STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006878	A. BUILDING: _____ B. WING _____	C 09/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODIN HEALTH AND REHAB CENTER	300 GREEN STREET ODIN, IL 62870

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S 000	Initial Comments Facility Reported Incident of 9/16/23/IL164765	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 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 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental 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. 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	S9999		

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S9999	Continued From page 2 and assistance to prevent accidents. These Requirements were not met evidenced by: Based on interview and record review, the facility failed to safely transport a resident in a wheelchair to prevent an accident for 1 of 3 residents (R3) reviewed for accidents in the sample of 3. This failure resulted in R3 sustaining a fall from R3's wheelchair that resulted in a laceration to the bridge of the nose, requiring treatment of glue to the nose at the local hospital emergency room. This past non-compliance occurred between 9/16/23 and 9/22/23. Findings include: R3's undated Admission Record documents that R3's initial admission date to the facility was 12/01/19, with current admission date of 01/03/20. R3's diagnoses listed on this document include, but are not limited to Chronic Obstructive Pulmonary Disease, Morbid (Severe) Obesity Due to Excess Calories, Atherosclerosis of Native Coronary Artery of Transplanted Heart Without Angina Pectoris, Generalized Anxiety Disorder, Dementia in Other Diseases Classified Elsewhere, Unspecified Severity, Parkinson's Disease, Cognitive Communication Deficit, Chronic Diastolic (Congestive) Heart Failure, Spondylolysis, Lumbar Region, and Essential Hypertension. R3's MDS (Minimum Data Set) dated 8/28/23 documents that R3 has a BIMS (Brief Interview of Mental Status) of 03, which indicates that R3 has severe cognitive impairment. The same MDS documents under Section GG that R3 uses a wheelchair for mobility. Section GG also notes that R3 requires supervision or touching	S9999		

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S9999	Continued From page 3 assistance (helper provides verbal cues and/or touching /steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittentiy) to wheel 50 feet with two turns and to wheel 150 feet. R3's Occupational Therapy Treatment Encounter Note with dates of service of 5/3/23 document the following: Precautions: Fall risk. Does not follow commands consistently due to cognition. Contraindications = No contraindications present .... Patient sitting up in w/c (wheelchair) in dining room for lunch and propels self throughout facility using BLEs (bilateral lower extremities). The facility's Verification of Incident Investigation/Administrative summary documents R3 having a fall with injury on 9/16/23 at 1440 (2:40pm), with a description of Injuries as "laceration to bridge of nose." The Summary of Investigative Findings documents "(R3) is an 87 year old female who in (sic) mostly wheelchair bound with transfer to and from bed as well as bathroom. Resident ability to perform ADLs (Activities of Daily Living) is very limited. Resident is confused at times. CNA (Certified Nurse Assistant) was assisting in pushing resident to dining room when resident put feet down abruptly, when wheelchair stopped abruptly resident went forward in wheelchair slowly to the floor. Small laceration to bridge of nose, no bleeding noted to area. Mild pain noted and resident not following commands. MD (Medical Doctor) and POA (Power of Attorney) notified. Orders received. Resident not moved and EMS called for transport to ER (Emergency Room). Upon assessment at ER resident noted to have small laceration to bridge of nose, glue used to close wound. CT (computerized tomography) and x-ray reports	S9999		

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clear. Resident was transferred back to facility same day, states that glue will wear from nose and to monitor. On investigation, noted resident was wearing shoes which abruptly stopped the wheelchair on tile floor." Follow-Up Actions Taken: Follow up and monitor resident for pain, assess laceration to nose every shift, will assess resident footwear for proper footwear, provided education to staff of abrupt stopping of wc (wheelchair), educated staff on wheeling resident slowly when assisting to locations in wheelchair.

The facility investigation document further documented that V2's (CNA) "statement remained same that he was taking R3 to lunch in wheelchair when she abruptly put feet down causing wheelchair to stop and resident slid from chair .... Inservice put in place following investigation stating that ALL residents that are propelled by staff need to have foot rests in place. Education provided."

R3's Care Plan documents a Care Plan focus of "At risk for falls and injuries r/t (related to) Medications: Medical Factors: Cognitive Impairment, Dementia, Hx (history) of falls ...Poor safety awareness, Unsteady Gait, Visual Impairment, Weakness" that was initiated on 3/13/23. Interventions include "instruct to avoid sudden position changes" and "observe for unsteady gait and balance" both initiated on 3/13/23. An intervention added on 9/20/23 includes "educate staff on resident having leg rests on chair at any time she is being assisted by staff for locomotion."

R3's Care Plan documents another focus area of "(R3) has had actual falls and is high risk for additional falls r/t dementia/generalized weakness that was initiated on 12/02/19 and revised on

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S9999	Continued From page 5 05/06/19. Interventions include to "anticipate and meet R3's needs" and "ensure R3 is wearing appropriate footwear" both initiated on 12/02/19. R3's Care Plan also documents a focus area of "(R3) has Parkinson's disease initiated on 3/13/23 and revised on 05/02/23. Interventions include "Monitor/document/report to MD PRN (as needed) s/sx (signs/symptoms) of Parkinsons complications: Poor balance ...Poor coordination ...Tremors, Gait Disturbance, Muscle cramps or rigidity, Decline in ROM (range of motion) ...Decline in cognitive function." An additional Focus Area notes "Decline with bilateral lower extremity related to joint mobility" initiated on 03/04/22 and revised on 3/23/22. On 9/26/23 at 9:16 am, R3 was observed sitting in her wheelchair at the dining room table. One foot pedal to the right side of wheelchair was observed. A small, well approximated cut was noted to the bridge of her nose with green/yellow/dark purple bruising observed to bilateral eyes. R3 was wearing footwear and stated these are the shoes she prefers. R3 was alert to person and place and confirmed that she did recently have a fall out of her chair. R3 said she wasn't sure exactly what happened, she just fell forward out of her chair. R3 was not able to provide details regarding the fall but described it as an accident. On 9/26/23 at 11:40 AM, V2 (CNA) stated that he was the CNA pushing R3 in her wheelchair when she fell. V2 stated that R3 was in her room sleeping in her chair and he went by and woke her up to head to the dining room for lunch time, he believes it was. V2 stated that later he went back by R3's room and she was still sitting in there, so he offered to assist her. V2 stated that	S9999		

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normally R3 propels herself throughout the facility but she just seemed drowsy, so he was trying to be nice and help her out. Stated R3's normal status is mildly confused but appropriately follows commands. V2 stated that R3 had stated "ok", and he instructed her to hold her feet up, which she did. V2 stated they were by the nurse's station and one of R3's feet hit the floor causing her to fall forward out of her chair onto the floor. V2 stated he yelled for a nurse, and several staff immediately responded. V2 stated since R3's fall the facility has completed a facility wide in-service that if a resident seems drowsy or isn't their normal self, to apply foot pedals during transport.

On 9/26/23 at 8:05 AM, V1 (Administrator) stated that R3 did recently have a fall. V1 said that R3 normally propels herself throughout the facility, making the use of foot pedals contraindicated as previously evaluated by therapy. V1 stated upon investigation, it was noted that R3 was drowsy, recovering from illness, so staff were assisting R3 to the dining room as a courtesy. R3 suddenly put down her feet and fell out of her chair. V1 stated that training was conducted with staff that if residents are requiring assistance with being pushed in their chairs throughout the facility, to apply foot pedals, to prevent any further similar falls. V1 stated all notifications were made regarding R3's fall and there have been no further incidents or concerns regarding R3's fall.

On 9/26/23 at 10:50 AM, V4 (Director of Nursing/DON) stated that R3 did have a recent fall after putting her feet down while being pushed (in wheelchair) by staff. V4 stated that R3 is not someone who usually requires transportation assistance, as she propels herself. V4 stated R3's cognitive status is mild confusion. V4 stated an investigation was completed regarding the fall

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S9999	Continued From page 7 and it was decided since R3 was experiencing a drowsy state that day, that when staff are propelling residents, foot pedals will be applied to the chair for transport. V4 stated R3 has experienced no pain or lasting negative effects from her fall. V4 stated R3 was transported to the local ER for treatment. On 9/26/23 at 10:56 AM, V5 (Certified Occupational Therapy Assistant/COTA) stated that R3's normal status is that she propels herself throughout the facility, therefore foot pedals would not be recommended. V5 stated given R1's poor cognitive status and mobility level, she would also consider it to be a fall hazard for R1 to have foot pedals on her chair all the time. V5 stated that she has performed previous evaluations on R3 and would consider this incident to not be a predictable accident. On 9/26/23 at 11:05 AM, V6 (CNA) stated that she frequently works with R3 and that R3 propels herself around the facility. V6 said she has recently completed training that foot pedals are to be applied to (wheel)chairs if the resident is drowsy so that their feet remain off the ground and don't experience any further falls. On 9/26/23 at 11:10 AM, V7 (CNA) stated she frequently works with R3 and that she cannot think of a time she has ever had to assist R3 with transport as R3 normally easily propels herself in her wheelchair throughout the facility. V7 said R3 does have altered cognition and is frequently confused. V7 said since R3 fell, she completed training regarding applying foot pedals to resident's wheelchairs that do not have them if they are experiencing a change in their normal status, such as being tired.	S9999		

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S9999	Continued From page 8 A facility Inservice/Education Record dated 9/22/23 documents "Summary of Content: Residents that are in wheelchairs MUST have foot rests in place while pushing to and from destinations. May remove if resident propels self, but if pushed by staff foot rest to be in place." (B)	S9999		