STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E848	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Decatur Rehab & Health Care CT	136 South Dipper Lane Decatur, IL 62522

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42702 Based on interview and record review the facility failed to provide pain control and failed to transfer a resident with a broken femur to the hospital in a timely manner for one (R1) of three residents reviewed for falls in the sample list of three. This failure resulted in R1 remaining in the facility for ten hours while in pain with a broken left femur before being transferred to the hospital for pain control and care. Findings include: R1's diagnoses include: Alzheimer's Disease, Dementia, Gastroesophageal Reflux Disease, Chronic Obstructive Pulmonary Disease, Peripheral Vascular Disease, Chronic Kidney Disease, Pulmonary Disease, Hypothyroidism, Atherosclerosis, Heart Disease, Hypertension, Anxiety Disorder, Cardiomyopathy, Left Hip Replacement, Anemia, Vitamin D Deficiency, Right Eye Blindness, Periodontal Disease, Falls, Nicotine Dependence and a History of Alcohol Abuse. R1's Minimum Data Set, dated dated dated [DATE] documents R1 as severely cognitively impaired. R1's Fall assessment dated [DATE] documents R1 as a high risk for falls. R1's care plan dated 3/20/24 documents recent fracture related to a fall. R1's medical record documents R1's blood pressures on the following dates: 167/82 on 2/10/24, 154/88 on 2/11/24, 137/74 on 2/15/24, 112/67 on 2/16/24 and 138/74 on 3/17/24. R1's hospital history and physical dated 3/18/24 at 1:53PM documents a left femur fracture as a result of the fall of 3/17/24 and an initial blood pressure of 189/85 with a pulse rate of 78. R1's progress notes document the following: On 3/17/24 at 9:50PM, R1 was found on the floor in the facility sunroom, in front of his wheel chair. On 3/18/24 at 1:00AM, R1 was heard yelling, Help me, help me, while complaining of pain, guarding his left leg, and he could not straighten out his left leg. (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 0684 Level of Harm - Actual harm Residents Affected - Few	On 3/18/24 at 3:30AM, R1 continues to yell out in pain from both hips. R1 was then removed from the bed and placed in a wheel chair. On 3/18/24 at 8:30AM, R1 continues to complain of hip pain, is unable to bear weight or lift his leg without pain. At this time, V8 Licensed Practical Nurse (LPN) documents a request for a portable X-ray of R1's left hip. On 3/18/24 at 10:00AM, R1 was sent to the emergency room due to continued pain and tenderness to R1's left leg and thigh at the request of V10, R1's family member. R1's March Medication Administration Record documents one administration of Tylenol 1000 milligrams (mg) on 3/18/24 at 1:00AM. R1's hospital discharge date d 3/2024 documents the decision by orthopedics to watch fracture and provide pain control with Tramadol (opioid pain medication) 50 milligrams (mg) ordered every six hours as needed for pain and Tylenol 650mg ordered every six hours as needed for pain. On 4/3/24 at 11:43AM, V10 R1's Family Member said that when she arrived at the hospital, R1 was moaning in pain. On 4/3/24 at 10:22PM, V7 RN stated, When I came on shift that night, (R1) didn't complain of pain. About 1:00AM, he was yelling Help me, so I helped him use his urinal and noticed that he was guarding his left leg, hip and thigh. That didn't seem like it was from a hip injury, so I gave him Tylenol and that seemed to settle him down. At about 3:30AM, he was yelling again and complaining of bilateral hip pain and grabbing his left thigh. I still didn't really think that it was his hip, so we got him out of bed, and he complained of pain when we transferred him, but then when he was sitting in the chair, he seemed ok. Around 4:45AM, he was sitting at the nurse's station and said that he was tired, but he didn't want to go back to bed. Later on, I thought about his dementia and probably should have sent him sooner. On 4/3/24 at 10:45AM, V6 Resident Care Coordinator (RCC) said she was notified when R1 fell and was told that he had no pain or obvious signs of injury. The next morning, V6 RCC was notified that R1 had pain all night and that V7 Registered Nurse had tried to call her to discuss it. V6 said, I told (V7 RN) that he knew that R1 had a fall and the first time that he complained of pain, he should have used his nursing judgement and have sent (R1) out. (R1) was hurt by the pain. On 4/3/24 at 2:20PM, V13 Medical Director said he was notified of the fall, but not of the pain until the next morning when (R1) was sent to the hospital. V13 said, The pain could have been controlled and hours of pain prevented if they had sent him sooner. A higher blood pressure can be indicative of a person experiencing pain. The facility pain policy dated 12/7/17 documents it is the policy of the facility to assess for, reduce the incidence and the severity of pain in an effort to minimize further health problems, maximize activity of daily living functioning and enhance quality of life.

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(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 - Actual harm Residents Affected - Few	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** 42702 Based on interview and record review the facility failed to implement effective interventions to prevent falls with injury for one (R1) of three residents reviewed for falls in the sample list of three. This failure resulted in R1 falling and sustaining a fractured left hip. Findings include: R1's diagnoses include: Alzheimer's Disease, Dementia, Gastroesophageal Reflux Disease, Chronic Obstructive Pulmonary Disease, Peripheral Vascular Disease, Chronic Kidney Disease, Pulmonary Disease, Hypothyroidism, Atherosclerosis, Heart Disease, Hypertension, Anxiety Disorder, Cardiomyopathy, Left Hip Replacement, Anemia, Vitamin D Deficiency, Right Eye Blindness, Periodontal Disease, Falls, Nicotine Dependence and a History of Alcohol Abuse. R1's undated face sheet documents R1 admitted to the facility on [DATE]. R1's Fall assessment dated [DATE] documents R1 as at high risk for falls. R1's March physician orders document an order for Plavix (blood thinner) 75 milligrams daily. R1's Minimum Data Set, dated dated dated [DATE] documents R1 as severely cognitively impaired. R1's Behavior Tracking Record dated March 2024 (1st-29th) documents a goal that R1 will not attempt to transfer R1's self without staff supervision/assist, with an intervention of keep in supervised areas while up in wheelchair. R1's fall care plan dated 1/18/24 documents that R1 is to be reminded to lock wheel chair brakes, keep call light in reach, and of safety precautions and limitations as needed. R1's progress notes dated 3/17/24 document that at 9:50PM, R1 was found on the floor in the facility sunroom, in front of his wheel chair. R1's progress notes document on 3/18/24 at 10:00AM, R1 was sent to the emergency room due to continued pain and tenderness to R1's left leg and thigh. R1's hospital history and physical dated 3/18/24 documents a fall that resulted in the fracture of R1's left hip and a subdural hematoma that could not be delineated as subacute or chronic. R1's medical record documents the result of R1's fall on 3/17/24 was a left hip fracture requiring toe touch weight bearing of the left lower extremity, two assist with transfers, physical and occupational therapy and pain management post fall. R1's facility fall investigation documents that R1 fell as a result of not having the awareness to be safe due to lack of cognition. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/3/24 at 10:22PM, V7 RN (Registered Nurse) said R1 stands up and tries to walk all of the time and because of his dementia doesn't have safety awareness. On 4/4/24 at 12:15PM, V11CNA (Certified Nurses Assistant) stated R1 tries to get up a lot and that they have to keep him up in the evenings so that he doesn't try to get up and fall. On 4/4/24 at 1:17PM, V12 CNA stated R1 tries to stand up from his wheel chair all the time. On 4/4/24 at 2:34PM, V3 Licensed Practical Nurse said he thought R1 was in bed when he fell on [DATE] and that R1 often tries to stand up from his wheel chair. V3 said, We usually hear him when he's wanting to get up but in that sunroom with the television, we can't hear anything. On 4/4/24 at 12:15PM, V11 Certified Nursing Assistant (CNA) stated she was at the nurse's station but that R1 wasn't within view.