### SUMMARY STATEMENT OF DEFICIENCIES

**W 331** Continued From page 17

**W9999** FINAL OBSERVATIONS

**LICENSURE VIOLATIONS**

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- **Section 350.1210 Health Services**
  - The facility shall provide all services necessary to maintain each resident in good physical health.

- **Section 350.1230 Nursing Services**
  - d) Direct care personnel shall be trained in, but are not limited to, the following:
    1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.
    2) Basic skills required to meet the health needs and problems of the residents.
    3) First aid in the presence of accident or illness.

- **Section 350.3240 Abuse and Neglect**
  - a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)
These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to provide nursing services in accordance with an individual's needs for one of one individual involved in a fall resulting in a fractured fibula (R4) when they failed to:

1) Obtain follow up assessment in a timely manner for R4, who suffered a fall with a change of condition.

2) Notify the nurse specifically of R4's change of condition.

Findings Include:

R4, per annual Individual Program Plan (IPP) of 10/16/12 is a 40 year old male with diagnoses of Profound Mental Retardation and a Seizure Disorder. R4's "Maximum Growth Potential Plan" from his IPP of 10/16/12 states that R4 "has a history of seizure disorder (seizures are controlled by medication). [R4] is also deaf with limited communication skills." Under the section titled "Language" the IPP states R4 "is deaf and uses limited sign language and gestures to communicate. He is receptive to some formal signs and gestures."

A Neurology follow up exam dated 9/18/12 states, "He does have a seizure disorder. [E3, direct care staff] states that ever since she has been working with [R4], it has been approximately 17

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Years, he has not had any breakthrough seizures. He did have bloodwork in May in which his Dilantin was somewhat low. Since he has been stable, no change was given to his medication. [R4] is nonverbal and does not hear. He is able to sign to his care givers. [E3] states that he eats well sleeps well. He has not been sick. He has not had any falls."

Under the section titled "Plan" the Neurology follow up exam dated 9/18/12 states, "He is on Lamictal and Dilantin. He has been stable for years. Bloodwork was obtained in May of this year. Since he has been so stable, we will obtain repeat bloodwork in a year. He is to follow up in office in a year, sooner if needed."

A report was submitted to the Department dated 3/02/13 regarding an incident involving R4. It states that R4 "initially came to staff around the time of noon medication administration and was stumbling. He fell sideways into a staff member who caught him and slowly took him to the floor. After a few minutes, [R4] was able to stand and had a notable limp." The report continues, "Around 1:30 [R4] came out of his room limping and required staff assistance to ambulate. He signed his left ankle 'hurt'. Staff took off his tennis shoe to find that his ankle was indeed swollen."

The report continues, "A little after 5pm however, another resident, [R2], came to the dining room to report to staff that [R4] had stood by himself and fallen to the floor. Two staff ran into the room and [R4] was seizing on the floor. It lasted approximately 30 seconds from the staff entering the room." The report continues that after E4
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[Supervisor on Duty for the weekend, Residential Services Director, {RSD} for another facility] returned to the facility to take R4 to the hospital for an X-ray. "As staff was assisting [R4] towards the van at approximately 6pm, [R4] stopped ambulating and began another seizure. This seizure lasted 1 minute and [R4] had very low blood pressure and intense sweating afterward. [R4] was immediately placed in a wheelchair and taken to the ER [Emergency Room]."

The report states that R4 was diagnosed with a "broken fibula near the ankle and with breakthrough seizures possibly brought on by pain upon attempting to ambulate on that injured ankle." The "Emergency Nursing Record" dated 3/02/13 from the local hospital states that the time R4 was in the room to be assessed was 7:10pm. Under the section titled "Chief Complaint" the Emergency Nursing record states, left ankle injury.

A "Follow Up on investigation regarding incident on 3/2/13 involving Resident [R4]" report dated 3/07/13, written by E4, and submitted to the Department, states that at approximately 12:30pm. E4 got a phone call from E5 [direct care staff] regarding R4 stumbling and being lowered to the floor by E5. Per the report it was reported to E4 [Supervisor on Duty] at that time "that he stood and had a limp."

The follow up report continues that E4 arrived at the facility at approximately 12:40pm. The report states that at that time E4 asked E5 to "call and report the injury to the nurse, [E6]." E5 was interviewed on 3/07/13 at 8:15am. When asked who was notified and when, E5 stated that she
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called both the RSD [E4] and the nurse [E6] and left a voice mail for the nurse. When asked who came to assess the injury, E5 stated it was E4 around 12:00pm or 12:30pm. E5 was interviewed again on 3/07/13 at 10:40am. When asked what time approximately did she call E6 [nurse], E5 stated around 12:00pm or 12:30pm. When asked if E6 returned her call, E5 stated, no.

The follow up report states that E5 "had taken [R4's] blood pressure, pulse and temperature after the fall - all of which were normal."

The report states that E4 interviewed E8 [direct care] who stated that R4 "had been walking fine when he got there that morning, but now was limping."

According to the follow up report, at approximately 1:30pm., E8 assisted R4 out to the dining room for an activity. E4 "asked if he [R4] had pain. He signed 'hurt' and pointed to his left foot. At this point, [E4] called the nurse [E6] to inform her of the change. [E4] left a message and was immediately called back."

According to the follow up report, E6 "indicated that the only way to see if an ankle was strained, sprained or broken was with an Xray. She said we may see some swelling. She stated that we should observe him for falls assist as needed for ambulation, encourage elevation of the foot, and ice for 15 minute increments if he would permit it." It continues, "She also stated that if he was not any better on his feet by morning time, she would recommend that he go to the hospital for an xray."
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E6 [Nurse] was interviewed by phone on 3/07/13 at 10:52am. When asked when she was notified of R4’s injury, E6 stated around 4:00pm or 5:00pm. E6 stated that she wrote 4:45pm on her nurses note entry. When asked who notified her, she stated, “[E4], acting as RSD.” When asked what she was told by E4, E6 stated that she was told R4 had stumbled and was limping. When asked if she was told he fell, E6 stated no. When asked if she was told R4 was in pain, E6 stated no. E6 stated that normally you would not have a break from stumbling but the only way to tell for sure is an X-ray. When asked if she was told if there was bruising or swelling, E6 stated no.

E6 was asked if she had a record of an earlier call on 3/02/13 and she said no. E6 did state that on Monday [3/04/13] she noticed on her phone it listed 1 missed call and 3 voice mails. E6 stated that one was from E5 and it was about R4 but she did not know what time it was left. E6 stated that she did not know why E5 would call after E4. E6 stated that she told E4 [supervisor on duty] regarding R4’s injury, if there is bruising, swelling or he continues limping to get an X-ray.

When asked if she was told by E4 that R4 was limping, E6 stated yes. When asked if she was told if R4 had swelling, E6 stated no. When asked if she was told if R4 had a fall, E6 stated no. E6 phoned surveyor back on 3/07/13 at 11:50am. E6 stated that surveyor had asked about a missing phone call. E6 stated that she looked at her phone log. E6 stated that there had been a call from the facility phone at 1:00pm on 3/02/13. E6 stated that it must have been the voice mail from E5. E6 stated that she first heard about the injury to R4 at 4:48pm.
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A "Nursing Notes" dated 3/02/13 by E6 states, "At approx [approximately] 4:45pm I was contacted by [E4] of [R4] limping on left foot. [E4] reported that [R4] had stumbled then started limping. When asked if [R4] fell I was told no he just stumbled. No swelling or bruising was noted by [E4]. I told [E4] there is no way to know if something is broken without an x-ray. I suggested to [E4] that the left foot be elevated and an ice pack applied in 15 minute increments. Told [E4] that [R4] needed to be monitored for swelling or bruising that may develop. If swelling, bruising, limping continues or pain is noted to send [R4] for x-ray."

A "Resident Injury Report" dated 3/02/13, under the section titled "Date and time the following were notified:" under the section for RN [Registered Nurse] it states, "3/2 12:30." Under the section titled RN Comments it states, "Observe + elevate foot. Ice for 15 min [minute] increments. Watch for falls." Under the section titled "Comments/Follow-up:" which was written by E4 it states, "Initially, nurse [E6] rec. [recommended] observation for further falls + to elevate foot and ice for 15 min intervals. Staff [E5 and E7] don't know the cause of injury - only that when he came for noon meds he stumbled sideways + after the fall had a swollen ankle + a notable limp." The comments section continues, "Upon investigation, it seems that [R4’s] ankle injury may have been caused by the initial fall since there was no evidence of a limp prior."

E4 [supervisor on duty] was interviewed on 3/07/13 at 12:10pm. When asked when she first notified E6 [nurse] of R4's incident, E4 stated that she didn't make the first phone call, she asked E5
**NAME OF PROVIDER OR SUPPLIER**

ALVIN EADES CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1000A WEST MICHIGAN
JACKSONVILLE, IL 62650

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| W9999 | Continued From page 24 to do it. When asked if E5 was able to reach the nurse, E4 stated, "If I remember, she left a message." E4 stated that she called the nurse and left a message approximately 1:45pm., and E6 "called back really pretty close right after that. I was still working on the craft." E4 stated that it would have been around 1:45pm. to 2:00pm.

When asked what specifically she told E6, E4 stated that she told E6 that R4 came out of his room, E8 kept his arm around R4, that R4 was limping and that R4 signed hurt. E4 stated that would have been around 2:00pm. When asked if she told E6 that R4 had fallen, E4 stated, "Yes, I did not say fall. He was kept from falling because [E5] kept him from falling. My exact words were that he stumbled sideways." When asked if she had told E6 that R4 had swelling, E4 stated, "At that point, no." E4 stated that after she got off the phone from E6, she noticed the swelling.

When asked what specifically did E6 tell you at that time, E4 stated that E6 stated, if it was a sprain it would be swollen. Without an X-ray you cannot tell if it's a strain or sprain. E4 stated that E6 stated to have him rest and elevate the ankle, put ice on it in 15 minute increments if permitted, if he request pain medication give him his PRN [as needed], and if not any better in the morning take him in for an X-ray.

When asked what she actually observed of R4 at the time, E4 stated that R4 was limping. E4 stated that R4 was still walking but he was "limping pretty good." E4 stated that R4 sat down for the activity but kept his leg stretched out. E4 stated that she asked R4 if he hurt and he signed that his ankle hurt. When asked if she saw the
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swelling, E4 stated, "I didn't see it then. I lifted his pant leg and saw it was swollen." E4 stated that she loosened his shoe string. When asked if this was all around 1:30pm. to 2:00pm., E4 stated, "Yes."

When asked when she was told by E6 to use ice, E4 stated at the 1:30pm call, "If he would let us." When asked if E6 ever told her that if the limping continues or swelling or bruising occurs to get an X-ray, E4 stated all she was told is if in the morning it wasn't better, if still limping or swollen take for an X-ray. When asked about telling E6 about the swelling, E4 stated, "I don't think so. I remember seeing it. I don't remember if I reported it or not."

The follow up report to R4's incident of 3/02/13 states that "After the phone call, [E4] again looked at [R4's] foot and lifted up the bottom of his pantleg. He did have some swelling, although no bruising was noted."

E4 failed to ensure that E6 was fully aware of R4's change of condition including the swelling of the ankle. The facility failed to take action to determine the reason for R4's change in condition including limping, requiring assistance for ambulation, swelling of the ankle and reported pain.

The follow up report to R4's incident of 3/02/13 states that at approximately 5:00pm., E4 was almost to her personal home when she got a call from E5. E5 stated that another resident stated that R4 "had stood and fallen to the floor." The report states that E7 "ran to the bedroom, and
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 14G317

**Date Survey Completed:** 03/22/2013

**Name of Provider or Supplier:** ALVIN EADES CENTER

**Address:**

1000A WEST MICHIGAN 
JACKSONVILLE, IL 62650

### Summary Statement of Deficiencies

**Event ID:** W9999

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[R4] was having what appeared to be a seizure. He experienced arm jerking and urinary incontinence.

At approximately 6:00pm., after E4 had returned to the facility, according to the follow up report, E5 provided E4 "with a scrap of paper indicating that [R4's] blood pressure had been very low after his seizure, his pulse was high and she told [E4] that [R4] had sweated a lot and had urinary incontinence." The report continues that E8 told E4 that R4 "was requiring complete assistance by then with ambulation." The report states, "At this point [E4] called [E6, nurse] again and left a message informing her that [R4] would be going to the Emergency Department for seizures, and that the ankle would be addressed as well."

The follow up report to R4's incident of 3/02/13 states that at approximately 6:20pm., "[R4] came out assisted by both [E5] and [E7]. [E4] was standing in the hallway to take over assisting with ambulation when [R4's] eyes shut and he went limp with his left arm jerking. [E4, E7 and E5] lowered him down. At this point, it had been about 20 seconds. [R4] stayed still except for slight jerking of his left arm and some sweat developing at his brow and on his head. About 30-40 sec [seconds] later, [R4] opened his eyes and seemed to have tears in his eyes. He was placed in a wheelchair and checked for any injury or pain by [E4]. He still indicated 'hurt' to his left foot. [E4] manually checked his pulse, which was elevated. He was quite sweaty on his head and had a tear down his face."

The report states that R4 was taken to the emergency room where, "The physician..."
### Name of Provider or Supplier

**ALVIN EADES CENTER**

### Summary Statement of Deficiencies

Each deficiency must be preceded by full regulatory or LSC identifying information.

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| W9999 | | | Continued From page 27 diagnosed [R4] with a broken fibula at the ankle, and breakthrough seizures possibly brought on by the pain of ambulation." The facility Resident Injury Report of 3/02/13 under the section titled Comments/Follow-up states, "[R4] was diagnosed w/a [with a] broken fibula near the Lt [left] ankle + breakthrough seizures possibly caused by pain."

The Neurology follow up exam dated 9/18/12 states, "He does have a seizure disorder. [E3, direct care staff] states that ever since she has been working with [R4], it has been approximately 17 years, he has not had any breakthrough seizures." Under the section titled "Plan" the Neurology follow up exam dated 9/18/12 states, "He is on Lamictal and Dilantin. He has been stable for years." |

(B)