, staggered, took tiny steps and shuffling gait while walking.

On 12/28/22 at 8:11 AM, R2 got back up from her recliner unassisted. R2 walked into another resident's room continues with short steps, shuffling gait, wobbling with unsteady gait. No staff was watching over R2 at this time.

On 12/28/22 at 8:17 AM, V10, CNA, saw R2 up and stated her gait is not steady, walked to R2 placed a gait belt on R2 and walked her in the hallway. R2's gait is unsteady, wobbly, she continues to take little steps and walks with shuffling gait. V10 took R2 to her room and requested that V12, LPN, help to assist R2 to bed and scoot R2 up in the bed.

On 12/28/22 at 10:48 AM, V18, facility Beautician/ R2's daughter in law, stated she visits R2 in the evenings after she gets done with work at the facility. V18 stated she takes in food and drinks for R2 and sits one on one and feeds her supper at times. V18 stated this facility has zero interventions they put in place for R2. V18 stated they sit her down in the recliner, or lay her in the bed, her anxiety is high and always has been

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S9999	Continued From page 9 before she got dementia. V18 stated many times when she goes in the unit during the evening, R2 is up walking in the hallway and very unsteady on her gait, she wobbles a lot when she walks. V18 states she sees CNA's on their phones most of the time or talking to each other instead of watching or taking care of the residents. On 12/28/22 at 3:45 PM, V15, CNA, stated she works as a float throughout the facility and the unit at times. V15 stated she witnessed R2 fall on Tuesday and Wednesday evening. V15 stated on Tuesday, she was in the hallway and heard another resident yell out R2's on her back on the floor crying. R2 fell down and hit her head, R2 had a huge knot on the back of her head, no bleeding. R2 fell in another resident's room. V15 called V2, DON, back to the unit and they moved R2 to a wheelchair. R2 did not go to ER, family did not want her sent out. V15 stated on Wednesday, R2 fell again. R2 had been sleeping in her bed, woke up and was wobbling out of her room. V15 stated she was charting outside of R2's room in the hallway. R2 had walked down to the locked door and had been knocking on the doors, she turned around wobbling, fell forward and her face hit the floor, there was blood coming from her forehead, her nose was bleeding from inside of her nose. V15 stated she yelled for V14 to use the intercom to call a nurse stat (immediately) to the unit. They applied pressure on her nose. R2 did not go to ER. V14 CNA and V15 CNA both stated Management gives us no new interventions or communication for any new interventions do the best we can with what staff we have. Family will come in at times especially the daughter in law she works here and will sit and feed her in the evenings. We need staff here to help Activities is here at times till 5pm on the unit but not daily.	S9999		

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S9999	Continued From page 10 On 12/29/22 at 10:09 AM, V7, Primary Physician, stated he was not aware that R2 had that many falls - he asked how many falls she had exactly because he was not aware. V7 then stated it upsets him that the facility did not put further interventions in place for R2 prior to giving her medications. V7 stated giving Ativan and Morphine increasingly puts R2 who has dementia at higher risk for falling. V7 stated he felt the facility should be doing more activities to keep R2's mind occupied, increase staffing in the unit, walking her with a gait belt, alarms. On 12/29/2022 at 11:06 AM, V19, Nurse Practitioner, for V27, Psychiatrist, stated she saw R2 on 12/9/22 at the facility for psychiatric evaluation. She had multiple medication changes per medical doctor orders and hospital visit without my knowledge. V19 stated, "I did not get notification of all falls nor medication changes. By reviewing above doses with only one fall in all the 13 doses of Ativan administered, it is in my professional opinion that the Ativan is not a contributor to falls on 12/20/22 or 12/25/22. The use of Ativan with Morphine when used together may cause increased sedation affect fall rates. After reviewing the medical chart, it does not appear she was given these two medications at the same time." On 12/29/22 at 1:04 PM, V24, Physician Assistant (PA), for V7, Primary Physician, for R2, stated regarding R2's falls, he did not know that she had so many frequent falls. V24 stated he thought she had a few and was not of aware of all those falls. Went back to the clinic to discuss with V7 her falls and medications. But again neither one of us was aware of the number of falls she sustained. I did know she was placed on ativan for 14 days	S9999		

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S9999	Continued From page 11 but again would not have given the ativan or morphine with her having dementia and all those falls. Ativan and Morphine puts R2 at a higher risk for falls with her dementia and falls. The facility's Fall Risk Assessment policy and procedure, dated March 2018, documents, "The nursing staff in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident - centered falls prevention plan based on relevant assessment information. While many falls are isolated individual resident, some individuals fall repeatedly. Information and observation assist in identifying patterns and may illustrate underling case. After a first fall the staff (and physician, if possible) will refer the individual to therapy services to identify patterns of gait, balance, strength and other factors that may benefit from retraining, or strengthening. Therapy will make recommendation to the physician or staff about opportunities to reduce risk and improve safety. The interdisciplinary team, therapy team, nursing or physician will recommend specific interventions to reduce identified factors that increase risk for falling. The interdisciplinary team, nursing, physician will recommend specific interventions that may reduce the probability of serious injury in the event a fall does occur. Nursing is responsible for implementation these interventions. Nursing and MDS are responsible for assuring timely and accurate Care Planning to assure full assessment and interventions implementation." (B)	S9999		