Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145610	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bloomington Rehabilitation & Hcc	1925 South Main Street Bloomington, IL 61701

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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37813 Failures at this level require more than one deficient practice statement. A. Based on interview and record review, the facility failed to implement recommendations to prevent a fall for a resident recently on anticoagulant therapy with a history of a fall with a serious injury for one of thee residents (R3) reviewed for accidents on the sample list of three residents. This failure resulted in R3 falling and suffering an acute subdural hematoma when R3 was left unsupervised on the toilet. The Immediate Jeopardy began on [DATE] when (R3) was left without supervision in the bathroom and sustained a fall resulting in a new subdural hematoma. V1, Administrator, V3, Administrator in Training, and V6, Corporate Nurse Consultant, were notified of the Immediate Jeopardy on [DATE] at 10:14 AM. The surveyor confirmed by interview and record review the Immediate Jeopardy was removed on [DATE] but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. Findings include: The Facility's Quality Care Reporting Form, dated [DATE] at 5:00 AM, documents, (R3) was found on bathroom floor by (V8), Licensed Practical Nurse (LPN) lying on left side after (R3) self-transferred in restroom stating, 'left leg went out.' (R3) stated (R3) 'smacked (R3's) head on the ground.' (R3) was sent to the emergency room via ambulance at 5:45 am. R3's nurse's note, dated [DATE] at 7:23 PM, documents, (R3) was admitted to (local hospital) Intensive Care Unit for subdural hematoma. The Quality Care Reporting Form, dated [DATE], for R3's [DATE] fall documents, Resident is educated to call for assistance. PT (Physical Therapy) to screen for appropriate transfer status upon return. R3's nurse note, dated [DATE] at 2:20 PM, documents (R3) returned from hospital with a new order for PT/OT/ST (Physical Therapy, Occupational Therapy, Speech Therapy) evaluation and to hold Eliquis (anticoagulant) until [DATE]. This note also documents, Bruising to face and neck. 15 min checks for 24 hours. (continued on next page)

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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The Physical Therapy Plan of Care, dated [DATE], documents, Reason for Referral: Pt (patient) w/ (with) recent mechanical fall and subsequent decline in functional mobility/independence. The A.I.M. for Wellness Form (Assess, Intercommunicate, Manage), dated [DATE], documents R3 had an unwitnessed fall in the bathroom and was found on the floor. The Form documents R3 had a swollen area to R3's middle forehead, R3 was recently on Eliquis (anticoagulant), and R3 was sent to the emergency department. R3's emergency room (ER) Physician's note, dated [DATE], at 9:11 PM by V13 (ER Physician) documents, I personally spent 45 minutes providing critical care for this patient. This required my direct attention, intervention, and personal management because of the high probability of imminent or life-threatening deterioration due to acute subdural hematoma, ground level fall, end stage renal disease, atrial fibrillation, schizophrenia, vascular dementia, hypothyroidism, nursing home resident. R3's Computerized Axial Tomography (CT) scan, dated [DATE], documents, New Left Hemispheric Convexity Subdural Hematoma. No significant midline shift. Redemonstrated Right Anterior Frontal Subdural Hematoma. The Facility's Quality Care reporting form, dated [DATE], documents, care plan intervention is assistance with toileting. R3's Care plan with last revision date of [DATE] does not document this intervention. R3's Nurse's Note, dated [DATE] at 4:20, documents, (R3) returned to facility with a diagnosis of subdural hematoma and a referral for Hospice. R3's Nurses notes, dated [DATE] at 9:25 AM, documents (R3) expired on [DATE] at 9:22 AM. Family and Hospice updated. On [DATE] at 10:42 AM, (V8) stated on [DATE], (V8) was doing (V8's) morning medication pass and heard a scream. (V8) ran to the bathroom where (V8) heard (R3) screaming. (R3) told (V8) 'I fell trying to get in my chair.' (R3) was found lying on bathroom floor on (R3's) left side. (V8) stated (V8) noticed a large bump on (R3's) forehead immediately. (V8) obtained (R3's) vitals (Temperature, Pulse, Respirations, and Blood Pressure) and called Emergency Medical Services. (V8) stated when (V8) came to work that night on [DATE] at 7:23 PM, (V8) called the hospital to get an update on (R3) and was told (R3) was in the Intensive Care Unit with a subdural Hematoma. (V8) stated, After the fall on [DATE], (R3) was shaky and afraid of falling when sitting on toilet. (R3) didn't like to be in bathroom alone. (V8) noticed a decline after (R3's) second fall on [DATE]. On [DATE] at 3:15 PM, V12 (Director of Rehabilitation) stated, On [DATE] (V12) told the Intradisciplinary team in morning meeting that (R3) should always have supervision while in bathroom. (V12) stated, After the fall on [DATE], (R3) told (V12) (R3) pulled her call light in the bathroom, 'but it took too long,' so (R3) transferred self and that's when (R3) fell . When (R3) came back ([DATE]) (V12) educated all staff to not leave (R3) alone in the bathroom as (R3) was not safe. (continued on next page)

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Note: The nursing home is disputing this citation.

On [DATE] at 2:34 PM, V2 (Director of Nursing) stated, After (R3) fell on [DATE] and came back to the facility, nursing staff were educated to stay with (R3) while in the restroom to prevent falls. A staff member should have stayed with (R3) while in the restroom. V2 confirmed, This intervention is not on care plan. The facility's Employee In-service, dated [DATE], documents, Staff educated that no resident is to be left alone while on toilet. Provide privacy but do not leave. Especially those who need assistance. V2 stated V2 came in on third shift to In-service staff and the rest of staff were in serviced by V2 on [DATE], but V2 cannot find the sign in sheet.

On [DATE] at 1:30 PM, V6 (Nurse Consultant) stated, The care plan was not revised after the fall on [DATE] to update new interventions.

On [DATE] at 1:00 PM, V4, Care Plan Coordinator, stated, We have a red binder at the nurse's station that has current Care Plans. They are accessible to staff. (V4) is not aware of staff being educated to look at the binder for updates. (V4) stated (V4) has never had staff ask (V4) where to find a care plan. Staff typically ask the nurse or other staff member questions about resident transfer status.

On [DATE] at 11:21 AM, V9, Registered Nurse (RN), confirmed (V9) was working when (R3) fell . (V9) stated (V9) was called to the hallway restroom because (R3) was on the floor. A Certified Nurse's Aide (CNA) who's name (V9) can't remember put (R3) on the toilet in the hallway restroom and gave (R3) a call light to pull when finished. (R3) was alert when (V9) came into bathroom and denied hitting (R3's) head. (V9) noticed an area on (R3's) middle forehead that looked like a bruise, so (V9) called the physician who gave an order to send (R3) to the emergency room because of (R3's) past fall and taking blood thinners. (R3) never pulled the call light when (R3) was finished which wasn't usual for (R3) after the last fall. V9 stated if V9 has questions on transfers status or ADLs (Activities of Daily Living) for a resident, this facility does verbal communication, or staff must ask someone. V9 stated, At times if a resident is alert, we ask them. V9 stated V9 was not aware of any other communication tools for resident changes or ADL function.

On [DATE] at 12:10 PM, V10 (Certified Nursing assistant) stated on [DATE], V10 put R3 on the toilet after lunch in the hallway bathroom. V10 said R3 was tired and crying. V10 said R3 asked for a new gown, so V10 gave R3 the call ligh,t and left the bathroom to get R3 a new gown, and when V10 came back the nurse said R3 was on the floor.

On [DATE] at 11:57 AM, V14 (Family Nurse Practitioner) stated, It was not safe for (R3) to be left alone in the restroom because (R3) had a cognitive decline for several months prior to the fall on [DATE]. I recommended Hospice due to (R3's) decline. (R3) had multiple medical issues related to Kidney failure and was passing out at Dialysis. I am aware staff had been told several times (R3) should not be left alone in the restroom as (R3) was impulsive and could fall. (R3's) hemoglobin was always low (R3) had anemia. A subdural bleed is usually the result of trauma. I originally brought up Hospice to previous DON (Director of Nursing) in February 2024; the DON was supposed to discuss with family. We realized (R3) was continuing to decline, however, family wasn't ready for (R3) to be on Hospice at that time.

The facility's Accidents and Incidents policy, last revised [DATE], states, All accidents/incidents involving a resident shall require an incident report. The interdisciplinary team (IDT) will complete an investigation to determine root cause and implement appropriate interventions.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The Immediate Jeopardy that began on [DATE] was removed on [DATE] when the facility took the following actions to remove the immediacy. 1. All residents were evaluated for fall risk with resident centered interventions implemented for those at risk. Completed [DATE]. 2. Staff were educated to ensure knowledge and utilization of fall interventions. Staff including new staff and agency staff were inserviced by V6, Registered Nurse Consultant, on [DATE] on the Fall Program/Prevention and Anticoagulation policies, on knowledge of and implementation of interventions for residents high-risk for falls and/or bleeding, and on which residents are at risk for falls/bleeding with a roster posted out of public view until an electronic system is fully implemented. All direct care staff will be in-serviced before they take the floor to work. Completed [DATE]. 3. The Medical Director was notified of the Immediate Jeopardy on [DATE]. 4. All resident fall assessments were reviewed and updated by V2. Completed [DATE]. 5. All Care plans for fall risk related to supervision and monitoring were reviewed and updated by V4, Care Plan Coordinator, and V2. Completed [DATE]. 6. All residents on anticoagulation/antiplatelet therapy were identified by V4 and V2. Completed [DATE]. 7. All residents on anticoagulation/antiplatelet therapy with high fall risk were identified to ensure implementation of fall interventions and post fall responsibilities for residents who are at risk for bleeding by V4 and V2. Completed on [DATE]. 8. Fall policies were reviewed/updated by the QAPI (Quality Assurance Performance Improvement) team. Completed [DATE]. 9. An audit tool was developed to ensure sustained compliance with objectives ([DATE]). V2 or designee will perform audits three times weekly for four weeks. 10. The QAPI (Quality Assurance Performance Improvement) team will meet/discuss Fall Program/Prevention Plan on an ongoing basis. The facility presented an abatement plan to remove the immediacy on [DATE]. The survey team reviewed the abatement plan and was unable to accept the plan to remove the immediacy. The abatement plan was returned to the facility for revisions. The facility presented a revised abatement plan on [DATE], and the survey team accepted the abatement plan on [DATE]. B. Based on observation, interview, and record review, the facility failed to establish/assess a resident's level of safety, and failed to ensure a walker was maintained in safe operating condition prior to permitting outside unsupervised outings, for one of three residents (R1) reviewed for accidents in a sample list of three residents. These failures resulted in R1 falling while out of the facility and sustaining a fracture of the first metatarsal bone. Findings Include: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	R1's Physician's Order Sheet (POS) for [DATE] includes the following diagnoses: Anxiety, History of Frost bite with Amputation to Left Lower Extremity, and Seizure Disorder. R1's Minimum Data Set (MDS), dated [DATE], documents R3 is Cognitively intact and uses a walker to complete his ADLs (Activities of Daily Living). This MDS also documents R1 had functional limitations in both lower extremities. R1's Protocol for Outside Independent Passes, dated [DATE] and [DATE], documents, Residents are on a 30 day probationary period with regard to outside unsupervised outings. No resident will be allowed to leave the facility unsupervised until they are reviewed by the IDT (Intradisciplinary team) during the last day of the probationary period. However, the resident can go out with family, Power of Attorney, (POA) or guardian. Resident must notify a staff member prior to going out in the patio area or fenced area. After safety review and meeting with IDT, if deemed safe and responsible, the resident will be able to go out on walks on a limited basis in a progressive manor as safety permits. There is no documentation to support the IDT (Intradisciplinary team) met or a safety assessment was completed for R1. R1's level of safety for unsupervised outings is not addressed on R1's Care Plan. R1's substance use Disorder is not addressed on R1's Care Plan. R1's Nurse's note, dated [DATE] at 3:30PM, documents, (R1) swaying and stumbling. Alcohol smell present. Afternoon medication held. APN (Advanced Practice Nurse) notified. OK to hold. Resident left facility with walking cane transport with acquaintance car. On [DATE] at 12:33PM, V5, Witness to R1's [DATE] fall, stated, I was driving on a busy local road when I saw a man (R1) with a slate blue wheeled walker going down the road in the left lane of traffic. The walker looked wobbly, like maybe it was broken. I saw (R1) stumble and fall. (R1) could have been hit by a car. This is a busy road. The speed limit is 45 miles per hour. There is no sidewalk. I stopped my car and got out to help (R1). (R1) was drenched with sweat, weak, and smelled of alcohol. (R1) couldn't get out of the road, and I could not get (R1) out of the street. I called EMS (Emergency Medical Services), and a bystander helped me get (R1) to safety. (R1) told me (R1) was at his brother's trailer where (R1) 'had a few drinks and jammed to some music.' (R1) told me he stayed at (the facility). I called the facility. The phone rang and rang. It was about 8:30PM. The phone rang so long it stopped ringing. When I called again, they finally answered. (V7), Licensed Practical nurse (LPN) called the Administrator, and called me back stating (V7) would pick up (R1). By that time, the Fire Department arrived, but (R1) refused an ambulance. The only injury I saw was a small open area to (R1's) left leg.` On [DATE] at 1:00PM, R1 stated, The day (V5) helped me I was at my brother's trailer. We drank some alcohol. I was walking to the bus stop. The bus hadn't come, so I started to walk back to (the facility). It was hot and I fell in the road. I had to get help to get on my feet again. My foot hurt that night. I told the nurse. That's the only time I fell . Anyway, in a couple of days my foot hurt so bad I went to the emergency room and my foot was broke. I do leave on my own. I'm [AGE] years old. I was supposed to be here for rehab for my amputation and go somewhere else. I have no place else to go, and I got frost bite when I was homeless. I thought This facility was going to find me a place. Yes. I drink; wouldn't you if you were me? I have the choice of either sitting here with old people staring at the walls or going out to fish and drink. I know the door alarm code a lot of us do. I leave on my own. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	R1's Nurse's Note, dated [DATE] at 9:00PM, documents, R1 complained of Left stump pain ,d+[DATE] with 10 being the worse pain ever. PRN (as needed) Ibuprofen given 200MG (milligrams) one tablet administered by mouth. No follow up- documented as to response to pain medication. No notification of physician documented. R1's hospital ER discharge, dated [DATE], documents a diagnosis of: Nondisplaced Fracture of First Metatarsal Bone Left Foot. R1's X-ray report from the emergency room , dated [DATE] at 12:47 PM, confirms this diagnosis. On [DATE] at 9:00AM, R1 stated, My walker is broke. I have told the staff, but I still have to use it. The left rear wheel of R1's slate blue walker was loose and wobbly. On [DATE] at 1:00PM, R1 was in the front parking lot sitting on the seat of the broken walker. R1 stated R1 was waiting on a ride to a doctor's office. On [DATE] at 11:57 AM, V14 (Family Nurse Practitioner) stated, (R1) was sober for quite a while, but I know (R1) has been leaving the facility lately and drinking. Of course that is not a safe situation for (R1). (R1's) walker should be in good repair to maintain safety. No policy for safety assessment prior to unsupervised outings was provided.