STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

APOSTOLIC CHR HOME OF EUREKA	0012328
Facility Name	I.D. Number

610 CRUGER EUREKA, IL 61530
Address

Date of Survey: 4/1/04

Incident Report Investigation of 2/19/04

As a result of a survey conducted by representative(s) of the Department, it has been determined the following violations occurred. Please respond to each violation. The response must include specific actions which have been or will be taken to correct each violation. The date by which each violation will be corrected must also be provided. Forms are to be submitted with the original signature.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

300.1210a) The facility must provide the necessary care and services to attain or maintain the highest
300.1210b)6) practicable physical, mental, and psychosocial well-being of the resident, in accordance with
300.3240a) each resident's comprehensive plan of care. 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.

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.

An owner, licensee, administrator, employee or agent of a facility shall not neglect a resident.

The regulations are not met, as evidence by the following:

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300.1210a) Based on record review, interview, and observation, the facility failed to ensure that all sling
300.1210b)6) straps remained securely attached to the mechanical lift during transfer of 1 of 1 combative
300.3240a) residents (R1). R1 fell to the floor during the mechanical lift transfer, hitting the back of her
(Cont-d.) head, resulting in a subdural hematoma. R1 died four days later with diagnosis of subdural hematoma as cause of death .

Findings include:

A.) Resident Care Guide dated 12/01/03 documents R1's diagnoses to include Alzheimer's Dementia and Legally Blind. Behavior Intervention flow records for December 2003, January 2004 and February 2004 list behaviors of physical aggression and combativeness during cares. The Resident Care Guide also shows that R1 requires total care, is unable to make correct decisions, and is not cooperative.

During interviews with E1 (Director of Nursing) on 03/24/04 at 9:45 a.m. and 10:45 a.m., with E2 (Assistant Director of Nursing,) and interviews with E3 and E4 (2nd shift Certified Nursing Aides) on 03/24/04 at 10:45 a.m., all stated that R1 was combative, flailed her arms, and would kick and bite during cares. All verified that R1 was combative and would resist care during transfers. All stated that even when they tried to calm R1 down and later would go back to retry cares, R1 would become combative again, with staff then having to go ahead and continue with cares.

The incident report dated 02/20/04 provided the following information:

R1 fell at approximately 3:15 p.m. while two Certified Nursing Aides (CNA's) were transferring R1 from her bed to her wheelchair by using a mechanical lift. R1 was resisting care, becoming agitated and combative during the transfer, grabbing and pulling on her indwelling urinary catheter. Also, it notes that R1 was hitting and scratching the CNA's, flailing her arms and grabbing at other items. The report notes that the CNA's had hooked the mechanical lift straps and R1 continued to try to pull out her catheter, flailing her arms and grabbing at the mechanical lift straps. One CNA tried to calm R1 down and held R1's arms and hands while the other CNA began to raise the lift and transfer R1 from the bed to the chair. The report shows that R1's previous flailing movements apparently caused one of the straps to loosen which

resulted in R1 to fall to the floor during the transfer. R1 was assessed with a 5 centimeter x 3 centimeter lump on back of the head, an approximately 6 inch abrasion on the outer calf of right leg, and a 3 centimeter x 2 centimeter bruise on the right elbow. R1 was then transferred to the emergency room.

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300.1210a) R1's hospital emergency notes dated 02/19/04 indicated, "Has advanced Alzheimer's disease
300.1210b)6) and during the transfer during which (mechanical) lift was used, the patient fell about three feet
300.3240a) to the ground and hit her head." The Computerized Tomography report dated 02/19/04 showed
(Cont-d.) "acute hyperdense subdural hematoma in interhemispheric fissure. The width of the hematomas was measured to be 1.5 centimeter but lengths difficult to assess. Has moderate to severe atrophy, right parietal scalp soft tissue hematoma; head injury, acute subdural interhemispheric hematoma." The Emergency Room record shows that R1 was transferred back to the facility with physician orders for supportive and comfort measures only.

At 11:00 a.m. on 03/24/04, E1, E2, E3, and E4 demonstrated with the same mechanical lift how E3 and E4 transferred R1. The hooks on the mechanical lift now have Velcro pads around the hooks to help prevent the straps from slipping out.

E3 and E4 stated on 03/24/04 at 11:00 a.m. during demonstration of how they used the mechanical lift on R1, that on 02/19/04, R1 continued to throw herself around while E3 and E4 were trying to hook the straps from the mechanical lift sling to the lift itself. E4 stated she tried to calm R1 down and gently hold her hands and arms, while E3 moved the mechanical lift from the bed to the chair by the bed. There was a jolt and R1 fell to the floor and hit the back of her head. Both stated that R1 must have hit the bar at the leg end of lift while still lying in bed, causing the strap to come back out of the hook and repositioning the strap onto the top of the hook. They explained that with R1 still lying in bed that there was no weight bearing on the hooks and bars. R1 may have hit the bar with her leg or arm, causing the strap to slip out of the hook to the top of the hook. E3 and E4 stated that they had checked the straps once before transfer and realized the leg straps were not crossed right so they connected the straps correctly. Both staff verified that when they began transferring R1 with E3 holding R1's hands, that neither one rechecked the straps again. E3 and E4 verified that R1 was still being combative, kicking and flailing during the transfer. E3 had to take R1's catheter and hook it on the mechanical lift so R1 could not reach it. E3 stated R1 kept trying to grab her catheter

and pull it out. R1 was grabbing at E4 and trying to dig her nails into E4's arms and hands. E3 and E4 both verified that R1's jerking must have moved the strap out of place while both the CNA's were trying to control R1, and did not notice the strap moved. Both E3 and E4 verified that there is always two staff transferring R1 with a mechanical lift and that R1 is always combative during transfers.

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300.1210a) 300.1210b)6) R1's February and March, 2004 care plan note R1's behaviors but there are no specific approaches related to R1's combativeness during transfers before or after the fall on 02/19/04.

300.3240a) (Cont-d.) During interview on 3/24/04 at 1:50 p.m. with E11(Physical Therapy Assistant), E11 stated that R1 had been assessed as needing a mechanical lift transfer, due to not being able to stand for the stand lift. E11 stated that three people in attendance during the mechanical lift would be advisable due to R1's combativeness.

Memo dated 2/20/04 by E1(Director on Nurses) notes that "we recently had an incident of a resident falling from a lift. After investigating...feel that the resident flailing around may have pushed the strap up on top of the hook before any weight was put on the lift. The weight of the resident held the strap until she began flailing her arms and legs. Please make sure that all the straps are seated in the hooks as the resident's weight begins to tighten the straps..."

E2 stated that after R1 returned from the hospital after the fall, R1 was bedfast and was not transferred any longer. E2 stated and February nursing notes show that R1 was receiving care for pain, nausea/vomiting, and comfort measures only because of the head injury.

A physician (Z1) discharge summary dated 02/23/04 documents R1 died on 02/23/04 with subdural hematoma being the diagnosis for cause of death.

B) Based on record review, observation, and interview the facility failed to ensure that staff stayed with 1 of 1 sampled residents (R8) who had been assessed as needing 1 or 2 staff when ambulating with her walker. R8 fell when left unattended and fractured her hip.

Resident care guide dated 12/04/03 indicates that R8's diagnoses include weakness, arthritis, anxiety, and has some confusion. R8 is assessed as needing 1 or 2 staff (depending on weakness) during transfers and with ambulating with a walker.

On 03/29/04 at 10:35 a.m., during interview with E10 (Certified Staff), E10 stated that on 02/04/04, E10 was walking with R8 to the bathroom while R8 used her walker. E10 stated she left R8 standing by the bathroom door with her walker while E10 went into the bathroom to hang up R8's clothes on the bathroom rack. E10 stated she turned around, saw R8 let go of her walker and fall sideways inside the doorway of the bathroom. R8 hit her head as she fell to the floor. E10 stated that R8 was complaining of head pain and was sent to the hospital. E10 stated she works a lot as a float in the facility, so she was not real familiar with R8's needs, but knew she needed to stay by R8.

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300.1210a) E10 stated she was counseled by E1 (Director of Nursing) for not using a gait belt while
300.1210b)6) transferring R8. When asked why E10 left R8 to stand alone since R8 is unsteady and weak and
300.3240a) why E10 did not sit R8 down first in the bathroom before hanging up R8's clothes, E10 stated, "I
(Cont=d.) was in a hurry."

E1 stated on 03/29/04 at 12:20 p.m., that because of R8's unsteadiness, that R8 should not be left alone and a gait belt should be used on R8 at all times (a corrective action notice dated 02/04/04 was given to E10 in regards to using a gait belt).

The hospital history and physical record dated on 02/04/04 indicates R8 fell on 02/04/04 and suffered a left subcapital hip fracture. The hospital record continues to document that on "a follow-up for (R8) on 02/10/04, there was found some very mild serous drainage noted from the left hip incision. On 02/29/04, found copious amounts of drainage from left hip which was greenish and somewhat orthostatic, and on 03/02/04, a culture of the drainage in the left hip showed Staph Aureus 03/04/04, (R8) was admitted to the hospital for exploration of wound and irrigation and debridement."

On 03/29/04 at 10:10 a.m., R8 was in bed and a I.V. (intravenous therapy) with Vancomycin antibiotic medication was set at to run at 125 cc per hour. R8 stated she cannot remember the fall itself on 02/04/04, but was told she fell and has a broken hip. R8 was alert and oriented with some confusion with dates and times. R8 verified that the staff did not use a gait belt while walking with her before, but they do now.

R8's nursing assessment dated 09/11/03 shows R8 needed partial assistance with standing /balance, and extensive assistance with one person to transfer and ambulate. R8's has had falls on 05/18/03, 05/24/03, 04/20/03 (fractured left scapula), 11/20/03 (fractured T-10 Vertebrae), and then on 02/04/04 (fractured left hip).

(A)