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ROBINSON REHAB AND NURSING	600 EAST ROBINWOOD DRIVE ROBINSON, IL 62454

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S 000	Initial Comments Complaint Investigation #2452133/IL170940	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	S9999		

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comprehensive care plan for each resident that includes measurable objectives and timetables to 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.

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These Requirements were not met evidenced by:

Based on observation, interview and record review, the facility failed to implement progressive person centered interventions for fall prevention for 1 (R1) of 3 residents reviewed for falls in the sample of 3. This failure resulted in R1 experiencing 4 falls between 2/20/24 and 3/3/24 which required Emergency Room evaluation and/or treatment for injuries that included skin tears to right arm, a right orbital fracture, head lacerations, and "baseball" size hematoma to the head.

Findings Include:

R1's "Admission Record" documented an initial admission date to the facility as 9/22/23. R1 is documented on this same record as being 72 years old with diagnoses including but not limited to: Unspecified Dementia, unspecified severity, with agitation; Type 2 Diabetes Mellitus; Major Depressive Disorder; Insomnia; Muscle Weakness; and Cognitive Communication Deficit. V9 (Physician) is documented as being R1's Primary Care Physician. R1 was observed as being alert to person only during this survey.

Review of R1's "Progress Notes" in her Electronic Health Record documented falls most recently occurred on 2/20/24, 2/23/24, 2/29/24, 3/3/24, 3/13/23, and 3/27/24. R1's Electronic Health Record included the following documentation in relation to these falls:

1. A "Nursing Progress Note" documented on 2/20/24 at 11:02 AM that at 6:00 AM that day, R1 was "found in her room lying on the floor following an apparent fall. Resident was lying flat on her

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back and clearly had a laceration to her right orbital. The fall was not witnessed and resident was not able to provide any information otherthan (sic) she had fallen. Pressure was applied to the laceration until EMS (Emergency Service Personnel) arrived, resident was encouraged to stay in place...."

The local hospital "Discharge Instructions" dated 2/20/24 documented the diagnosis of "Blow-out fracture of orbital floor; Facial laceration."

A "Nursing Progress Note" documented on 2/20/24 at 7:24 PM, that R1 returned to the facility from the local hospital with x-ray's to R1's right wrist and shoulder being normal, but a CT (Computed Tomography) of her head revealing a "FX (fracture) to right orbital." 4 sutures are documented as being in place to right orbital laceration.

R1's current Plan of Care documented a focus area of being at high risk for falls, initiated on 9/26/23. Interventions listed following this fall include: "hipsters" with a date initiated of 2/21/24, and "Therapy to screen" with a date initiated of 2/20/24.

On 3/27/24 at 10:13 AM, V1 (Administrator) confirmed the accuracy of the documented interventions.

2. A "Nursing Progress Note" documented on 2/23/24 at 8:23 PM that R1 "experienced unwitnessed fall. States hit their head. Has two skin tears 2 in. (inches) in length and 0.5 in. diameter to the right forearm. C/o (complains of) shoulder and arm pain. No visible injuries to the head...." V9 (Physician) is documented as being notified with orders to send to ER (Emergency

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Room) for evaluation and treatment.

The local hospital "Discharge Instructions" dated 2/23/24 documented the diagnosis of, "Carotid artery calcification; Closed head injury; fall." "Major Tests and Procedures" documented as being completed on this same form include a CT of head or brain without contrast and CT of spine cervical without contrast. No findings of significance were discovered in relation to the fall.

Review of R1's current Plan of Care documented no new interventions were implemented following this fall.

On 3/27/24 at 10:13 AM, V1 confirmed R1's Plan of Care was reviewed, and no new interventions were implemented following this fall as she stated new interventions had just been implemented following her previous fall and not had time to show their effectiveness yet.

3. A "Nursing Progress Note" dated 2/29/24 at 9:38 AM documented R1, "Found on the floor, yelling help. Unwitnessed fall. Resident states they hit their head trying to walk. Notable laceration to the R (right) temple. R (right) temple bleeding. Resident denies hitting any other part of body. Alert to person only. Resident follows commands, and eyes can track movement." V9 is documented as being notified with orders to send to the ER for head trauma. 911 was called for transport. This note also documents "Chair next to residents bed knocked over."

The local hospital "ED (Emergency Department) Note - Physician" dated 2/29/24, documented a chief complaint of, "Fell this am, 3rd fall in 1 week, opened old wounds to right eye brow. 1 3 cm (centimeter) laceration and 1 1 cm to right eye

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brow." "History of Present Illness" includes the following notation, "Differential includes intercranial hemorrhage, skull fracture, laceration. CT scan obtained and independently interpreted by myself. Is negative for internal injuries....Given that the wound is old and now reopened, there is no indication to close it. This will have to heal by secondary intent..."

R1's current Plan of Care documented a focus area of being at high risk for falls. Therapy screenings were documented as being completed on 2/27/24, with services now being provided. The plan documented a new intervention of "Resident to wear soft helmet for head protection 2/29/2024. If resident takes off or refuses to wear. Staff is to chart behavior. Soft helmet use following this fall" with date of initiation documented as 2/29/24.

On 3/27/24 at 10:13 AM, V1 confirmed the accuracy of R1's documented interventions and confirmed the soft helmet use was to be implemented at all times, removed only for bathing.

4. A "Nursing Progress Note" dated 3/3/24 at 9:26 AM documented "...CNA (Certified Nurse Assistant) called for help. This nurse went to resident's room. Resident was laying on her back. She was next to the sink. Her walker was turned over and laying above her head." An additional note made on 3/3/24 at 9:27 AM documented, "...Resident did c/o (complain of) head pain. Nurse assessed a significant size hematoma to the parietal area on the back of the head...MD notified. NO (new order) to send to ER for eval and treat ..."

The local hospital "ED Note - Physician" dated

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3/3/24 documented a chief complaint of, "...unwitnessed fall this am. Per report from (V2's name-Registered Nurse/ RN), patient has frequent falls and old laceration and bruising above right eye and old fx (fracture) to right wrist. Today, baseball size hematoma to right occipital area..." A CT scan of R1's head is documented as being obtained, demonstrating a "scalp hematoma."

R1's current Plan of Care documented no new interventions implemented after this fall. The care plan documents "Continue with therapy for balance and strengthening" with a date initiated of 3/3/2024. In addition, therapy services are documented as being continued for balance and strengthening on the "Intervention Timeline 2024" provided by V1.

On 3/27/24 at 10:13 AM, V1 confirmed the accuracy of R1's documented interventions.

On 3/26/24 at 1:32 PM, V2 (RN) stated that R1's normal status is confused and forgetful. V2 stated that staff are to document if R1 refused to utilize equipment such as her helmet. V2 stated she cannot recall who the CNA (Certified Nurse Assistant) was that called for help during R1's fall on 3/3/24. V2 stated that she recalled R1 was lying in front of the sink on the floor, in her room. V2 stated R1's helmet was not in place at the time of the fall. V2 stated the fall occurred in the morning and she had not yet seen R1 yet that day. V2 stated R1 had a large knot to the back part of her head. V2 stated that if R1 is refusing to comply with fall interventions, such as wearing her helmet, staff should re-approach later to offer interventions and document the refusal if that is still the case after later failed attempts.

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On 3/27/24 at 9:13 AM, V14 (CNA) stated she was the staff member working on 3/3/24 when she observed R1 lying on her back in front of the sink in her room. V14 stated she had heard something, and when she went to check, found R1 on the floor. V14 stated R1 didn't have her helmet on and isn't sure if it had even been implemented yet at the time of this fall. V14 stated once the helmet was implemented, it was to be worn at all times. V14 stated she doesn't know if R1 can remove the helmet herself. V14 stated R1 seems to leave the helmet on as far as she knows and has observed, at the times she's worked with R1. V14 stated at the time of R1's fall, R1 was complaining of her head hurting. V14 stated that R1 is not supposed to walk by herself but is very confused and does.

R1's Electronic Health Record documented no refusal notation regarding R1's soft helmet on 3/3/24.

An "Orders - Administration Note" dated 3/3/24 at 8:55 AM, entered by V2 (RN) stated "Note Text" as, "Ensure frequent rounding is being done by staff and ensure soft helmet and hipsters are in place. Chart any non-compliance. Every shift for MONITORING. Resident non-compliant with soft helmet."

On 3/27/24 at 11:35 AM, V16 (Director of Nursing/DON) stated that she does recognize R1's Clinical Record lacks documentation regarding any refusal of services R1 has had or different interventions the facility staff may have attempted in an effort for fall prevention. V16 stated that she would expect staff to document any refusal of care or interventions such as the helmet in her record. V16 stated that R1 was not always compliant with wearing her helmet and did

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have some refusals at the start of its initiation, but is doing better now. In reference to the Administration Note documented above, V16 stated she views non-compliant and refusal as having two separate meanings. V16 stated non-compliant would mean that redirection is needed to fulfill the intended task. Such as if R1 would allow her helmet to be on, but needed frequent reminders to leave it in place, or re-apply the helmet...the desired outcome could be reached with the task being re-attempted, etc. V16 stated refusal of a service would be that despite redirection and interventions, R1 would not allow the service or intervention to be provided. V16 stated there is no official program or direction in place to deal with R1 being non-compliant or refusals. V16 stated if R1 was refusing to wear her helmet, there was no alternative intervention in place to implement. V16 stated that the "Administration Note" (referenced above) in R1's "Progress Notes" stems from entries staff have made in the Medication or Treatment Administration Record (MAR/TAR) that automatically transcribe over into the progress notes then. V16 stated that she had put entries on R1's Treatment Administration Record to remind staff of interventions in place for R1's falls. V16 confirmed for example, the Administration Note made in R1's record at 8:55 AM on 3/3/24 of R1 being non-compliant with her soft helmet, does not mean R1 was refusing to wear her helmet at that time, or was even being viewed at that time, but is a general entry statement for the shift that day. V16 stated if R1's status was to change where she was actually refusing, a progress note should have been made to document that status.

On 3/27/24 at 11:57 AM, V2 stated she does not recall the circumstances that triggered the entry

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that R1 was being non-compliant with her soft helmet on 3/3/24, as she had not seen her that morning prior to her fall. V2 stated she does not recall anything being reported to her regarding any non-compliance or refusal of services with R1 that morning. V2 stated usually what she does, is if it is reported to her that a resident is refusing a service, she will make a progress note in the record. For entries on the TAR reminding staff to ensure interventions, she makes the TAR entry at the time she is initially viewing the resident for that shift.

On 3/27/24 at 10:13 AM, V1 confirmed that R1 was to wear her helmet at all times. V1 stated that in the beginning of the helmet being implemented, R1 would refuse to wear it, and she would expect those refusals to be documented. V1 acknowledged R1's record contains a lack of documentation which would have reflected more frequent refusals of wearing the helmet, should they have existed. V1 acknowledges the need for revision of a residents person centered care plan and documentation of interventions being implemented to add in addition to or replace ineffective interventions for effective fall prevention.

On 3/27/24 at 9:33 AM, V13 (Nurse Practitioner) stated that she has seen R1, but mainly just for continued evaluation for therapy progress. V13 stated she believes overall, R1 did pretty well with therapy, but just has a lot of confusion which results in behaviors and contributes to her falls. V13 stated V9 is R1's primary caregiver and would be the staff who receive the day to day calls of events. V13 stated she would expect the facility to revise a resident's Plan of Care to fit the resident needs for fall prevention.

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On 3/27/24 at 10:53 AM, V9 confirmed he is the Primary Care Provider for R1. V9 stated that R1's mental status has recently suffered a significant decline due to her progressing dementia. V9 stated that the facility does a good job of notifying him of any changes in a resident's status. V9 stated he would expect a resident's plan of care to be revised to fit their specific person centered needs and does acknowledge that should R1 have been wearing her helmet during a fall, it could potentially lessen or negate a head injury. V9 stated that R1 has sustained a facial fracture from a fall in the past, so protecting her head is important.

5. A "Nursing Progress Note" dated 3/13/24 at 9:51 AM documented, R1 "observed on floor in doorway by this nurse. Stated she just "fell down." No injuries..."

R1's current Plan of Care documented a focus area of being at high risk for falls. A new intervention following this fall with an initiation date of 3/13/24 is documented as "Refer resident to (name of outside acute psychiatric care hospital) for increased behaviors 3/13/2024." Another intervention listed as being initiated on 3/21/24 documents "Resident often leaves walker away from her and walks without it. Remind resident that she needs to have her walker with her and someone with her when ambulating."

On 3/26/24 at 12:38 PM, V1 stated that the facility received no response from (name of outside acute psychiatric care hospital) following the referral made.

On 3/27/24 at 10:13 AM, V1 confirmed the accuracy of R1's documented intervention of a (name of outside acute psychiatric care hospital)

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behavioral service referral following her 3/13/24 fall with no contact made with them as of 3/27/24.

6. A "Nursing Progress Note" dated 3/27/24 at 2:20 PM documented, "This nurse was outside the dining room and heard a noise, resident observed on the floor with chair turned on its side. Resident wearing soft helmet, and hipsters. CNA in the dining room witnessed event. Resident was assessed, neuro checks initiated, ROM (range of motion) performed. Resident denied any pain or injuries. No visible injuries were noted...."

R1's "Fall Risk Assess. (Assessment)" dated 9/24/23, documented a score of 12, indicating she was assessed as being at high risk for falls.

The "Fall Reduction Policy" with a revision date of June 17, 2022 documented the purpose of the policy included, "...To identify residents who are at risk for falling and to develop appropriate interventions to provide supervision and assistive devices to prevent or minimize fall related injuries. To promote a systematic approach and monitoring process for the care of residents who have fallen and/or those who are determined to be at risk." The same policy also documented under the section of "Prevention and Treatment Guidelines," "...12. The care plan should be reviewed after every fall and updated with a new intervention, when applicable."

(B)