

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2013
NAME OF PROVIDER OR SUPPLIER EASTVIEW TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 EASTVIEW PLACE SULLIVAN, IL 61951		
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F 000	INITIAL COMMENTS Complaint Investigation #1360503/IL61497 Eastview Terrace is in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities for this survey.	F 000			
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.680c) 300.682a)1)2)3)4)b)c) 300.1210b) 300.1210d)2)6) Section 300.680 Restraints c) Physical restraints shall not be used on a resident for the purpose of discipline or convenience. Section 300.682 Nonemergency Use of Physical Restraints a) Physical restraints shall only be used when required to treat the resident's medical symptoms or as a therapeutic intervention, as ordered by a physician, and based on: 1) the assessment of the resident's capabilities and an evaluation and trial of less restrictive alternatives that could prove effective; 2) the assessment of a specific physical	F9999			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F9999	<p>Continued From page 1</p> <p>condition or medical treatment that requires the use of physical restraints, and how the use of physical restraints will assist the resident in reaching his or her highest practicable physical, mental or psychosocial well being;</p> <p>3) consultation with appropriate health professionals, such as rehabilitation nurses and occupational or physical therapists, which indicates that the use of less restrictive measures or therapeutic interventions has proven ineffective; and</p> <p>4) demonstration by the care planning process that using a physical restraint as a therapeutic intervention will promote the care and services necessary for the resident to attain or maintain the highest practicable physical, mental or psychosocial well being. (Section 2-106(c) of the Act)</p> <p>b) A physical restraint may be used only with the informed consent of the resident, the resident's guardian, or other authorized representative. (Section 2-106(c) of the Act) Informed consent includes information about potential negative outcomes of physical restraint use, including incontinence, decreased range of motion, decreased ability to ambulate, symptoms of withdrawal or depression, or reduced social contact.</p> <p>c) The informed consent may authorize the use of a physical restraint only for a specified period of time. The effectiveness of the physical restraint in treating medical symptoms or as a therapeutic intervention and any negative impact on the resident shall be assessed by the facility</p>	F9999			

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F9999	<p>Continued From page 2 throughout the period of time the physical restraint is used.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</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>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:</p> <p>2) All treatments and procedures shall be administered as ordered by the physician.</p> <p>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>These REQUIREMENTS are not met as evidenced by:</p> <p>Based on interview and record review, the facility</p>	F9999			

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F9999	<p>Continued From page 3</p> <p>failed to ensure that R1 was not inappropriately physically restrained. Devices were used to restrain R1 that were not required to treat a medical symptom. After R1 was scooting and sliding out of her chair, the facility applied a seat belt restraint without assessing completely for the least restrictive device.</p> <p>The facility failed to ensure R1's physical restraint was identified, assessed and re-evaluated before applying the second physical restraint, an anti-thrust cushion, when R1 demonstrated she could slip under the seat belt restraint.</p> <p>The facility failed to obtain informed consent and obtain a physician's order with medical justification for the anti-thrust cushion.</p> <p>The facility failed to have R1 evaluated by Physical or Occupational Therapy before applying the second physical restraint, the anti-thrust cushion.</p> <p>The facility failed to take immediate action to prevent serious injuries or death resulting from the use of multiple physical restraints. This failure resulted in R1 sliding in her wheelchair and becoming entrapped with the seat belt restraint around her neck, causing strangulation and death.</p> <p>R1 was one of three residents sampled for physical restraint use in the sample of three.</p> <p>Findings include:</p> <p>The Admission Record states R1 was admitted to the facility on 1/2/12. The Physician's Orders</p>	F9999			

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F9999	<p>Continued From page 4</p> <p>Sheet (POS) dated January 2012 lists the following diagnoses: Dementia, Chronic Obstructive Pulmonary Disease, Hypertension and Diabetes Mellitus.</p> <p>The Minimum Data Set (MDS) dated 1/9/2012 documents R1 was severely cognitively impaired. The MDS states R1 required extensive assistance with two persons for bed mobility, transfers and toilet use. The MDS also states R1 used a limb restraint every day.</p> <p>R1's Nurses Notes dated 1/2/12 states R1 was admitted to the facility on 1/2/12 at 2:30 PM. Nurses Notes at 5 PM states " ... (R1) slides down in chair and frequent repositioning is required.....Talked with family and consent for belt restraint received." The Physician's Telephone Order dated 1/2/12 at 5 PM reads "May use belt restraint when in wheelchair for patient's safety-release for 10 minutes and reposition every two hours." The nurses note contains no documented evidence of any medical symptom being treated.</p> <p>The facility's form titled "Physical Restraint/Enabler Assessment" dated 1/9/12 assesses R1 as having no problems with balance or leaning forward while sitting .The assessment continues to state "(R1) has severe cognition impairment. (R1) attempts unsafe independent transfer, (R1) has seat belt restraint to prevent injury from falls. Per family all other lesser restrictions were ineffective at previous facility." The assessment states the Diagnosis/Medical Symptoms being treated are Urinary Tract Infection and Dementia.</p>	F9999			

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F9999	<p>Continued From page 5</p> <p>E3, LPN CPC (Licensed Practical Nurse Care Plan Coordinator) stated on 2/14/13 at 3:45 PM that R1 had purposeful movement (R1 had the ability to stand if not restrained) but due to the POA (Power of Attorney) statement about previous facility placement that the facility placed a seat belt on R1. E3 stated the only other devices used was a personal alarm and 15 minute checks on R1 for two to three hours prior to applying the seat belt restraint. E3 confirmed that no other types of devices were tried as least restrictive measures for R1 prior to the application of the seat belt.</p> <p>Nurses Notes for R1 dated 1/4/12 at 4 PM state "(R1) scooting self down in wheelchair (w/c). This nurse and CNA (Certified Nurse Assistant) repositioned (R1)...."</p> <p>Nurses Notes for R1 dated 1/17/12 at 8:35 PM read "(R1) found on floor in TV Lounge. Appeared to have slipped beneath her seat belt..."</p> <p>The same Physical Restraint/Enabler Assessment dated 1/9/12 had an additional notation dated 1/17/12 stating "(R1) attempting self transfer with seat belt in place. Anti-thrust cushion initiated to prevent further attempts at unsafe transfers." E3 confirmed that Physical or Occupational Therapy never evaluated R1 for this anti-thrust cushion, that it was a nursing intervention. E3 described the anti-thrust cushion as a square seat cushion with a built up front and an indentation of a circle for (R1's) buttocks to sit in .The anti-thrust cushion allowed R1 to lean back in the wheelchair while R1's legs were elevated . This anti-thrust cushion was</p>	F9999			

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F9999	<p>Continued From page 6</p> <p>placed in the wheelchair which contained dysom (anti-slipping product) in the seat of the w/c to hold the anti-thrust cushion in place while in the chair.</p> <p>The facility could not provide documentation of a physician's order or Power of Attorney's consent for the use of the anti-thrust cushion.</p> <p>Nurses Notes completed by E7 RN (Registered Nurse) dated 1/27/12 at 5 PM states "When went into TV Lounge to check (R1)'s blood sugar I found (R1) with feet and hips on floor in front of w/c, belt restraint and (R1)'s shirt were up around her neck. Called for help and with help of CNA's the restraint was cut and (R1) was layed on floor in front of w/c. (R1) was not responsive, no pulse or respiration. (E3, CPC) in facility and notified." E6 CNA stated on 2/15/13 at 9:19 AM that when R1 was found at this time, the anti-thrust cushion was still in place in the seat of R1's wheelchair.</p> <p>Nurses Notes dated 1/27/12 at 6:15 PM states "Coroner arrived, performed initial assessment". Nurses note at 6:35 PM states "Body released to coroner."</p> <p>E3, LPN confirmed on 2/15/13 at 2:45 PM that the facility was aware that R1 slid out of the wheelchair on 1/17/12 with the seat belt still intact. E3 stated the facility decided to use the anti-thrust cushion in addition to the seat belt to keep R1 from sliding out of the wheelchair.</p> <p>R1's Care Plan dated 1/22/12 states under "Falls...(R1) has risk factors that requires monitoring and intervention to reduce potential for self injury. Risk factors include....seat belt</p>	F9999			

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F9999	<p>Continued From page 7</p> <p>restraint when up in chair, anti thrust cushion in w/c, poor gait and balance....As evidenced by history of falls." Two of the interventions for falls in the care plan states "Bring (R1) to nurse's station when out of bed for observation and encourage (R1) to sit in areas well supervised by staff .."</p> <p>E3 confirmed on 2/14/13 at 3:45 PM that R1 was found alone in the TV Lounge.</p> <p>The facility policy titled "Physical Restraint Policy" dated 10/07 states "To allow residents to be free of physical restraints which are not required to treat the resident's medical symptoms or as a therapeutic intervention. Physical restraints shall not be used for the purpose of discipline or convenience...."</p> <p>Z1, Coroner stated on 2/19/13 at 9:30 AM that R1 died from strangulation due to the seat belt restraint around her neck.</p> <p>Report of Postmortem Examination completed by Z4, Forensic Pathologist, dated February 28, 2012, section titled "Cause of Death Opinion:...The cause of death of this 93 year old white female (R1), is strangulation due to restraint belt while in overturned wheelchair. Reportedly, (R1) was found restrained in her wheelchair with it tipped over and the restraint belt around her neck. This causes asphyxiation by occluding blood supply to the brain, resulting in respiratory depression, pulmonary and cerebral edema, and ultimately cardiopulmonary arrest and death."</p> <p>(AA)</p>	F9999			

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