

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005797	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2023
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NAME OF PROVIDER OR SUPPLIER MARIGOLD REHABILITATION HCC	STREET ADDRESS, CITY, STATE, ZIP CODE 275 EAST CARL SANDBURG DRIVE GALESBURG, IL 61401
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(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 11/2/2023/IL166592	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 each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999	<p>Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	<p>Continued From page 1</p> <p>resident to meet the total nursing and personal care needs of the resident.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>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:</p> <p>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.</p> <p>These requirements were not met as evidenced by:</p> <p>Based on record review and interviews the facility failed to provide a safe resident transfer for one of three residents (R1) reviewed for falls on the sample list of three. This failure resulted in R1 falling on 11/2/2023, hitting the back of R1's head, requiring transfer to the local hospital. R1 sustained a 2-centimeter (cm) laceration to the back of R1's head requiring staples, head pain and a subdural hematoma.</p> <p>Findings Include:</p> <p>R1 has the following diagnosis: Cerebrovascular disease with a stroke, Chronic Atrial Fibrillation, Heart Failure, Weakness, COPD (Chronic Obstructive Pulmonary Disease.)</p> <p>R1's Fall Risk Evaluation dated 6/26/2023,</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>documents the following: Gait/Balance 1.) Balance problem while standing 2.) Balance problem while walking 3.) Decrease muscular coordination.</p> <p>On 11/15/2023 at 8:05AM, R1 was alert and able to answer questions appropriately. R1 is sitting in the main dining room eating breakfast. R1 stated I am doing ok and feeling better.</p> <p>On 11/15/2023 at 8:25AM R1 stated, "V4 was trying to put me to bed when I stood up my legs gave out. My head hit the bedside table, then I fell to the ground hitting the floor. V4/CNA (Certified Nursing Assistant) did not use a gait belt on me. I probably would be ok if she did."</p> <p>R1's Nurses Notes, dated 11/2/2023, documents, "V4/CNA (Certified Nursing Assistant) called V3/LPN (Licensed Practical Nurse) to R1's room. Upon assessment R1 noted lying on her back on the floor with bilateral legs extended. Blood noted from back of head. R1 had a laceration approximately 2cm (centimeter) x 2cm in the back of her head. AROM (active range of motion), pupils equal and reactive to light, R1 complained of head pain. V4/CNA attempted to transfer R1 and while resident was standing V4/CNA turned to grab a washcloth and R1 fell sideways to the left. 911 called immediately."</p> <p>R1's Tele Hospitalist Initial Note, dated 11/3/2023, documents the following, "R1 is a 78-year-old female presented on 11/2/2023. Had a mechanical fall transferring from wheelchair to bed. Hit her head and sustained a laceration. CT (computed tomography) scan showed a small subdural hematoma. R1 has been awake and alert."</p>	S9999			

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S9999	<p>Continued From page 3</p> <p>R1's CT scan of the head, dated 11/2/203, documents the following: "Impression. Head CT: Subtle subdural hematoma with focal thickening and slight hyper attenuation along the cerebral falx".</p> <p>On 11/15/2023 at 8:17AM V2/Director of Nurses stated, "I know that V4/CNA was getting R1 up to go the bathroom and R1's knees buckled. R1 fell sideways and hit her head on the bedside table, then fell on the floor sustaining a laceration to the back of the head. I did not interview the resident, but I got this statement of occurrences from V4 who was transferring her. Yes, I do expect all staff that are helping a resident transfer or ambulate to use a gait belt."</p> <p>On 11/15/2023 at 9:04AM V3/LPN (Licensed Practical Nurse) stated, "V4 had just taken R1 down the hall to take R1 to her room and put R1 to bed. Then, I was summons to R1's room by V4 because R1 had fallen and was on the floor. When I entered the room R1 was lying next to her bed with her legs extended out and a pool of blood underneath her head. V4 stated she was transferring R1 to bed and went to grab a washcloth from the bedside table and R1 fell. No, I did not see a gait belt on R1."</p> <p>On 11/15/2023 at 2:45PM V4/CNA stated, "I was getting R1 ready for bed. When R1 stood up on her feet her legs weakened and gave out and R1 fell hitting her head on the bedside table then landed on the floor and again hit her head. I turned around to get a depend off the bed side table and that was when R1 fell. I had a gait belt around her, but only one had was under the gait belt. When I called for the nurse, I hurried and removed the gait belt because R1 was already on the floor. R1 had blood coming from her head."</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>On 11/15/2023 at 12:49PM V5/LPN (Licensed Practical Nurse) MDS (Minimum Data Set) Coordinator. stated,"R1 is an extensive assist of one or two. R1 is alert and she knows what is going on with her. I asked R1 what had happened, R1 said that she was standing up and V4/CNA was getting R1 ready for bed and her legs gave out. R1 hit her head on bed side table then R1 landed on the floor hitting her head again. I asked R1 if V4 had applied the gait belt around her waist and R1 said "No!"</p> <p>On 11/15/2023 at 1:28PM V6/CNA stated, "I am familiar with R1. I always use a gait belt when I transfer R1 because she is weak and unsteady on her feet due to the stroke she had back in June. R1 knows what she is talking about, and she would know if we were not using the gait belt. R1 will tell you she does not want to fall."</p> <p>On 11/15/2023 at 1:34PM V7/CNA stated, "I use a gait belt anytime a resident needs assistance with ambulation or transfers. R1 is one resident that is getting stronger, but a gait belt still needs to be used."</p> <p>(A)</p>	S9999		