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
	IL6014674	A. BUILDING: ______ B. WING ______	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALHOUN NURSING & REHAB CENTER	**#1 MYRTLE LANE HARDIN, IL 62047**

(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 Annual Licensure 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 meet the resident's medical, nursing, and mental	S9999		

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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 as evidenced by:

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Based on observation, interview and record review, the facility failed to implement care plan interventions to prevent falls for 1 of 5 residents (R44) reviewed for falls in the sample of 46. R44 sustained multiple falls while at the facility, including a fall that resulted in a fracture of the left hip.

Findings include:

R44's Face Sheet, printed 7/19/24, documents she has a diagnosis of Other fracture of lower end of left femur, subsequent encounter for closed fracture with routine healing, Encounter for other orthopedic aftercare, and Fracture of unspecified part of neck of left femur, initial encounter for closed fracture.

R44's Minimum Data Set (MDS) dated 7/15/24 documents R44 is severely cognitively impaired and requires supervision and touch assistance for transfers into chair or bed to chair transfers.

R44's undated Care Plan with the goal date of 10/24 documents, "Safety Notes: I have a history of falling and am a continued fall risk. I have poor safety awareness. Make sure I have nonskid socks or shoes on before transfers or walking. Keep items that I frequently use within my reach, but keep area free of clutter and safety hazards. Transfer me per (brand name) Transfer Screen. Redirect me and reassure me when I get anxious and wander. I have a high/low bed and bilateral 1/2 rails on my bed, and I have non-skid strips on the left side of my bed because that is the side I get out on. Be sure my bed is in proper position in relation to my non-skid strips. I have a (alarm) to my wheel chair. I have been discontinued from being an elopement risk. If I start to wander, please redirect me or get social services. The

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goal for this care plan documents, "I want to be safe and free of falls. "

On 7/18/24 at 2:57 PM, R44 was lying in her bed with her wheel chair positioned beside her bed with the brakes unlocked. There were no non-skid strips on the floor on either side of her bed. V16, Certified Nursing Assistant (CNA) came in and pulled R44's blankets back off her feet and R44 had her shoes on in bed. V16 stated (R44) requires assist to transfer safely but will transfer herself at times. V16 stated she had just come down a little while ago to help (R44) lay down in bed and (R44) had already transferred herself into bed without assist. V16 verified there were no non-skid strips on (R44's) floor next to her bed or in her bathroom. R44 woke up and was pleasantly confused. She stated, "There is usually someone running around here to help me or I just get up by myself. I do alright."

R44's Fall Report dated 10/17/23 documents, "Resident was sitting at NS (nurses station) visiting with son. Son left facility and did not tell staff he was leaving and resident stood up, tripped over catheter tubing, and fell, hitting the back of her head. Swelling to back of head. Complaint of head hurting. Sent to (local hospital) for eval." Immediate post-incident action: Bladder training in progress to discontinue foley. Meds reviewed by NP (Nurse Practitioner) 10/17/23.

R44's Fall Report dated 10/21/23 documents, "Got up from bed unassisted, lost balance and fell. No injury noted." Immediate post-incident action: Ensure gripper socks are on when in bed.

R44's Fall Report dated 10/29/23 documents, "Unit aide walking by resident's room and saw resident sit herself on the floor between her bed

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and her wheel chair. Stated she was trying to walk to bathroom and that her legs gave out so she sat down. She did not hit her head." Immediate Post-Incident Action: Non-skid strips place on floor beside bed.

R44's Fall Report dated 12/18/23 documents, "Resident found sitting on floor next to bed. Wheelchair was facing bed with wheels locked, lights off, floor free of clutter and she had gripper socks in place. Resident stated she was trying to get back in bed when her feet just slid on the floor. Stated she fell like a child would and can't believe that she would do that. Resident denies hitting head, states she fell straight to her bottom in a slow manor. She stated the only thing that hurt is her pride. ROM (Range of Motion) and Neuros WNL (within normal limits) for resident." Immediate post-incident action: make sure bed is in proper position with non-skid strips in correct place in correlation to bed at transfer site.

R44's Progress Note dated 12/18/23 at 11:20 PM, which was included in the fall investigation, documents, " During examination of the room, noted bed was pushed over so non-skid strips on floor were under wheelchair instead near the area her bed was. Bed was moved back into position so non-skid strips in the proper place."

R44's Fall Report dated 1/6/24 documents, "Staff heard commotion on hall and upon passing room saw resident propped up on elbow on floor. Nurse alerted. Upon entering room resident was sitting on right hip leaning over on right elbow on floor. Resident states she was trying to transfer from wheel chair to stationary chair to read the newspaper on the side table and missed the chair. Shoes on , room lit. Floor did have spilled water from resident falling over as well as table

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and paper. AROM (active range of motion) WNL. Skin intact. Denies hitting head. Resident has been more confused today. "Immediate post-incident action taken: Additional chairs removed from room and request for UA (urinalysis) sent to MD (Medical Doctor).

R44's Fall Report dated 4/8/24 documents, "Charge nurse heard resident yelling and upon entering resident's room, observed resident lying on the floor on her back at the foot of her bed, between her bed and the BR (bathroom) door. She came and got writer off East hall to eval resident. Resident stated that she got up to use the bathroom and fell. She is screaming and crying in pain, holding left hip and left groin. LLE (left lower extremity) rotated outward and resident will not let writer perform PROM (passive range of motion) to LLE. Sent to (local hospital) for eval." Immediate post-incident action: will re-evaluate when returns to facility.

R44's Progress Note dated 4/9/24 at 4:52 AM documents, "Call placed to (local hospital) to check on resident. Nurse (hospital staff) stated that resident was being admitted with left hip fracture and that MD had already been consulted and that resident is to have surgery in am. "

R44's hospital Radiology Report dated 4/8/24 at 9:41 PM documents, "Impression: Mildly displaced transverse fracture through the base of the greater trochanter. Mildly displaced lesser tuberosity avulsion fracture."

R44's Morse Fall Scale dated 4/8/24 documents her fall risk score of 90. Per the assessment, a score of 46 or more indicates the resident is at a high risk of falls and high-risk fall prevention interventions should be implemented.

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S9999	Continued From page 6 R44's (name brand) Screen (for mobility devices) dated 5/24/24 documents R44 requires one person assist for transfers. On 7/19/24 at 10:08 AM V2, Director of Nursing (DON) stated after R44 returned from the hospital, they moved her to a different room because her previous roommate had too much clutter in her room and that was what caused R44 to fall and fracture her hip. She stated the roommate's wheelchair was blocking R44's ability to get into her own w/c and she got off the wrong side of the bed and tried to walk around and fell. She stated the non-skid strips did not have anything to do her fall. V2 stated when R44's room was moved she thinks it was just overlooked that she was supposed to have non-skid strips on the floor to help prevent her from falling. She stated the error has been corrected now. The facility's policy, "Accident & Incident Documentation & Investigation Resident Incident" revised 7/18, documents, "Accidents and/or incidents involving resident care will be investigated and documented on the Resident Incident Report entry form in the (computer) system. An "incident" is defined as an occurrence which is not consistent with the routine operation of the facility or the routine care of a particular resident. Accidents and incidents will be analyzed for trends and patterns to enable the facility to enhance preventative measures to reduce the occurrence of incidents." (A)	S9999		