

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/22/2013
NAME OF PROVIDER OR SUPPLIER PRESENCE HERITAGE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 901 NORTH ENTRANCE AVENUE KANKAKEE, IL 60901		
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F 371	Continued From page 28 "Potentially hazardous food requiring refrigeration after preparation shall be labeled or tagged with the date and time of preparation and rapidly cooled to an internal temperature of 41 degrees F... Potentially hazardous food... shall be pre-chilled and held at a temperature of 41 degrees F..." However, facility's staff did not follow the above procedures and policy.	F 371			
F9999	FINAL OBSERVATIONS Licensure Violations 300.610a) 300.1210a)b) 300.1210d)6) 300.1220b)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.	F9999			

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F9999	<p>Continued From page 29</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</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. Restorative measures shall include, at a minimum, the following procedures:</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p>	F9999			

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F9999	Continued From page 30 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.	F9999			

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F9999	Continued From page 31 Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Regulations were not met as evidenced by: Based on observations, interviews and record reviews the facility failed to adequately supervise 2 of 6 residents (R5 and R8) sampled for falls in the sample of 12, who are known to be at risk for falls. The failure resulted in R5 sustaining a right hip fracture and head lacerations (which required medical treatment and 6 to 7 staples) after falling and R8 sustaining skin tears and bruising after falling. Findings include: 1. Review of R5's Admission Face Sheet R5 is a 94 year old male with diagnosis including: Fracture Neck of Femur, Poly Arthritis, Osteoarthritis and Alzheimer's Disease. Facility's Incident Reports show that R5 has experienced	F9999		

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F9999	<p>Continued From page 32</p> <p>multiple falls in the facility. The Fall investigation documents the history of R5's fall occurrences:</p> <p>"6/26/2012 at 4:40 PM... Type of Incident: ...Fall... Type of Injury: ...hip fracture... Description of Event (Including injury): Resident (R5) seen laying on floor on buttocks... R5 was trying to assist roommate. He ambulated over to other resident and fell... Fall most likely related to internal risk factors... has some slight cognitive and perceptual problems. He would be a poor judge of his own limitation... unable to handle change or new situations..." The corrective action plan for this investigation lacks documentation regarding a method of staff providing supervision for R5.</p> <p>7/01/2012 at 12:45 PM... Location Resident's (R5's) Room... R5 was found face down laying on the floor..." The investigation documented that the certified nurse caring for R5 on 7/01/2012 at 12:45 PM stated she was in another room taking care of a resident, when R5 fell. This investigation documented that R5 had periods of confusion, recently had surgery and may still be under the affects of anesthesia. The recommended corrective action plan had no documentation of increase in staff supervision of R5 due to periods of confusion.</p> <p>"7/01/2012 at 6:35 PM... R5 had locked himself in bathroom near nurses office... Door to bathroom was unlocked. R5 falling to floor and was then on the floor landing on his right side between wall and wheelchair..." The statements of the staff, on duty for 7/01/2012, did not document any staff providing R5 with supervision before he (R5) locked himself</p>	F9999			

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F9999	<p>Continued From page 33 in the bathroom and fell. The recommended corrective action plan did not identify/document a method for staff to supervise R5 to prevent further falls.</p> <p>"12/12/12 at 3:30 AM... R5 calling out for help, upon entering room, noted resident lying on the floor in left lateral position, bleeding from laceration to top of head (which required 7 staples to the laceration)." Review of the staff's statements documented that they were doing other things and not supervising R5. The corrective action plan documented the same interventions and had no documentation of any method to increase staff's supervision of R5. This investigation also did not have a detailed analysis of factors causing R5's fall. It documented R5 sometime had confusion, but not a method for staff to supervise R5.</p> <p>Review of R5's Nursing Note, dated 2/05/2013 at 5:29 PM states: R5 found on the floor at 1630 (4:30 PM)... R5 stated he only slid to the floor on his buttocks..." There was documentation that R5 had a seatbelt alarm, which was unhooked and turned off. The nursing note documented that R5 "has been known" to unhook and turn off his seatbelt alarm. The nursing note lacked documentation of staff using/identifying a more effective mean of supervising R5.</p> <p>Review of R5's care plan had no documentation of a method to provide R5 with increase staff supervision until after R5 had multiple falls, some with serious injuries.</p> <p>On 3/12/2013 at 12:36 PM, R5 was interviewed in his room. R5 was alert, with periods of confusion,</p>	F9999			

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F9999	<p>Continued From page 34</p> <p>and wheel chair bound. R5 stated he was unable to ambulate by himself, and often failed to get staff's assistance.</p> <p>The nurse (E11) and CNA's (E13) providing care for R5 were interviewed on 3/13/2013 at 10:20am and 3/14/2013 at 1:45pm. Both reported that R5 was alert with periods of confusion and impulsive behavior. E11 and E13 stated R5 was at risk for falls and needed to be monitored.</p> <p>The restorative nurse (E4) was identified as being responsible for doing resident fall investigations. E4 stated on 12/13/2013 at 11:15am that R5's fall occurrence on 6/26/2012 "happened before my time as restorative nurse. (R5) was trying to help roommate get up and in the process he fell. R5 fractured his hip and had been on fall precautions. (R5) had a wander guard and alarm cushion. Based on the fall risk score prior to the fall, R5 was at risk for falls. He's alert with periods of confusion. She (the prior restorative nurse) assessed his fall (on 6/26/2012) related to poor cognitive skill and judgement." Upon reviewing R5's care plan dated 4/06/2012, E4 stated, "I don't see anything related to fall on care plan (for R5)... In December 2012, I was here when he had a fall. It happened at 3:30 AM..." E4 said that R5's December fall was caused by: "his impulsive behavior of not waiting for assistance."</p> <p>E12 cared for R5 on 2/05/2013, stated on 3/15/2013 at 10:15 AM, "The CNA was busy... R5 had a seatbelt alarm on. It was on him, but not alarming. R5 frequently took it off and hooked it back up by himself...(R5) is at risk for falls because he is noncompliant, forgetful and</p>	F9999			

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F9999	<p>Continued From page 35</p> <p>impulsive. He's not impulsive all the time but sometimes impatience and does it himself."</p> <p>According to the admitting assessment (12/15/12) R8 is a 94 year old female admitted to the facility on 12/15/12 for rehabilitation after a fall with hip fracture. R8's diagnoses also include Atrial fibrillation, Hypertension and Glaucoma. R8 has been identified by the facility as a high risk for falls and decreased safety awareness per review of incident investigation following the first unwitnessed fall on 1/5/13.</p> <p>Review of facility Incident Reports indicate the following:</p> <p>On 01/05/13 at 7:30 PM R8 was found sitting on the floor at the side of her bed. R8 stated that she wanted to clean her room and tried to get up by herself. R8 sustained a bruise to the right hip. The fall was unwitnessed. According to the facility's investigation R8 is alert and oriented with periods of confusion. The facility identified decreased memory, periods of confusion and unsteady gait from recent fracture as contributing factors to the fall. R8 was reinstruct regarding use of call light due to her decreased memory. A floor mat alarm was recommended to remind R8 to call for assistance when needed and to alert to staff to her need for assistance.</p> <p>On 02/03/13 at 11:00 AM R8 was again found on the floor in her room. R8 was sitting on the floor alarm with a skin tear noted to the left lower leg. R8 apparently tried to get up while in her recliner. When interviewed by facility staff, R8 was unable to explain why she tried to get up. The facility's incident investigation again identifies impaired</p>	F9999			

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F9999	<p>Continued From page 36</p> <p>cognition and decreased safety awareness as contributing factors to R8's fall but documented that the fall could not be anticipated because the safety interventions had been effective in past days. R8's chair alarm was changed to a contact alarm to alert staff sooner. The fall was unwitnessed.</p> <p>On 02/20/13 at 6:40pm R8 was again found in her room sitting on the floor in front of her wheelchair. The alarm was going off and R8 was taking her shoe off stating she was getting ready for bed. The fall was unwitnessed. The facility's interventions included to continue the current safety precautions and to keep R8 involved in as many activities as possible where she is in full view of others.</p> <p>On 02/23/13 at 6:05pm R8 was again found in her room sitting on the floor after staff heard her alarm going off. R8 stated that she tried to get up but became weak in the knees and fell on the floor. The fall was unwitnessed. R8 sustained a skin tear to the left elbow. The facility scheduled a follow up with a neurologist, continued use of alarms and more involvement in activities.</p> <p>Although the facility had identified R8 as cognitively impaired with decreased safety awareness, R8 was still left in her room unsupervised after 4 unwitnessed falls resulting in 2 injuries. There was no evidence in the medical record that R8 was reassessed for additional activities as stated as an intervention in the last 2 falls or for increased supervision by staff.</p>	F9999			

