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

CHAMPAIGN TERRACE — Facility Name
0034934 — I.D. Number

808 NORTH THIRD, SAINT JOSEPH, ILLINOIS 61873 — Address

Reviewed By

9/30/05 — Date of Survey

ANNUAL — Type of Survey

Surveyed By

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 of 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):

The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.

There shall be evidence of training and habilitation services activities designed to meet the training and habilitation objectives set for every resident.

Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in:

Periodic reevaluation of the type, extent, and quality of services and programming.

Development of a written plan for each resident to provide for nursing services as part of the total habilitation program.

Modification of the resident care plan, in terms of the resident's daily needs, as needed.

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Direct care personnel shall be trained in, but are not limited to, the following:

Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.

Basic skills required to meet the health needs and problems of the residents,

First aid for accident or illness.

Sufficient, appropriately qualified nursing staff shall be available, which may include licensed practical nurses and other supporting personnel, to carry out the various nursing service activities.

AN OWNER, LICENSEE, ADMINISTRATOR, EMPLOYEE OR AGENT OF A FACILITY SHALL NOT ABUSE OR NEGLECT A RESIDENT. (Section 2-107 of the Act)

Based on observation, interview and record verification facility nursing neglected to: 1)ensure adequate health care assessment in accordance with R5's changing health and mobility status in that; a) R5's IPP (Individual Program Plan) has not been modified to reflect her change in health/mobility status and there is no modification of nursing assessment/recommendations in response to R5's change in health/mobility status; b) R5 did not receive an additional updated evaluation from the occupational therapist to assess and make recommendations for her daily physical safety {ie bathing, ambulating, how and when staff are to assist in ambulation, need for special equipment, possible need for audio monitoring equipment}; c) R5's 07/05 physical therapy evaluation cannot be accessed for recommendations from that report and R5's 9/9/05 request for a physical therapy update has not been completed as of 9/22/05, when R5 fell in the bathroom and received two fractures to her left leg. 2) implement with other members of the IDT (Interdisciplinary Team) a system to ensure appropriate protective and preventive measures relative to R5's mobility and safety, relative to R5's changes in her mobility status; and 3) ensure that direct care staff demonstrate proficiencies in implementing nursing protocol when R5 required emergency medical services, specific to falls and contacting emergency services.

Per review of R5's Psychological Evaluation dated 8/18/04, R5 functions in a Moderate Level of Mental Retardation and has a diagnosis of Schizophrenia and Bipolar Disorder. Per review of R5's physician orders dated 9/01/05 to 9/30/05 she also has multiple diagnoses that include Diabetes Mellitus/ Non-Insulin Dependent, Hypernatremia, Insomnia, History of Urinary Tract Infections, and Sensory Ataxia 2nd to Severe Polyneuropathy.

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Further review of R5's Psychological Evaluation dated 8/18/04 indicates that she resided in a 24 hour skilled nursing facility from 10/2002 until her admission to this facility on 10/01/04. This report indicates that she had Non-Insulin Dependent Diabetes Mellitus for several years. This report also said that R5's, "intellectual functioning falls within the moderate range of mental retardation and whose overall level of adaptive functioning is within the severe range of mental retardation.... Relative limitations are that R5 has significant deficits in her verbal and nonverbal reasoning and problem solving abilities, her adaptive skills are significantly below average for someone her age... she is easily distracted."

Review of R5's current physician's orders document that R5 receives Avandia 4mg. one tablet po (by mouth) twice daily and Glipizide 10 mg. tablet, l tablet po twice daily for her Type II Diabetes. Her physician order sheet also documents that her physician has current orders for a monthly FBS (fasting blood sugar) and a HGB AIC every 3 months.

Per observations made at the facility on 09/20/05 throughout the day, R5 was observed to be ambulatory and verbal, speaking in complete sentences.

During the review of R5's record, reports called Nursing Consultant Synopsis were reviewed. The following information was documented on these reports in regards to falls and incidents that R5 has sustained:

11/5/04 - tripped over another client's wheelchair landing on the footrest of the wheelchair.
4/13/05 - she walked into another wheelchair bumping her left knee - the facility nurse recommended elevating leg and applying ice.
5/18/05 - slipped in the kitchen at the facility and fell onto the door of the dishwasher hitting her right hip.
5/20/05 - "has a bruise around her right eye, on both knees, and a scrape on her right elbow from a fall outside in parking lot. (She tripped and fell.) R5 conts. to be in a confused state w/hallucinations and the inability to concentrate or follow through w/simple self care skill psych visit was yesterday 5/19/05 med adjustments made." The nurse recommended medication for pain as needed and an ice pack on bruises on 10 minutes and off 30 minutes until bedtime.
6/01/05 - fell onto the floor from the couch - "seems disoriented ... bruises noted to both knees".
7/30/05 - received a cut on her left knee after falling onto the dishwasher door.
8/14/05 - fell out of bed at 2:30 a.m . hitting her face/cheek area on the nightstand - black eye from the fall.

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Additionally per review of the nurses notes the following documentation was found in R5's record:

11/11/04 - tripped over another resident's wheelchair and landed on her knee.
4/19/05 - "to ER for con't increase psychosis, c/o chest pain, diaphoresis, on 4/14/05 with dx of UTI... Concern of OOR labs possibly dehydration."
4/19/05 - "Transferred to ER for psych admission attempt per M.D. Refused, returned home."
6/1/05 - "Resident had psych appt for increased agitation and possibly manic...Dr. made med changes ... Dr. ordered Wellbutrin and continued Abilify ...".
6/7/05 - (QMRP/PSYCHIATRIC NOTES) - "lack of balance (she has fallen at least 5x in past week....some days she comes in with slurred speech.....".
6/8/05 - "resident having incidents of falling and continues to be agitated very easily... QMRP instructed by RN to make neurology appt., Dr. d/c'd Wellbutrin decreased Abilify."
6/15/05 - "Resident has bruising on legs from falls and scrape on nose.....On 6/12/05 resident was taken to ER (arrow up) psychosis...injections of Haldol & Ativan...staff were unable to wake resident up for meds that evening....".
6/15/05 (Nursing Health Review & Physical Assessment) - Under Neurological section, "Unsteady Gait and Change of speech pattern" is checked - " @ this time (arrow down) balance @ X's (times)".....slurring speech".
6/22/05 - "Resident was taken to ER on 6/20/05 for continued display of unstable mental health; Resident continued to have loss of balance; slurred speech; refusing to eat; Resident was admitted to hospital for neuro eval & to adjust pych med; awaiting discharge for new order."
6/24/05 - "Resident d/c'd from hospital (with) dx of UTI .....resident guardian refusing Abilify...f/u (follow-up) (with) (physician) on Tues....continues to display (arrow up) psychosis and slurred speech...f/u (with) neuro on 7/15 and (physician) on 7/11/05.....".
6/30/05 - "Resident had psych visit.....".
7/6/05 - "Resident had neurology appt resident dx (diagnosed) (with) sensory ataxia ...severe poly neuropathy....to use walker for distance: PT to evaluate for fitting of walker....".
7/11/05 - "Resident had psych visit....holding Haldol and (arrow up) Seroquel...return 2 wks; started on Lasix on 7/12; feet swelling down...had appt....for foot impressions..but feet were swollen.....Dr. appt for open sore on tailbone...referred to wound center.....".
7/27/05 - "...no longer unsteady gait; no falls, much more steady.....".

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8/3/05 - "Resident was helping (with) dishes when fell on dishwasher; small cut to knee received.....".
8/15/05 - "Resident fell out of bed and hit face/knee on nightstand.....received black eye...".
8/22/05 -"Resident had molds for feet.....will be done in 2 wks.....".
9/13/05 - "Resident had arch supports put in shoes.....gait much better now; but may use cane or walker, for distance.....".
9/19/05 - "Over weekend staff reported that resident gait unsteady again; resident fell no apparent injury noted, resident showing signs of altered mental status again. Psych appt moved up." (The 9/17/05 incident report states that, (R5) fell to the floor for no apparent reason. Stated she tripped although there was nothing on floor for her to trip on).
9/21/05 - "Resident had appt (with) (Z1) on this day; labs were drew; awaiting results...taken to Dr. for unsteady gait and c/o's (complaints of) body aches...in bed lying down after appt...got up for lunch..walking into dining room (with) walker...started to lose her balance; RN assisted resident; resident fell to the floor; RN assisted to floor; resident stayed conscious; 911 called; pulse 88 B/P 152/78...resident answering questions...transported to ER.....".
09/22/05 - "In am resident was in shower and fell; Resident taken to hospital by ambulance and admitted d/t (due to) fx (fractured) leg.....". (Per surveyors observations of this incident, R5 was in the bathroom, but was not taking a shower. When discovered by surveyors, R5 was lying on the bathroom floor with her nightgown on).

On 09/21/05, surveyors were seated at the south dining room table, adjacent to the women's wing. E2 (consulting nurse) was seated at the next dining room table, closest to the facility office. At approximately 1:25 p.m., R5 was observed entering the dining room area (from the south east wing). R5 was utilizing a walker. R5 appeared to be unsteady on her feet (leaning forward with body weight on walker, slow ambulation, not picking up feet to avoid tripping), and as she ambulated with her walker past the table where surveyors were seated, it appeared that R5 stumbled, but did not fall at this time. R5 took a few more steps forward (still utilizing the walker). At this time R5 started to fall. E2 was able to reach R5 and assisted R5 to the floor, breaking her fall. 911 was called at this time. While waiting for emergency services to arrive, E2 was observed to check R5's carotid pulse and check her blood pressure. Emergency services arrived at approximately 1:34 p.m. Emergency personnel reported that her blood sugar was 140; blood pressure 142/86 and oxygen saturation was 87% on room air. Emergency personnel also noted that her pupils were not responding to light very well, and administered oxygen. When questioned, R5 complained of dizziness. (Per review of a 9/21/05 nursing consult note it states that R5 had had an appointment with her consulting physician in the a.m. on this same date. Labs were drawn and the facility was awaiting the results. These nursing notes document that R5 was taken to this physician appointment for her unsteady gait and complaints of body aches. The notes state that R5 had been lying down in her bed after returning from this appointment and had gotten up for lunch. Vitals were recorded as pulse/88; blood pressure - 152/78; and respirations - 16; resident (R5) answering questions).

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In an interview with E1 (Administrator) on 9/27/2005 at the facility in the a.m., E1 confirmed that R5 had been returned to the facility the same day (9/21/05) with no new orders, except Motrin for pain.

On 9/22/05 at approximately 9:20 a.m., surveyors were seated at the south dining room table, adjacent to the women's wing. Per observations, there was one staff in the facility (E6 - Habilitation Aid). This staff person was in the kitchen and a radio was on in the facility. Both surveyors heard a noise on the south east wing, that sounded like someone or something had hit the floor. Surveyors then found R5 in the bathroom (adjacent to her bedroom). R5 was lying on her back with her feet towards the door exit and her head at the shower/bath area. R5 was observed to have a cut under the left side of her chin. The cut was bleeding freely, with blood running down her neck. The bathroom floor was observed to be wet. R5 was barefooted and wearing a knee length night gown. R5's walker was observed to still be in her room, positioned adjacent to her bed. R5 was conscious and complained of pain in her left leg and continued to complain of pain in this leg throughout the observation time. One surveyor went to the kitchen to alert E6 of R5's situation, while the other surveyor stayed with R5. {In a 9/26/05 interview with E6 at the facility, E6 confirmed that she had not heard the noise that had alerted the surveyors to this fall}.

E6 and surveyor returned to the bathroom where R5 had fallen and remained in the same position. At this time surveyors observed a purplish bruise forming on R5's left outer thigh. Additionally, at this time surveyors observed R5's leg was turning in at the ankle area and had two swollen bumpy areas above the ankle close to the tibia. E6 talked to R5 and wiped the blood from R5's chin/neck area with a dry paper towel. When the blood was cleared away from the cut, it appeared that R5 has sustained a horizontal cut approximately one inch across. E6 then assisted R5 to a sitting position and told R5 that she was going to help R5 up to a standing position. At this time, surveyors intervened, stating concerns for R5's turned in leg and the two swollen bumpy areas; and verbalized concerns that R5 should not engage in weight bearing on her left leg. (Surveyors did not observe E6 assess R5 for any further injuries, other than R5's cut under her chin). E6 stated that she was going to call E4 (QMRP). Surveyors voiced concern that 911 should be called immediately. A surveyor went back up the hall to get the phone for E6, who then called 911. Surveyors retrieved two pillows from R5's bedroom, the bedspread and a blanket. The pillows were positioned behind R5's head by E6, the bedpsread was partially slid under R5's right side and R5 was assisted to a lying position again by E6. The blanket was used to cover R5. E6 stated that emergency services had requested that someone be outside to meet them at the door. One surveyor then went outside to wait, while E6 and the other surveyor stayed with R5. Prior to emergency services arrival, E5 (Residential Services Director) arrived and waited outside for emergency services. Surveyors copied the Medication Administration Record (MAR) for emergency services. R5's bruise to her left upper thigh was now observed to be approximately half dollar size and purple/blue in color. E6 was not observed to take any vitals prior to the arrival of emergency services.

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E1 (Administrator) and E4 (QMRP) also arrived. Ambulance services administered vitals, immobilized R5's neck and left leg, administered oxygen, and applied a cold pack to R5's ankle area. At approximately 9:50 a.m., ambulance staff asked E1 which hospital to take R5 to. When E1 responded with the hospital name, emergency staff stated that they would take her to the requested hospital, but that sometimes this hospital has a orthopedic diversion and that they might have to take R5 to a different hospital for orthopedic care. R5 was then transported to the hospital via emergency vehicle.

On 09/23/05 in an interview with E1 at the facility in the a.m., E1 stated that R5 had sustained two fractures to her left leg (tibia area), that after her surgery R5 will be admitted to a nursing home for a period of time, as she will require skilled care for the healing of her left leg.

2) In review of R5's current IPP (Individual Program Plan) of 11/01/2004, R5's bathing skills assessment summary is as follows: "(R5) needs verbal directions to bathe herself or dry herself. She needs physical assistance to initiate bathing and adjust her water temperature. Comments: (R5) is independent with most bathing skills, but she will allow others to provide physical assistance if it is offered or easily obtainable. Facility staff provide minimal assistance if possible, but monitor R5 for accuracy. Recommendations: Provide monitoring to insure (R5) maintains her bathing skills." No special equipment is recommended for R5 regarding to her bathing skills. There is no reproducible evidence that facility nursing has provided updated recommendations in the IPP based on R5's changed health/mobility status.

In review of R5's Medical Profile, Strengths, Needs & Recommendations (summary of the consulting nurses assessment - E2), per the 11/01/2004 IPP it states that R5 needs no assistance with bathing. Under the recommendations area there are no recommendations for R5 regarding her bathing skills. There is no reproducible evidence that facility nursing has provided updated recommendations in the IPP based on R5's changed health/mobility status.

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In review of R5's self-care evaluation/washing, bathing, shaving & using deodorant, per the 11/01/2004 IPP, it states, "Provide supervision to insure (R5's) independence with personal care skills maintained."

In review of R5's most current occupational therapy report in her file, dated 10/8/2004, the report states that R5 is ambulatory and independent for activities of daily living. Under strengths it states, "Independent mobility and for ADL's". Recommendations are for monitoring her diet, exercise and reduce cigarette smoking. At this evaluation no mobility concerns are cited and there are no recommendations regarding R5's mobility. There is no reproducible evidence that facility nursing has provided follow-up and made recommendations/ensured that R5 receive an occupational therapy update in accordance with her changing health/mobility status.

On 7/5/05, R5 had an appointment with neurology. Per review of the documentation from that visit, the neurologist recommended a walker for distance. Nurses notes dated 7/6/05 state, ".....to use a walker for distance: PT to evaluate for fitting of walker....". In review of R5's personal chart, no reproducible documentation is found for this physical therapy evaluation. Per interview with E1 on 9/27/05, E1 stated that a physical therapy evaluation was completed, but could not be found and therefore could not be utilized for any further recommendations that might be in the report. She further stated that the therapist who completed the evaluation was no longer in the area and could not be contacted for a copy of the evaluation. On 9/27/05, E1 presented a physical therapy consult request for R5 with regards to her falls and walker use. The date of the request is 9/9/05. As of 09/22/05 (when R5 received two left leg fractures due to her bathroom fall), no new physical therapy assessment has been completed.

Per file verification, R5 has not received a re-evaluation from occupational therapy since her change in health/mobility status (ie: documented falls with injuries, unsteady gait, episodes of slurred speech, loss of balance symptoms - as described above); and R5 has not had an updated physical therapy evaluation since 07/05. Confirmed per interview with E1 on 9/27/05 at the facility in the a.m.

Per review of a typed note by E12 (Registered Nurse consultant) dated 6/13/05, it documents that R5 had returned from the emergency room for exacerbation of behaviors and staff were concerned that R5 was unable to be aroused. Per the document E12 had spoken with the emergency room nurse who explained that R5 had been administered Haldol and Ativan to reduce her exacerbation and insure that she would sleep all night. "She is not awake enough to eat or drink, therefore I have instructed you to not attempt any PM or HS meds...". E12 however states that staff must monitor her blood pressure and pulse every 4 hours until R5 regains alertness. "Additionally, I have requested that you monitor her blood sugar every 4 hours during this time, but I am told there is no accucheck machine of any kind in the house and no one would know how to use it. Therefore I have instructed (E4) to have the staff review the section in the nursing protocol for high and low blood sugars and the symptoms to watch for...This is important as (R5) has not had anything to eat & will not have had her medicine."

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