STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145647	A. BUILDING _____ B. WING _____	C 01/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY REHAB AT NORTHMOOR	**1500 WEST NORTHMOOR ROAD PEORIA, IL 61614**

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F 000	INITIAL COMMENTS Original Complaint Investigation #2120092/IL#129975	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement fall interventions, provide adequate supervision, and provide assistance of two for Activities of Daily Living (ADL's) for one of three residents (R2) reviewed for falls with injury in the sample of three. These failures resulted in R2 being left unattended during ADL's, falling out of bed, sustaining a right hip fracture and experiencing excruciating pain. Findings include: The facility's Fall policy, dated 6-4-18, documents, "It will be the standard of this facility to complete an initial assessment, on-going monitoring/evaluation of resident conditions and subsequent interventions development in an attempt to prevent falls and injuries related to falls. Based on evaluation of falls, pertinent interventions will be implemented by staff such as, but not limited to: resident education if	F 689	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: Information related to R2 was identified during a historical document review. (b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: By 2/9/2021, the Director of Nursing Services/designee conducted a review of	2/9/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/06/2021

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F 689	Continued From page 1 appropriate, staff re-educating regarding transfer techniques and safety during ADL (Activities of Daily Living) care, and maintaining close proximity of frequently used times." R2's Minimum Data Set (MDS) Assessment, dated 11-10-20, documents R2 has diagnoses of Cerebral Palsy, Aphasia (loss of ability to understand or express speech), Paraplegia, Seizure Disorder, and Depression. This same MDS documents R2 is severely cognitively impaired and requires extensive assistance of two staff physical assistance for bed mobility, transfers, dressing, and toilet use. R2's Fall Risk Care Plan, dated 10-9-20, documents, "Goal: I will not sustain a fall related injury by utilizing fall precautions through the review date 2-10-21. Interventions: 5-21-20 Keep (R2's) bed in low position at all times while in bed. 5-21-20 Floor mats/landing strips at bedside per medical doctor orders. 11-4-20 Prior to assisting (R2) to bed verify that both floor mats are present on each side of (R2's) bed every shift." R2's Progress Notes, dated 12/31/2020 at 12:26 PM, and signed by V5 (Registered Nurse/RN), document, "(R2's) bed was in low position and (V3/Certified Nursing Assistant/CNA) had moved the fall mat to perform cares on (R2). (R2) was having cares performed on her when (V3) walked away from (R2's) bed to grab a bed pad and (R2) rolled out of bed onto the floor. Staff assisted (R2) back to bed after this nurse evaluated (R2). (V6/Licensed Practical Nurse) then asked (V5) to assess (R2's) right hip area due to seeing that the right hip was protruding and (R2) was crying out in pain and grabbing at the right hip area. (V5)	F 689	residents who had fallen in the last 30 days to ensure: 1. Care was provided in accordance with the resident plan of care and/or physician orders. 2. Residents were not left unattended during care, contributing to the fall. 3. Interventions related to falls management were in place in accordance with the resident's plan of care and/or physician orders. (c) What measures will be put into place or what systemic changes you will make to ensure that the practice does not recur: By 2/9/2021, the Director of Nursing Services/designee re-educated the nursing staff on the components of this regulation with emphasis on ensuring: 1. Care is provided in accordance with the resident plan of care and/or physician orders. 2. Residents are not left unattended during the provision of care, contributing to a fall. 3. Interventions related to falls management are in place in accordance with the resident's plan of care and/or physician orders. The Interdisciplinary Team (IDT) will review falls in the next clinical meeting to ensure the resident's plan of care and/or physician orders were followed and conduct an analysis to attempt to identify root cause and establish appropriate interventions related to falls management.	

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F 689	Continued From page 2 noted that the area looked abnormal. 911 was then called to have (R2) transported to the hospital for an evaluation." R2's Right Femur X-Ray, dated 12-31-20, documents, "Impression: Right intertrochanteric femur fracture (right hip fracture)." R2's Hospital Admission History and Physical, dated 12-31-20, documents, "Closed right femoral intertrochanteric fracture: fell from bed at the nursing home. Orthopedics consulted." V3's typed statement, dated 12-31-20, documents, "I was assigned to (R2) on 12-31-20. I was providing cares to (R2) and moved (R2's) floor mat out of the way to provide cares and get (R2) dressed. I realized that I needed a bed pad, so I went to the utility room to retrieve one. Upon arriving back to (R2's) room, (R2) had rolled out of bed onto the floor." R2's Surgical Report, dated 1-2-21, documents, "Procedure: Open reduction internal fixation right femur with c-arm." V3's Employee Counseling Form, dated 1-4-21, documents, "Reason for counseling: Violation of safety rules. (V3) was getting (R2) dressed for the day (12-31-20) and had to leave (R2's) room to go get a fresh bed pad. Floor mats were not properly in place which resulted in a fall to (R2)." On 1-11-21 from 11:10 AM to 12:30 PM, R2 was lying in bed facing the left side of the bed. R2 had an eight-inch floor mat on the floor next to the left side of the bed. During this time there was no floor mat next to the right side of R2's bed.	F 689	(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Director of Nursing Services/designee will conduct a weekly quality review of residents with falls X 4 weeks and then every 2 weeks X 2 months to ensure: 1. Care is provided in accordance with the resident plan of care and/or physician orders. 2. Residents are not left unattended during the provision of care, contributing to a fall. 3. Interventions related to falls management are in place in accordance with the resident's plan of care and/or physician orders. Findings of these quality review audits will be reviewed in the facility QA/Risk Management committee meeting monthly until such time as the committee determines substantial compliance has been achieved.	

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F 689	Continued From page 3	F 689		

On 1-11-21 at 12:10 PM, V2 (Director of Nursing) stated, "On 12-31-20 (V3) removed (R2's) floor mat and left (R2's) room to go and get a bed pan. When (V3) left (R2) unattended, (R2) rolled out of bed on the left side of the bed. (R2) sustained a right hip fracture. Whenever (R2) is left in bed unassisted, (R2) is to have floor mats on both sides of the bed. (V3) should have made sure he had all supplies at the bedside before caring for (R2) and should have made sure that the floor mats were put back beside (R2's) bed before leaving (R2) unattended. (V3) did not make sure (R2's) bed was in the lowest position when leaving (R2) unattended. According to (R2's) MDS, (R2) should have had two staff assisting (R2) with dressing and toileting."

On 1-11-21 at 12:30 PM, V2 (Director of Nursing/DON) stated R2's right side floor mat was missing and was in another resident's room. V2 stated R2 is to have bilateral floor mats at all times when R2 is in bed.

On 1-11-21 at 12:40 PM, V7 (CNA) stated she did not know that R2 was supposed to have bilateral floor mats at all times while in bed.

On 1-12-21 at 8:30 AM, V5 (RN) stated, "On 12-31-20 (V6/LPN) called me to assess (R2). (V3) had moved (R2's) floor mat and had left the room to get a bed pad. (R2) fell out of bed when (V3) left (R2) unattended, and (R2) sustained a right hip fracture. (R2) was in excruciating pain. I sent (R2) to the emergency department."

On 1-12-21 at 9:40 AM, V3 stated, "On 12-31-20 I was getting (R2) ready to get up. I moved (R2's) floor mat to provide cares to (R2). I was dressing (R2) and needed a clean bed pad. I had to leave

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F 689	Continued From page 4 (R2's) room to get a bed pad and forgot to put the floor mat back next to (R2's) bed. I had left (R2's) bed raised and not in the lowest position when I left (R2's) room. When I returned to (R2's) room, (R2) had fell out of the bed and was lying on her right side in pain. (R2) was whimpering and crying. I immediately got the nurse (V6/Licensed Practical Nurse). I know (R2) needs two staff to provide cares, but I did not have time to ask any other staff to help with (R2's) cares."	F 689		