

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007231	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/10/2013
NAME OF PROVIDER OR SUPPLIER PARKVIEW HOME - FREEPORT			STREET ADDRESS, CITY, STATE, ZIP CODE 1234 SOUTH PARK BOULEVARD FREEPORT, IL 61032		
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Z 000	COMMENTS Incident Report Investigation of 04/01/13 / IL62546	Z 000			
Z9999	FINDINGS Licensure Violations: 300.610a) 300.1210 b)5) 300.1210c) 300.1210d)6) 300.3240 a) 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. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care	Z9999			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Z9999	Continued From page 1 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: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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 300.3240 Abuse and Neglect	Z9999			

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Z9999	Continued From page 2 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. THESE REQUIREMENTS ARE NOT MET AS EVIDENCED BY: Based on observation, interview, and record review the facility failed to ensure a resident, at high-risk for falls, was supervised during toileting on 4/1/13. The facility staff failed to execute R1's fall-care-plan approaches. These failures allowed R1 to fall while unsupervised. R1 sustained multiple facial fractures and a C-3 vertebral fracture that contributed to his death, three days after the fall. The findings include: The April 2013 Physician Order sheets show R1 was admitted on 07/18/2012 with diagnoses to include Cognitive Impairment and Weakness. A nursing progress note dated 08/16/12 states, "was admitted to sheltered care ... due to increasing weakness ... family stated he had a "bad fall" prior to their making the decision to bring him to (the facility) ... Since being admitted, (R1) has had multiple falls ... the doctor decided it would be best if (R1) were in the Health Center (HC)..." The facility's fall risk evaluation (updated 01/06/13) shows R1 had a fall risk score of 22 (a score of 10 or higher indicates a resident is at increased risk for falls). The facility's care plan (dated January 2013) states, R1 "is at high risk	Z9999			

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Z9999	Continued From page 3 for continued falls with injuries due to he has had several falls since admission. He has unsteady, shuffling gait, dementia, poor eyesight in one eye and forgets to use his walker at times (R1) is permanent HC and remains at risk for falls.... Methods and staff responsible for them: ... Nursing - Transfer and ambulate with wh(eeled) walker and gait belt assist of 2 staff...Nursing - Move closer to nurses station when room is available...Stay with resident in the bathroom when resident is in the bathroom." The same plan of care documents R1 had 11 falls, since his admission on 07/18/12 ,7/25/12, 7/30/12, 8/10/12 [two falls], 8/12/12 [two falls], 9/6/12, 9/25/12, 10/23/12, 12/19/12, and 4/1/13). On 4/5/13 at 2:00 PM, E2 (Director of Nursing) stated, R1 "Was at high risk for falls ... R1's Care plan states he goes to bathroom with the assist of one (staff member). That means someone should have stayed in the bathroom with (R1)." On 4/9/13 at 10:20 AM, E3 (Assistant Director of Nursing/Care Plan Coordinator) stated, "Residents should not be left unattended in the bathroom, if they are at high risk for falls." On 4/9/13 at 11:40 AM, E4 (Registered Nurse, RN) stated, "This fall could have been prevented had someone kept an eye on him; it would have been much safer." On 4/10/13 at 8:55 AM, E5 (RN) stated, "The fall could have been prevented if someone would have been with him or watching him... They should have stayed in the bathroom with him." On 4/5/13 at 3:00 PM, E7 (Certified Nursing Assistant, CNA) stated, it is the "facility policy not to leave a resident unattended" in the bathroom if they are at risk for falls. R1 would request we step out, and I "maintained eye contact outside the bathroom door. That would have prevented R1 from falling... I never leave (R1) in the bathroom unattended." On 4/9/13 at	Z9999			

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Z9999	<p>Continued From page 4</p> <p>1:08 PM, E6 (CNA) stated, "took (R1) to the hall (common) bathroom on the health center.. If (R1's) room had been closer we would have used his bathroom. We stepped out of the bathroom and I stood outside of the restroom... I didn't see (R1) get up or fall.... If I had taken him to his room I would have kept an eye on him... I know I could have prevented him from falling had he been in his room..."</p> <p>On 4/9/13 between 9:00 AM and 2:00 PM, E2 and E3 both said a resident who is at high risk for falls should be as close to the nursing station as possible. R1's room was 204. Room 204 is the farthest room from the nursing station and the adjacent lounge area. The common bathroom on the healthcenter was approximately 100 feet from the nursing station. The common bathroom is attached to a shower room and had a tile floor. On 4/5/13 there were no obstructions in the area where R1 was toileted, to impede a fall directly onto the tile floor.</p> <p>The Narrative Report (dated 4/1/13) sent to the Illinois Department of Pubic Health states, "It was found that (R1) always asked the CNA's to step out of the bathroom so he could have privacy." The 4/1/13 facility incident report states (R1) "transferred to toilet with two assist, lost balance leaning to the right, landing onto right side/chest. No loss of consciousness. Remained on floor in position until ambulance arrived." The 4/1/13 nursing notes states, "Resident up to bathroom with two assist and wheelchair. Transferred to toilet. CNA standing outside of door slightly open. Resident lost balance falling onto right side/abdomen. Laceration present on upper nose, glasses removed frames bent. Noted sanguinous (bloody) drainage present on right side of face, unable to assess. Reports right side</p>	Z9999			

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Z9999	Continued From page 5 of head pain and left wrist pain." The Hospital Admission History & Physical dated April 1, 2013 states, "Assessment & Plan: C3 and right facial fracture after a fall at a nursing home. Progressive dementia - family notes that patient neglects right side over the past few months... Plan: admit to NICU (Neuro Intensive Care Unit) overnight. Will be given supportive care and kept in a cervical collar... He will be assessed in am by neurosurgery for his C3 fracture... Exam: Head: sutured lac(eration) above the right eyebrow. Right periorbital ecchymosis (bruising)." The computerized tomography (CT) of Head or Brain taken on 4/1/13 states, "Findings: ... Findings consistent with multiple fractures of right maxillary sinus and minimally depressed fracture of the right zygomatic arch. Air-fluid and/or air blood level present within the right maxillary sinuses probably secondary to acute trauma..." The CT of Facial Bones taken on 4/1/13 states, "Findings: ... Again there is evidence of comminuted fracture of the posterior lateal wall of the right maxillary sinus extending into the lateral wall of the right orbit. There is a depressed comminuted fracture of the anterior wall of the right maxillary sinus. Depressed fracture right zygomatic arch. Blood floor of the right orbit... Right periorbital emphysema noted... Impression: Multiple facial fractures..." The CT of Cervical Spine taken 4/1/13 states, "Findings: There is an acute fracture of the anteroinferior aspect of the C3 vertebral body consistent with hyperextension injury. There is slight posterior subluxation C3 with respect to C4." On 4/10/13 at 9:30 AM, Z1 (Primary Care Physician) stated, R1 "was at high risk for falls. His fall was the cause of his death. He should	Z9999			

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Z9999	Continued From page 6 not have been left alone in the bathroom. The fall probably could have been prevented had staff supervised or stayed in the room with the resident." The facility Fall Risk Assessment Policy (updated 4/4/13) states, "Persons with a score of 10 or above are considered to be at risk for falls...Residents expressing a desire for privacy while toileting will be evaluated to determine (the) need for staff to remain in the bathroom during the toileting process for safety purposes..." (pp 1-2) (AA)	Z9999			