

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145992	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/15/2013
NAME OF PROVIDER OR SUPPLIER ASTA CARE CENTER OF COLFAX			STREET ADDRESS, CITY, STATE, ZIP CODE 402 SOUTH HARRISON COLFAX, IL 61728		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323 F9999	Continued From page 6 resident attempting to get up because a medication cart was blocking E10's view. E2 also confirmed that E10 was disciplined for failure to follow safety precautions and that R2 sustained a left hip fracture as a result of the fall. FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.	F 323 F9999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145992	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/15/2013
NAME OF PROVIDER OR SUPPLIER ASTA CARE CENTER OF COLFAX			STREET ADDRESS, CITY, STATE, ZIP CODE 402 SOUTH HARRISON COLFAX, IL 61728		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F9999	<p>Continued From page 7</p> <p>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. 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.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) 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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These requirements were not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure fall interventions were in place as outlined in the care plan for one of four residents reviewed for falls (R2) in a sample of four</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145992	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/15/2013
NAME OF PROVIDER OR SUPPLIER ASTA CARE CENTER OF COLFAX			STREET ADDRESS, CITY, STATE, ZIP CODE 402 SOUTH HARRISON COLFAX, IL 61728		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F9999	<p>Continued From page 8 residents. This failure resulted in R2 sustaining a fall which resulted in a fractured hip.</p> <p>Findings include:</p> <p>Face sheet for R2 indicates that R2 was admitted to the facility on 3-29-13. Fall Risk Evaluation, dated 3-29-13, documents that R2's total score was 18. Evaluation states, "A resident who scored a 10 or higher is at risk."</p> <p>Care plan for R2, includes a focus area, initiated 4-12-13, that states, "(R2) is alert with confusion. (R2) was admitted with (right) hip fracture..(R2) is impulsive and attempts to transfer self. (R2) has a history of falls at home..." Interventions included for that focus area include: "pressure alarm pad in wheelchair" and "make sure alarms in place/working."</p> <p>Nurses Note, dated 4-19-13 at 4 AM states, "Resident sitting in chair at nurse's desk. Writer charting heard a thump. Res noted on floor on L(eft) hip, yelling in pain." The note was signed by E10/LPN (Licensed Practical Nurse).</p> <p>Occurrence Report/Fall Details Report, dated 4-19-13 at 4 AM, documents that the "preventive measure at the time of the fall included a "alarm" that was "not sounding." The report also states, "Staff did not apply chair alarm when got resident up. Resident fell out of wheelchair...Staff was disciplined for not following protocol."</p> <p>History and Physical for R2, dated 4-19-13 and signed by Z3 (physician), states, "This is an 89 year old patient of (Z2/orthopedic surgeon) who asked me to admit to the hospital after she</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145992	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/15/2013
NAME OF PROVIDER OR SUPPLIER ASTA CARE CENTER OF COLFAX			STREET ADDRESS, CITY, STATE, ZIP CODE 402 SOUTH HARRISON COLFAX, IL 61728		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F9999	Continued From page 9 slipped out of a wheelchair with a left hip fracture...Patient is in severe pain requiring narcotic pain relievers." On 5-15-13 at 2:55 PM, E2/DON (Director of Nursing) confirmed that E10/LPN (License Practical Nurse), who got R2 out of bed, did not apply the alarm at that time. E2 stated that E10 did not put the alarm on because R2 was sitting near the nurse's station, but E10 did not see the resident attempting to get up because a medication cart was blocking E10's view. E2 also confirmed that E10 was disciplined for failure to follow safety precautions and that R2 sustained a left hip fracture as a result of the fall (B)	F9999			