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
	IL6010391	A. BUILDING: ______ B. WING ______	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY REHAB AND CARE CENTER	**100 ROSEWOOD VILLAGE DRIVE SWANSEA, IL 62220**

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S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3)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 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	S9999		

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and shall be practiced on a 24-hour, seven-day-a-week basis:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review the Facility failed to seek medical interventions in a timely manner for 1 of 5 residents (R39) reviewed for medical interventions in the sample of 37. This failure resulted in R39 having a fall and not being sent out to the hospital for 2 hours and 34 minutes and sustaining a fracture of her left ankle.

Findings include:

R39's Physician Order Sheet (POS) July 2024, documents a diagnosis of Pneumonia, unspecified organism; Unspecified severe protein-calorie malnutrition; Hypertensive encephalopathy; Memory deficit following unspecified cerebrovascular disease; Unspecified osteoarthritis, unspecified site; Essential (primary)

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hypertension; Other specified nutritional anemias; dry eye syndrome of unspecified lacrimal gland; Polyarthritis, unspecified; Gastro-esophageal reflux disease without esophagitis; Anxiety disorder, unspecified; Hyperlipidemia, unspecified; Overactive bladder; Pain, unspecified; Allergy, unspecified, subsequent encounter; Major depressive disorder, recurrent, unspecified; Constipation, unspecified; Alzheimer's disease, unspecified; Personal history of COVID-19; Acute cough; Urinary tract infection, site not specified (History of); Constipation, unspecified; Pneumonia due to other specified infectious organisms; Deficiency of other vitamins; Other chronic pain; Opioid use, unspecified, uncomplicated; Unspecified fracture of left lower leg, subsequent encounter for closed fracture with routine healing; Dyspnea, unspecified; Other pancytopenia; Encounter for desensitization to allergens; Unspecified dementia, unspecified severity, with other behavioral disturbance; Hypokalemia; Altered mental status, unspecified; Unspecified open-angle glaucoma, stage unspecified; Encounter for prophylactic measures, unspecified; Vitamin D deficiency, unspecified; Vitamin deficiency, unspecified.

R39's Minimum Data Set (MDS) dated 2/19/2024 documents R39 was moderately impaired for cognition for activities of daily living.

R39's Care Plan documents, "Requires assistance with ADL's (activities of daily living) due to decreased strength and balance, decreased activity tolerance, decreased safety, impulsive, impaired cognition. Category: ADLs Functional Status/Rehabilitation Potential Start Date: 3/15/2024."

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R39's Care Plan: "Problem: At risk for falls due to history of falls, dementia, poor safety awareness, behaviors of refusing care, medications, high blood pressure, pain, arthritis, left knee problems (gives out), poor vision, abnormal labs. 6/9/23 Fall, 7/28/2023 Fall, 03/05/2024 Fall. Resident will be free from injury/harm over the next 90 days. Target Date: 06/15/2024 (Long Term Goal).

R39's Progress Notes dated 3/5/2024 at 2:50 AM, Resident found on floor beside bed, resident assessed and noted to have small lump on internal LL (left leg). Resident has complaints of pain. No other complaints of pain or injuries noted elsewhere. Resident stated when asked what occurred "my legs became twisted, and I fell out of bed" Neuro checks WNL (within normal limits) resident assisted back to bed per 2 staff with a gait belt. Resident continued to complain of LL leg pain, call placed to POA (Power of Attorney) who stated, "it was too late in the night to send to emergency room, I want STAT (immediately) x-rays done". (V19 Nurse Practitioner) notified and ordered stat L ankle and L tib/fib x-rays. (X-ray company) notified of stat x-ray order, on call nurse notified."

R39's Progress Notes dated 3/5/2024 at 2:52 AM, This nurse spoke with (V22 POA) and explained to her that (X-ray company) does not perform stat x-ray services overnight anymore and that they start x-ray services again at 8:00 AM, in the morning, and couldn't guarantee when (x-ray company) would arrive at the facility and (V22 POA) stated that's fine. This nurse explained to (V22) that resident had a small bulge in her left lower extremity and that resident was holding her leg and repeatedly stating that her leg hurt. (V22) again stated that she wanted stat x-rays done that it was too late in the night to send her to the

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hospital."

R39's Progress Notes dated 3/5/2024 at 5:24 AM, "Resident has continued to hold her left leg and scream out in pain, resident is screaming "I don't care what my daughter said, I want to go to the hospital". DON notified. Left voicemail for (V22) to return call. Ambulance notified of need for transport."

R39's Progress Notes dated 3/5/2024 at 10:49 AM, "Resident returned to the facility via ambulance at 10:50 a.m. and was transferred to bed by EMT's. Resident is alert and oriented. Resident has a fractured L (left) ankle with a standard order for (acetaminophen)."

On 7/25/2024 at 9:24 AM, V18 (Certified Nursing Assistant/CNA) placed the gait belt around R39's waist and as she was placing the gait belt around R39, V18's foot was touching R39's left foot, R39 yelled out, "ouch you hurt my leg, I broke my leg, be careful," V18 stated, "you did not break your leg."

On 7/25/2024 at 9:28 AM, V18 was asked if she was positive R39 had never broke her leg and she stated she was agency and did not know anything and was not aware R39 had broken her ankle previously.

R39's Final Fall Report documents, "(R39) is a 96-year-old female that admitted to the facility on 11/3/2018 with the following diagnosis: Alzheimer disease, unspecified dementia with Behavioral disturbances, hypertensive encephalopathy, unspecified osteoarthritis, essential hypertension, polyarthritis, generalized anxiety disorder, hyperlipidemia, pain, vitamin D deficiency, unspecified severe protein-Calorie Malnutrition,

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S9999	Continued From page 5 and Major depression disorder. According to her most recent MDS, (R39) has a BIM (Brief Interview of Mental Status) score of 8 (moderately impaired for cognition). (R39) resides in the facility long term with no plans to discharge. On 3/5/2024 at approximately 2:50 AM, (R39) was in her room in the bed. (R39) had pulled all the linen away from the mattress and her bilateral lower extremities became tangled in the sheets. She rolled over in the bed and fell to the floor twisting her left leg and foot. The charge nurse completed an assessment and palpated an abnormal raised area to left shin/ankle. (R39) did have complaints of pain with tactile stimuli. The charge nurse proceeded to notify the doctor and POA (Power of Attorney). The POA requested to have a STAT x-ray performed in house and refused transfer to the ER (emergency room). When scheduling the x-ray, the charge nurse was notified the STAT x-rays were no longer offered overnight, and exam would have to be scheduled for after 8:00 AM. The exam was scheduled, and the charge nurse informed the POA. The POA continued to refuse transfer to the ER at that time. At approximately 5:15 AM. (R39) continued to exhibit symptoms of pain and informed the DON (Director of Nursing). It was decided that she be transferred to the ER (Emergency Room) for treatment. The following was completed immediately: skin pain evaluation, PROM (Passive Range of Motion) to extremities (Medications evaluated), Care Plan reviewed, most recent labs reviewed, MD/POS/DON notifications, Transfer to ER (Emergency Room). Investigations completed. (R39) returned from the ER with a diagnosis of Closed fracture of Distal end of Fibula, unspecified fracture, Morphology, initial encounter. During record review and staff interviews, it was reported that (R39) often uses profanity and can be verbally aggressive at time.	S9999		

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She had an increase in behavior over a short period. (R39) required more redirection, verbal cueing, and one-on-one care with staff including family phone calls. (R39) had been refusing to seek assistance, yelling out, making false allegations towards peers and staff, and attempting to propel herself in the wheelchair when asked to remain in common areas. (R39) reported that she wrapped in bed covers and rolled from the bed. However, it is believed that due to her cognition and poor safety awareness, (R39) was attempting to turn and position herself in the bed and was lying close to the edge when she rolled and fell. (R39) has a history of falls and bone/joint issues. It has been determined that she is at an increased risk for fractures due to a decreased bone density."

R39's Initial Serious Injury Incident Report, with incident date of 3/5/2024 documents, "Resident observed on floor from bed wrapped in sheet and cover. Stated that she got tangled and rolled out of bed. Sent to ER for x-ray. Fracture of distal end of fibula. Investigation started immediately. Final/Summary to follow.

R39's Hospital Records dated 3/5/2024 at 6:24 AM, documents, (R39) 96-year-old female presenting to the ED (emergency department) from (Facility) complaining of left knee and foot pain. Patient states she fell out of bed. Episode occurred around 2:30 AM, given Tylenol. Still complained of pain. R39's Hospital records document she was given 5-325 mg (milligrams) tablet of hydrocodone-acetamonophen (Norco) (narcotic) and was given an splint/Brace immobilizer to wear as directed with no weight bearing for her fractured distal end of fibula.

R39's Hospital Records dated 3/5/2024 at 6:24

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S9999	Continued From page 7 AM, documents XR (x-ray ankle) left 3 or more views, XR knee left 1 of 2 views: Diagnosis: Closed fracture of distal end of fibula, unspecified fracture morphology, initial encounter. Clinical fracture of distal end of fibula, unspecified fracture morphology, initial encounter. Findings: Mildly displaced fracture of the distal left fibular shaft. On 7/25/2024 at 4:39 PM, V19 (Nurse Practitioner) stated, "I was contacted by the facility on 3/5/2024 regarding (R39) having a fall and ordered a STAT x-ray. The facility never contacted me again telling me the STAT x-rays were no longer be performed overnight and or they would not be available until 8:00 AM the following morning. I normally give them a four-hour window. If the resident was still in pain and if they would have contacted me and the resident was yelling and screaming, I would know there was not much else we could do for her and would have had her sent out to the Emergency Room right away and would not wait." On 7/26/2024 at 5:15 PM, V2 (Director of Nursing) (R39) was trying to get herself out of bed and got caught up tangled in the sheets. (R39) was complaining of pain and when we contacted her daughter, she told them not to send her out to the hospital and to get an x-ray in house. I was not present for the conversation. I was told that later (R39) was still complaining of pain and I was contacted by the nurse, and I told her to send her out." On 7/26/2024 at 9:32 AM, V31 (Registered Nurse) stated, "I remember (R39) falling. I was at the nurse's station, and I heard her scream. When I went to her room, I found her sitting Indian style on the floor on her mat. Her leg had a	S9999		

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bulge to it, and she was in pain. I called the daughter (V22) and told her I wanted to send her out and she was adamant about not wanting to send her out to the hospital and to get a STAT x-ray in the facility. I told her it would be better for her to be seen in the ED, but she refused. I do not remember much else except (R39) was screaming and was in a lot of pain and we finally sent her out. I do not remember one way or the other about calling the doctor again."

The Change of Condition Reporting Policy with a revision date of 2/2018 documents, "(Facility) will notify the resident's physician and the resident's representative whenever, there is a significant change in the resident's health, mental or psychosocial status. Assess the resident condition as warranted which may include, but is not limited to checking vital signs, completing a physical assessment as indicated speaking with the resident about the symptoms and noting the presence or absence of pain. Notify the physician of the change/incident/accident There is an accident (incident or unusual occurrence). Notify the physician of the change of condition/incidents/accidents/unusual occurrences and accident findings. may be reported to the physician. (Changes of condition/incidents/accidents/unusual occurrences may be reported to the physician."

"B"