

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

PRINTED: 07/10/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/06/2013
NAME OF PROVIDER OR SUPPLIER NEW ATHENS HOME FOR THE AGED			STREET ADDRESS, CITY, STATE, ZIP CODE 203 SOUTH JOHNSON STREET NEW ATHENS, IL 62264		
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F 505	Continued From page 30 R2's Basic Metabolic Panel laboratory results dated 1/1/13 were sent to the facility on 1/1/13. R2's Carbon Dioxide result was 42 mEq/L. Again, this result was a Critical High result. Also, R2's Blood Urea Nitrogen and Creatinine results were abnormal. The laboratory result had a stamp documented "Faxed" on 1/15/13 and a stamp documenting "Received January 15, 2013." This was 15 days after the results were faxed to the facility. Z2 documented on the laboratory results she reviewed the results on 1/18/13. On 4/26/13, at 2:05 PM, an interview was conducted with E5, Licensed Practical Nurse (LPN). E5 stated usually the nurse's will fax laboratory results to the physicians. E5 stated the physician should be notified of critical laboratory values immediately. On 4/26/13 at 2:10 PM, an interview was conducted with E4, LPN. E4 stated the nurse's will stamp "Faxed" on the laboratory results. E4 stated the nurse will place the date the fax was sent below the stamp. E4 stated the physician's office will then return the fax with a stamp "Received" and a date the physician received the laboratory results.	F 505			
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 300.3240a)	F9999			

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F9999	Continued From page 31 Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care 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. 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	F9999			

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F9999	<p>Continued From page 32</p> <p>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 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>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.</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. (Section 2-107 of the Act)</p> <p>These requirements were not met as evidenced by:</p>	F9999		

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F9999	<p>Continued From page 33</p> <p>Based on interview and record review, the facility failed to assess, identify causative factors contributing to falls, implement progressive interventions and modify and monitor those interventions when injuries continue for one of six residents (R11) reviewed for falls in the sample of 11 and one resident (R22) in the supplemental sample. This failure resulted in R11 falling and sustaining a skin tear to his left elbow, a bruise and laceration to his head and a right acute intertrochanteric femoral fracture.</p> <p>Findings include:</p> <ol style="list-style-type: none"> R11's Physician's Order Sheet (POS) dated August 2012 documented he had the partial diagnosis of History of Falls. R11's Physician's Order dated 8/29/12 documented "Pressure Alarm (and) Personal Alarm d/t (due to) falls." R11's Physician's Order dated 8/29/12 documented "D/C (Discharge) PT & OT (Physical Therapy and Occupational Therapy) eval (evaluation) & treat (secondary to) poor rehab potential." <p>R11's Minimum Data Set (MDS) dated 9/6/12 documented his balance was not steady. The MDS documented he was only able to stabilize with staff assistance when moving from seated to standing position, walking, turning around while walking, moving on and off toilet, and during surface-to-surface transfers. R11's MDS documented he had moderately impaired decision-making abilities.</p> <p>R11's Care Plan dated 9/10/12 documented he was at risk for falls due to dementia and unsteady gait. The Approaches for this Care</p>	F9999			

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F9999	<p>Continued From page 34</p> <p>Plan Problem were to notify the family and physician if R11 fell, follow the protocols for falls, and personal and pressure alarms in place at all times.</p> <p>R11's Nurse's Note dated 9/28/12 at 10:45 PM documented "Heard noise while @ (at) the desk (and) report - CNA (Certified Nurse's Aide) went to check on res (resident). She noticed he grabbed the linen cart (and) fell backwards (and) hitting his head - (upper crown)."</p> <p>R11's Risk Management Report, 9/28/12, documented he sustained a 0.5 centimeter (cm) cut to crown of his head with a 1 cm bump. The Action/Intervention Section of the Report documented "Alarms in place (and) working properly. Attempted AM (morning) meds Risperdal and Ativan and Res spit out onto floor." The Report documented R11's personal alarm was present at the time of the fall but was not attached. There were no new progressive interventions documented or implemented after this fall. R11's Care Plan was not updated after this fall with any new interventions.</p> <p>R11's Risk Management Report, dated 10/5/12 documented R11's alarm began to sound at 9:50 P.M. R11 was found standing unassisted in his doorway and his left forearm was bleeding. R11 sustained a skin tear to his left arm measuring 0.6 cm by 0.6 cm. The Action/Interventions Section of the Report documented staff applied a treatment to his arm and all alarms were in place. R11's Care Plan was revised on 10/5/12 regarding current treatment to his skin tear. However, there were no new interventions regarding R11 attempting to ambulate</p>	F9999			

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F9999	<p>Continued From page 35 unassisted.</p> <p>R11's Nurse's Note dated 10/30/12 at 1:15 PM documented "Laundry staff found res laying on R (right) side of body on floor in green room. Personal alarm on w/c (wheelchair) but not sounding."</p> <p>R11's Risk Management Report dated 10/30/13 documented R11 was found laying on the floor in the green room. The Action/Intervention Section of the Report documented "15 min (minute) (checks), neuro (checks)." R11's Care Plan was not revised after this fall with any new interventions.</p> <p>R11's Nurse's Note dated 11/17/12 at 12:00 PM documented "This nurse called to South hall by CNA to report that res fell out of w/c on to floor hitting face on the floor causing a 3 cm x 3 cm knot to L (Left) forehead." The Nurse's Note continued to document "This nurse asked CNA what happened CNA stated Res was sitting in w/c et (and) leaned forward et fell onto floor. Personal alarm in place et working properly, res wearing non-skid socks, floor clean et free of debris."</p> <p>R11's Risk Management Report dated 11/17/12 documented R11 fell and hit his face on the floor. The Action/Intervention Section of the Report documented "Sent to ER for eval. Ice applied to L side of forehead." No new interventions were implemented to prevent R11 from future falls. R11's Care Plan was not revised with any new interventions to prevent him from falling in the future.</p>	F9999			

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F9999	<p>Continued From page 36</p> <p>R11's Risk Management Report dated 11/29/12 documented he was in the hallway in his wheelchair. R11 dropped a blanket on the floor and fell out of his wheelchair onto the floor. The Actions/Intervention Section of the Report documented "Inc (incident) f/u (follow-up) x 72 (hours), 15 minute (checks) x 72 (hours)." R11's Care Plan was not revised with any new interventions to address R11 from falling out of his wheelchair.</p> <p>R11's Risk Management Report dated 12/8/12 documented "CNA reported to this nurse that resident was on the floor. Upon entering room found resident on knees c (with) back against his bed." The Report documented he sustained a 0.6 cm by 0.4 cm abrasion to the top middle of his back. The Action/Intervention Section of the Report documented "Instructed resident to wait for staff assistance and not to transfer self. In bed (with) alarms in place." Z3, Former Director of Nurse's (DON) documented 15 minute checks were initiated.</p> <p>R11's Risk Management Report dated 1/6/13 at 4:15 PM documented "CNA reported to this nurse that resident was on the floor. Upon entering room found resident laying beside his bed on his L side facing the wall. Summary of Investigative Finding dated 1/7/13 documented "15 minute visual checks initiated. Call light (with) in reach. Resident educated on use of call light. Alarm continues." R11's Care Plan was not revised to address this fall and no new interventions were implemented or documented in R11's medical record to prevent R11 from falling in the future.</p> <p>R11's Significant Change MDS dated 2/8/13</p>	F9999			

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F9999	<p>Continued From page 37</p> <p>documented he had a history of falls with injuries. His Care Plan, dated 2/8/13 documented staff were to continue to apply a personal and pressure alarm and notify his family and physician if he fell. In addition, floor mats were to be placed at his bedside.</p> <p>R11's Risk Management Report dated 3/2/13 at 5:05 PM documented "CNA and North hall nurse called for this nurse to report that resident was on the floor. Found resident laying on his (R) side (with) body against the wall. Was located in front of South Nurses Station. Noted resident was bleeding. After cleansing blood noted a 1.7 cm by 2 cm ST (Skin Tear) to R (Right) elbow. Steri-strip (and) Drsg (Dressing) applied. 1.4 cm laceration by R eye. Drsg applied. 2.2 cm by 1.5 cm bruise to R side of forehead and small 0.3 cm open area above bruise. Drsg applied. Redness noted to R side of upper back." R11 complained of no pain throughout 3/2/13.</p> <p>The facility's Investigation for Fall on 3/2/13 documented R11 began to complain of pain to the right hip area on 3/3/13. R11 was sent out to the Emergency Room. R11's Xray Report dated 3/3/13 documented "Right Acute intertrochanteric femoral fracture, mildly comminuted."</p> <p>On 5/1/13, at 1:30 PM, an interview was conducted with E3, Social Service Director. E3 stated he was a member of the Interdisciplinary Care Plan Team. E3 stated the team would review trends regarding fall at least quarterly. E3 stated the team would utilize the Fall Risk Guidelines when a resident would fall. E3 stated "I know we did different things for him (R11)." E3 stated all interventions should be updated and</p>	F9999			

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F9999	<p>Continued From page 38 documented on the care plan.</p> <p>The facility's Fall Risk Guidelines, dated 4/1/11 documented "Individualized fall risk plans updated in care plan for each incident (toileting, medical reasons, behaviors, change in mental status, equipment failure, environmental factors, medication changes, and other individualized factors identified at incident)."</p> <p>2. The Physician's Order Sheet dated 4/1/13, documented R22 to have a diagnoses in part of; Diabetes, Arthritis, and Non-Alzheimer's Dementia. The most recent Minimum Data Set (MDS) dated 1/11/13, documented R22 as; Severely Cognitively Impaired, does not walk, and needs staff assistance for all transfers. The most recent Care Plan dated 12/17/12 documented; R22 at risk for falls due to Dementia and unsteady gait. Has had one fall since admission on 12/4/12. Ambulates ad lib, is incontinent, and requires staff assist for most Activities of Daily Living.</p> <p>A review of the Facility's Fall Reports from 1/1/13 through 2/10/13, documented R22 had stood up from her wheel chair and fallen 4 times. On 1/10/13 R22 stood and was lowered to floor by staff. On 1/20/13, R22 thought she was going to meet her parents and stood up from her chair and fell to floor, sustaining abrasions to her back. On 1/25/13, R22 stood up from her wheel chair, fell backwards and sustained abrasions to her head. On 2/10/13, R22 stood in the dining room and while being redirected to sit down, lost her balance and fell.</p>	F9999			

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F9999	<p>Continued From page 39</p> <p>On 2/10/13, a fall assessment documented R22 scored 18, High Risk for falling. No progressive interventions to prevent R22 from having further falls were documented on the Fall Reports or on R22's Care Plan.</p> <p>A review of the Facility's Fall Report from 2/11/13 to 4/30/13, documented R22 had slid out of her wheel chair onto the floor 8 times.</p> <p>On 2/11/13, R22 was sitting in her chair and slid forward and out of her chair. The intervention documented was for R22 to call for assistance.</p> <p>On 2/14/13, R22 slid out of her wheel chair, and a non-skid pad was applied.</p> <p>On 3/5/13, R22 attempted to stand and slid off her wheel chair seat onto the floor.</p> <p>On 3/14/13, R22 slid out of her chair onto the floor, although the non-skid pad was in place.</p> <p>On 3/15/13, R22 was in the hall by the dining room, and slid out of her wheel chair to the floor. No intervention was documented on the Fall Report. A Fall Risk Assessment dated 3/15/13, documented R22 score had increased to 20 / High Risk for falls.</p> <p>On 3/22/13, at 9:45 AM, R22 slid off her wheel chair seat again, and the intervention documented was for R22, to ask for help.</p> <p>On 3/22/13 at 3:15 PM, R22 reached for a door handle and pulled herself out of the wheel chair onto the floor.</p> <p>On 4/27/13, R22 was sitting in her wheel chair and slid off of the seat onto the floor. The report documents the anti skid pad was in place.</p> <p>On 5/2/13, at 11:15 AM, E7, Care Plan Nurse, reviewed the Care Plan dated 1/11/13, and stated "no, I did not update the care plan after R22's falls in January 2013, February 2013 or March</p>	F9999			

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F9999	<p>Continued From page 40</p> <p>2013. I was not always informed when R22 had fallen." E7, stated "I usually wait to update care plans and don't do it until the quarterly review is due. When I was trained, I was not told to update the Care Plans other than at the quarterly reviews." E7, stated she had done a quarterly update to R22's care plan about 2 weeks ago, however, it was locked in the computer, due to a virus, and could not be retrieved.</p> <p>A review of the Facility Fall Risk Guidelines dated 4/1/11, documented (in part): Individualized fall risk plans updated in care plan for each incident. Evaluation of adaptive equipment after falls.</p> <p>On 5/2/13 at 11:25 AM, E3, Assistant Administrator, reviewed R22's Care Plan dated 12/17/12, and stated, "R22 is very confused, so the intervention of R22 asking staff for help, probably won't work. R22 will scoot forward on the seat, and then she slides off onto the floor. Fortunately, R22 has not sustained any serious injury from this behavior.</p> <p>The 15 minute checks documented in the Care Plan are from an old fall, we are not doing them now. We did put anti-tippers on her wheel chair, but apparently they have not slowed down her falls. It seems the anti-skid pad in her seat hasn't done much either to slow down her sliding out of her chair. R22 also has personal alarms on and in her chair.</p> <p>I was not aware that the care plan was not updated with any of these interventions. E7 should have been printed out the updated care plan for staff to use when she wrote it 2 weeks ago. I was not aware E7, was only doing updates at the quarterly review, she should be updating</p>	F9999			

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F9999	<p>Continued From page 41</p> <p>R22's Care Plan more frequently because of her many falls. We will have to review R22's falls and options for other more effective interventions."</p> <p style="text-align: center;">B</p> <p>300.615e) 300.615f)</p> <p>Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information</p> <p>e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act [20 ILCS 2635] for all persons 18 or older seeking admission to the facility. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act)</p> <p>f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender.</p>	F9999			

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NAME OF PROVIDER OR SUPPLIER NEW ATHENS HOME FOR THE AGED			STREET ADDRESS, CITY, STATE, ZIP CODE 203 SOUTH JOHNSON STREET NEW ATHENS, IL 62264		
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F9999	<p>Continued From page 42</p> <p>These requirements are NOT MET as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure that all residents' Illinois State Police (SP) Background Checks are completed within 24 hours of admission, and / or Illinois Sex Offender (ISO), and Department of Corrections (DOC), website checks are completed shortly after admission for 4 residents (R16, R17, R18, R19) in the supplemental sample reviewed for timeliness of background checks.</p> <p>Findings include:</p> <p>On 5/2/13, at 9:30 AM, the facility documented the following background checks were completed for:</p> <p>R16, admitted 3/28/13 - SP check done 4/2/13, DOC and ISO check done 4/12/13. R17, admitted 3/22/13 - SP check not done. DOC and ISO check done 3/25/13. R18, admitted 1/24/13 - SP check not done. R19, admitted 1/04/13 - SP check done 1/14/13. DOC and ISO check done 1/7/13.</p> <p>On 5/2/13 at 10:00 AM, in an interview with E6, Office Manager, she stated "I thought the background checks were to be done within 10 days of admission, so I thought they were done on time." E6, stated that R17 and R18 were not done because they were admitted as Hospice residents. E6 stated she thought Hospice residents were excluded from background checks because of their declining physical condition.</p>	F9999			