

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146017	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/29/2021
NAME OF PROVIDER OR SUPPLIER Illini Heritage Rehab & Hc		STREET ADDRESS, CITY, STATE, ZIP CODE 1315 Curt Drive, Suite B Champaign, IL 61821	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385</p> <p>Based on observation, interview, and record review, the facility failed to complete a thorough fall investigation and implement fall interventions for one (R1) of three residents reviewed for accidents in the sample of three. The facility failed to ensure a floor mat was in place per R1's care plan resulting in R1 sustaining a right pubic rami fracture during a fall.</p> <p>Findings include:</p> <p>The facility's Fall Prevention policy revised 11/10/18 documents: 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. 6. The unit nurse will place documentation of the circumstances of a fall in the nurses notes or AIM (Assess Intervene and Monitor) for Wellness form along with any new interventions deemed to be appropriate at the time. The unit nurse will also place any new intervention on the CNA (Certified Nursing Assistant) assignment worksheet. 7. Report all falls during the morning Quality Assurance meetings Monday through Friday. All falls will be discussed in the Morning Quality Assurance meeting and any new interventions will be written on the care plan.</p> <p>R1's Physician's Orders dated 12/18/21-12/31/21 document R1's diagnoses include Functional Quadriplegia, Legally Blind, Osteoporosis, and a history of Left and Right Hip Fractures. R1's Minimum Data Set, dated dated [DATE] documents R1 has moderate cognitive impairment, and is dependent on one staff person for bed mobility and at least two staff for transfers.</p> <p>R1's Fall Risk assessment dated [DATE] documents a score of 18 indicating R1 is high risk for falling, and R1 uses a full mechanical lift for transfers.</p> <p>R1's Care Plan with a start date of 6/18/19 documents: (R1) has risk factors that require monitoring and intervention to reduce potential for self injury. This care plan documents an intervention dated 8/21/21 to keep R1's bed in low position when R1 is not eating, R1 has had increased confusion. R1's care plan documents an intervention dated 9/21/21 to have a fall mat beside R1's bed.</p> <p>R1's AIM for Wellness form documents on 12/14/21 at 4:45 PM R1 was found lying on R1's back on the floor next to R1's bed. R1 hit R1's head and complained of right hip pain.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R1 was confused and believed R1 was at R1's family member's house. R1 was transferred to the local hospital. There is no documentation in R1's nursing notes or AIM for Wellness form that R1's bed was in low position, or fall mat was in place at the time of R1's fall.</p> <p>R1's Medical History and Physical Note dated 12/15/21 at 2:55 AM documents:</p> <p>R1 admitted to the hospital on 12/14/21. R1 fell reaching for a glass of water. R1 hit R1's head, has right leg shortening, and has previous right hip surgery. R1's diagnosis is documented as fall with acute closed right pubic rami fracture without hematoma. R1's Abdomen/Pelvis CT (Computed Tomography) dated 12/14/21 at 9:40 PM documents: Acute minimally displaced fractures of the right superior and inferior pubic rami and right parasymphseal pubis. No associated hematoma.</p> <p>The facility's Final Report dated 12/21/21 and signed by V1 Administrator documents: R1 had an unwitnessed fall and was found on the floor of R1's bedroom. R1 told staff that R1 had sat on the edge of R1's bed, attempted to grab a bottle of water, and fell forward from R1's bed. R1 had a bump on R1's forehead and was sent to the local hospital for treatment. The facility was notified R1 had a right pubic ramus fracture. The facility interviewed staff working at the time of R1's fall. V4 and V6 CNAs had assisted R1 to bed prior to the fall.</p> <p>V7 Licensed Practical Nurse (LPN) had been in R1's room prior to the fall, gave R1 a bottle of water and a snack, and positioned R1's tray over R1's bed. This report does not document the position of R1's bed or if a floor mat was in place prior to or at the time of R1's fall. The root cause of R1's fall is documented as R1 had an increase in R1's positioning ability. The facility believes R1 pushed R1's overbed tray table away and later attempted to retrieve R1's water. A bed alarm was initiated as R1's fall intervention.</p> <p>There is no documentation in R1's medical record that a bed alarm was implemented subsequent to this incident.</p> <p>On 12/29/21 at 10:46 AM, R1 was lying in bed and R1's bed did not contain an alarming device. There was a fall mat on the floor beside R1's bed. R1 said, recently had a fall and broke R1's right hip. At the time of R1's fall, R1 had sat R1's self up on the side of the bed to attempt to reach a water bottle that was on an overbed table across R1's room. R1's socks slid across the floor and R1 fell from the bed onto the floor.</p> <p>At 11:25 AM, R1 was sitting in R1's wheelchair in R1's room. R1's bed did not contain a bed alarm. R1 stated, doesn't use a bed alarm. R1 was unsure if the floor mat was a new intervention or if it was in place at the time of R1's fall.</p> <p>On 12/29/21 at 1:23 PM, V3 CNA stated: R1's fall interventions include placing the call light within reach and encouraging to call for assistance. R1 had been having some confusion thinking R1 is working, so educating R1 to use the call light didn't always stick. R1 never previously tried to sit R1's self up on the side of the bed before, and R1's last fall was about 5 or 6 months ago. R1's fall was unusual in the fact that R1 sat R1's self up on the side of the bed. R1 uses two people for bed mobility and transfers. R1 would use the bed controls to adjust R1's bed height. We had stopped giving the controls to R1 and had been using a floor mat prior to R1's fall.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/29/21 at 1:46 PM, V5 CNA stated, CNAs do not use a worksheet. Fall interventions are discussed at shift report at the beginning of each shift. V5 was not working at the time of R1's fall but regularly provides care for R1. V5 stated, R1 had been using a fall mat beside R1's bed for the last couple of months. R1 hasn't used any type of bed alarm.</p> <p>On 12/29/21 at 2:01 PM V4 CNA stated: At the time of R1's fall, V2 and V4 were walking up the hallway. V4 saw R1's overbed table was tipped over and R1 was on the floor. Initially V4 stated, there was a floor mat on the floor. Then V4 stated no, now that I (V4) think about it, I (V4) don't think there was a floor mat in place. I (V4) think that was something that was implemented after R1's fall. V3 and V4 stated, fall interventions are discussed as part of a shift huddle at the beginning of each shift. V3 knows resident fall interventions by looking at the care plan and attending the morning meetings where falls are discussed.</p> <p>On 12/29/21 at 10:50 AM, V2 Wound Nurse/Licensed Practical Nurse was asked about R1's 12/14/21 fall. V2 stated: It was close to supper time and V2 and V4 CNA's were coming down the hall and noticed R1's overbed table was tipped over. R1 was lying on the floor with R1's head on a pillow near the foot of R1's bed, and R1's feet near the head of the bed. R1 said, I was trying to reach my water. V4 and V6 CNAs had been in R1's room about 30 minutes before the fall and had scooted R1 up in bed and given R1 water. V7 LPN had also been in R1's room to give R1 medications and a bottle of water prior to R1's fall. R1 said, R1 was not trying to get out of bed, and R1 had sat R1's self up on the side of the bed. When R1 went to push R1's self back, R1's feet slid on the floor, and R1 was wearing regular socks.</p> <p>At 11:29 AM, V2 stated: The new post fall intervention for R1's fall was a floor mat beside the bed. R1 does not use a bed alarm and one was not used after R1's fall.</p> <p>At 1:34 PM, V2 stated, at the time of R1's fall, there was not a fall mat on the floor. R1's bed was low to the floor. Falls are discussed in the morning meeting and management is updating the resident care plans with fall interventions. V2 has been assisting since the facility does not currently have a Director of Nursing.</p> <p>At 3:00 PM, V2 stated, staff are expected to look at the resident's care plan to determine fall interventions. Care plans are kept at the nurse's station and available for staff to review. The facility does not use a CNA worksheet to document fall interventions.</p> <p>On 12/29/21 at 1:40 PM, V1 Administrator stated: R1's post fall intervention for R1's 12/14/21 fall was to have a bed alarm, but the bed alarm did not work for R1 so we implemented a floor mat. V1 Confirmed R1's care plan documents a fall intervention for the use of a floor mat on 9/21/21.</p> <p>On 12/29/21 at 2:10 PM, V1 stated, V1 had no additional documentation to provide for R1's fall investigation or that a bed alarm was implemented after R1's fall on 12/14/21.</p>		