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
	IL6007041	A. BUILDING: ____ B. WING ____	C 02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PA PETERSON AT THE CITADEL	1311 PARKVIEW AVENUE ROCKFORD, IL 61107

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S 000	Initial Comments Complaint Investigation 2311282/IL156455	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)2 300.1210d)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 each resident's comprehensive resident care plan. Adequate and properly supervised nursing	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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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:

2) All treatments and procedures shall be administered as ordered by the physician.

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 are not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure a resident received the necessary emergency care and services in a timely manner after a fall with a fracture, while displaying signs of facial grimacing and yelling out in pain. This applies to 1 of 3 resident (R4) reviewed for falls.

The findings include:

R4's Face Sheet shows she was admitted on hospice on 12/23/22. The same document shows R4's diagnoses included encephalopathy, myocardial infarction, dementia, anxiety, depression, occlusion and stenosis of carotid artery, chronic kidney disease, and disorientation.

On 2/16/23 at 12:30 PM, V15 RN said R4 had an unwitnessed fall on the morning of 1/2/23. V15

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said she assessed R4 and found her to be without injuries so V15 (and staff) used a mechanical lift to put R4 in a wheelchair and called V10 NP (Nurse Practitioner) and the POA (Power of Attorney). V15 said R4's pain increased so she called V10 again and she (V10) ordered a STAT (to be done immediately) X-ray.

On 2/16/23 at 2:00 PM, V10 said when a resident experiences an unwitnessed fall, the nurse should do an assessment that includes active and passive range of motion, assess for point tenderness, observe if one leg is shorter than the other, and note any rotation of the limbs.
V10 said it's possible that R4's hip displaced after being placed in the wheelchair. V10 said R4 had a very small dose of morphine ordered. V10 said it would have been reasonable for the nurse to call her back when the X-ray company didn't show in a timely manner, while R4 was still experiencing pain. V10 said, "I could have sent her (R4) to the emergency room or ordered more pain medication."

On 2/16/23 at 3:00 PM, V2 DON (Director of Nursing) said if the stat X-ray has not been performed within 4 hours the company should be called, and the NP should be called to see if the resident needs to go to the Emergency Room.

On 2/17/23 at 9:30 AM, V11 Hospice CNA (Certified Nursing Assistant) said, on 1/2/23 at 10:00 AM, she saw R4 in a wheelchair. V11 said R4 was grimacing in pain. V11 said R4 refused a shower because she was in too much pain.

R4's MAR (Medication Administration Record) shows she had an order for Morphine Sulfate Oral solution 10 mg (milligram)/5 ml (milliliters) and could receive 0.25 ml by mouth (0.5 mg)

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every 2 hours for pain as needed. R4 had an order for Hydrocodone/Acetaminophen 7.5/325, 1 tablet every 12 hours for moderate to severe pain but it was never dispensed for the length of her stay.

R4's Progress notes and MAR (Medication Administration Record) shows the following timeline:

On 12/23/22 at 11:25 AM, R4 was admitted to the facility on hospice for long term care placement.

On 1/2/23 at 7:54 AM, R4 was found on the floor of her room. V15 did an assessment of R4's injuries and determined R4 had no limitation. R4 was transferred to a wheelchair using a mechanical lift. V15 then notified V9 POA (Power of Attorney), V10 NP, and V2 DON (Director of Nursing).

On 1/2/23 at 9:48 AM, R4 was experiencing pain at an 8 on the pain scale (based on the pain scale, where 1 is mild, 5 is moderate, and 10 is the worst pain ever). Morphine was given at a dose of 0.5 mg.

On 1/2/23 at 10:37 AM, R4 showed facial grimacing and showing signs of pain, and screaming "help me" to V15. V15 called V10 in regard to R4'S pain and to see if R4 could get an order for an X-ray.

On 1/2/23 at 3:39 PM, R4 was experiencing pain at a 9 on the pain scale. Morphine was given at a dose of 0.5 mg.

On 1/2/23 at 5:48 PM, R4 was experiencing pain at a 9 on the pain scale. Morphine was given at a dose of 0.5 mg.

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S9999	Continued From page 4 On 1/2/23 at 9:42 PM, the X-ray company arrives and X-rays R4's left femur, which showed a left femoral neck fracture. V10 was informed and ordered R4 out to the local emergency room. The time between the X-ray order and when it was performed was 11 hours and 5 minutes. On 1/2/23 at 10:08 PM, R4's hospital documentation shows R4 was complaining of severe pain. On 1/2/23 at 10:21 PM, R4's hospital documentation shows staff gave R4 Morphine 4 mg for pain. On 1/9/23 at 9:29 AM, R4 experienced another fall. On 1/9/23 at 4:00 PM, the Physician ordered morphine sulfate 10 mg every 4 hours (regular scheduled), and morphine 10 mg every 4 hours PRN (as needed for pain). On 1/11/23 at 2:26 PM, R4 had no heart sounds upon auscultation. The DON and hospice were notified, the family was present with R4. R4's 12/26/22 Interim Care plan shows she was a high fall risk. R4's 12/26/22 Morse Fall scale shows a score of 75 which indicates a high fall risk. The 1/2/23 X-ray report shows R4 suffered an acute displaced femoral neck fracture of her left femur. R4's 12/29/22 MDS (Minimum Data Set) shows she needs extensive assistance with the help of 2 people to transfer.	S9999		

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R4's 1/2023 POS (Physician Order Sheets) shows her morphine went from 0.5 mg every 2 hours to 10 mg every 4 hours on 1/9/23.

R4's 1/7/23 IDT (Interdisciplinary Team) notes shows, the root cause for R4's fall was poor safety awareness related to her dementia and other comorbidities. The intervention will be to keep R4's bed in a low position at all times and frequent reminders to ask for help with getting up. IDT will reassess for effectiveness and update POC (plan of care) as indicated.

The Policy and Procedure, Assessing Falls and Their Causes (revised 3/2018) shows, after a fall: 1. If a resident has just fallen or is found on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine and extremities. 3. If there is evidence of injury, provide appropriate first aid and/or obtain medical treatment immediately. 5. Notify the resident's attending physician and family in an appropriate time frame. a. When a fall results in a significant injury or condition change, notify the practitioner immediately by phone. 6. Observe for delayed complications of a fall for after an observed or suspected fall and will document findings in the medical record. 7. Document any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility; and any changes in level of responsiveness/consciousness and overall function. Note the presence or absence of significant findings.

A Policy and Procedure was requested for in house, stat X-rays and V2 said the facility doesn't have one.

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