STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007496	A. BUILDING _____ B. WING _____	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLINSVILLE REHAB & HEALTH CC	614 NORTH SUMMIT COLLINSVILLE, IL 62234

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S 000	Initial Comments Annual Licensure and Certification Survey	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 comprehensive care plan for each resident that includes measurable objectives and timetables to	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 and assistance to prevent accidents. These Requirements were not met evidenced by:	S9999		

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S9999	Continued From page 2 Based on interview, observation and record review, the facility failed to provide adequate supervision and progressive devices to prevent falls for one of thirteen residents (R2) reviewed for falls in the sample of 50. This failure resulted in R2 falling from the toilet when left unsupervised and sustained multiple rib fractures and laceration to his head. Findings include: R2's "Cumulative Diagnosis Log" undated documents diagnoses Paranoid Schizophrenia, anemia, hypothyroidism, hyperlipidemia, gastroesophageal reflux disease, vitamin D deficiency, anxiety, repeated falls, and major depressive disorder. R2's Fall Risk Assessment dated 09/13/23 documents, a score of 20. 10 or more points = High Risk Score. R2's MDS, (Minimum Data Set), dated 09/13/23 documents, a BIMS, (Brief Interview of Mental Status), score of 15 out of 15. The MDS documents, that R2 requires limited assistance of one person for bed mobility, transfer, locomotion on unit, locomotion off unit, and personal hygiene. The MDS documents, that R2 requires extensive assistance of one person for toilet use. The MDS documents, that R2 is not steady, only able to stabilize with staff assistance. R2's Care Plan dated 03/07/19 documents, "Has risk factors for falls: balance, assistive devices, needs assist for transfer, vision problems, medical conditions, meds, poor safety awareness, and behaviors put resident at risk."	S9999		

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S9999	Continued From page 3	S9999		

R2's Interventions: 02/26/23 r/t, (related to), fall, staff to check on frequently when in bed. 03/06/23 r/t fall, staff to utilize pressure alarm for bed and wheelchair. 08/17/23 r/t fall, educated resident and staff to ensure that w/c, (wheelchair) is locked during all transfers. 09/06/23 r/t fall, instructed to use call light and wait for assistance.

R2's Nurses Note dated 11/06/22 at 6:27 AM documents "Resident has a fall this morning he stated that his pain was 5 he was found lying on his left side. Stated that his left hip hurts. Vitals were B/P, (blood pressure), 120/58, P (pulse) 88, R, (respiration), 21, T, (temperature), 97.1. He stated that he was trying to put his tablet in his drawer.

R2's Quality Improvement Review Note dated 11/07/22 at 9:00 AM documents, "QA, (quality assurance), committee met to review fall on 11/07/22, resident attempting to put item in drawer, encourage to ask for assistance.

No note written for fall on 11/22/22.

On 11/16/23 at 3:00 PM, V2, DON, (Director of Nursing), stated that she could find a nurses note about any fall on 11/22/22.

R2's Quality Improvement Review Note dated 11/22/22 at 9:15 AM documents, "QA committee met to review fall with no injury noted. Resident was attempting to sit in w/c and missed, resulting in him sitting on floor in front of wheelchair. Encouraged resident to use call light and wait on staff assistance. Medical workup obtained.

R2's Nurses Note dated 02/26/23 at 8:40 AM documents, "This nurse passing HS meds when

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S9999	Continued From page 4 resident reported to nurse having severe pain 8/10 to left rib area. This nurse asked what happen to area, he reports he had a fall at 3a (SIC) while attempting to go to restroom in bedroom. Resident was able to recall event and states prior to falling he felt dizzy. Resident states he fell on the toilet landing on his left side and hitting head on the wall. Resident states he did not report incident sooner because he was scared and thought Jesus would heal him sooner. This nurse does not see any visible injuries. VS, (vital signs), WNL, (within normal limits). ROM, (range of motion), WNL. Lying in bed currently. Schedule PP, (pain pill), given. Call light in reach. Will follow up with NP, (Nurse Practitioner), for orders to send to ER, (Emergency Room). R2's Nurses Note dated 02/27/23 at 2:00 AM documents, "Nurse from (local hospital) called states resident is being d/c, (discharge), with multiple rib fracture and sternum mass on liver, no transportation to get resident back to facility, phone call to (V1) administrator to make her aware of situation, states (psychosocial program) can pick him up from hospital @ 7a (SIC) when they arrive." R2's Quality Improvement Review Note dated 02/27/23 at 10:30 AM documents, "QA committee met r/t fall reported on 02/26/23. Resident reported to staff nurse that he fell overnight trying to go to bathroom w/o, (without), assistance, stated he felt dizzy and fell over toilet, he was sent to ER for eval, resident sustained multiple rib fractures from unwitnessed fall, he returned back to facility, staff to check more frequently when in bed." R2's Nurses Note dated 03/06/23 at 8:45 AM documents "Resident was ambulating to	S9999		

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S9999	Continued From page 5 bathroom on his way back out of bathroom he lost his balance, fell to floor landing on his left side. States he hit his head. Assessment by nurse. Moves all extremities WNL for this resident neuro checks started. V/S 120/77 - 66 - 18 - 97.8 96% RA, (room air), O2 sats, (oxygen saturation). C/o, (complaint of), pain to left ribs area. R2's Quality Improvement Review Note dated 03/07/23 at 10:15 AM documents QA committee met r/t fall on 03/06/23, resident attempted to go to bathroom without assistance. Resident lost balance and fell, staff to utilize pressure alarm for bed." R2's Nurses Note dated 05/19/23 at 11:35 AM documents, resident chair alarm going off. CNA went to room and resident noted to be on knees on the floor. this nurse came to room and resident was getting up from floor by himself. Resident states he has no pain to knees. Resident states he also hit his left shoulder on his roommate's bed. denies pain to shoulder and ROM WNL. Redness/abrasions noted post-fall. Attempted to call emergency contact (POA) but the number is incorrect. Attempted to call NP x 2 but went voicemail and voicemail is full. Will try again. neuro checks WNL - ROM WNL. VS 126/74, 72, 18, 97.5, 96% RA. Resident denies hitting head. Will monitor. Spoke with NP - 0 new orders. monitor for bruising/pain." No Quality Improvement Review Noted for fall on 05/19/23. No intervention noted for fall on 05/19/23. R2's Nurses Note dated 08/17/23 2:10 AM documents, Resident had a fall in bedroom. Staff was in room with resident. No injury noted. NP	S9999		

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S9999	Continued From page 6 was notified. Administrator was notified. Resident emergency contact notified." R2's Quality Improvement Review Note dated 08/12/23 9:30 AM documents "QA committee met r/t fall with zero injury noted on 08/17/23. Resident attempted to sit back in w/c after incontinent care with CNA, (Certified Nurse Aide), and w/c moved causing him to land on buttocks. Educated resident and staff to ensure that w/c is locked during all transfers." R2's Nurses Note dated 09/06/23 at 6:25 AM documents, "Resident had a fall in his room. Writer went to resident room. Found him on the floor sitting on his buttocks. Resident stated, "that he was trying to go to his closet to shut the door and went in the opposite direction and slipped and felled (SIC). No injury noted. Vitals are B/P 130/80, P - 113, R 22, T 97.4. Notified emergency contact, notified NP, notified Administrator, notified DON. Will follow facility protocol related to falls. R2's Quality Improvement Review Note dated 09/07/23 at 9:15 AM documents "QA committee met r/t fall on 09/06/23 with no injury noted. Resident stated he was closing his closet door and walking backwards and fell, instructed to utilize call light and wait for assistance." R2's Nurses Note dated 11/06/23 at 6:27 AM documents "Resident has a fall this morning he stated that his pain was 5 he was found lying on his left side. Stated that his left hip hurts. Vitals were B/P 120/58, P 88, R 21, T 97.1. He stated that he was trying to put his tablet in his drawer. No Quality Improvement Review Noted for fall on 11/06/23.	S9999		

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S9999	Continued From page 7 No intervention noted for fall on 11/06/23. On 11/17/23 at 10:59 AM, R2 observed sitting in dining area in wheelchair unsupervised. Chair alarm noted attached to resident. On 11/17/23 at 10:55 AM, V16, CNA stated that they use bed and alarms to prevent (R2) from falling. She stated that he started ambulating with a walker under supervision with a wheelchair following. On 11/17/23 at 11:30 AM, V12, LPN, (Licensed Practical Nurse), stated that to prevent (R2) from falling they use bed alarm and chair alarm. (R2) is a one assist from staff. She stated that they re-educate him on using the call light. On 11/17/23 at 12:45 PM, V2, DON stated that she would expect there to progressive interventions added to a resident's care plan following a fall. Facility's "Fall Prevention" policy dated 11/10/18 documents "To provide for resident safety and to minimize injuries related to falls; decrease falls and still honor each resident's wishes/desires for maximum independence and mobility. 5. Immediately after any resident fall the unit nurse will assess the resident and provide any care or treatment needed for the resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions. (B)	S9999		