

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008528	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/18/2013
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NAME OF PROVIDER OR SUPPLIER SHAWNEE CHRISTIAN NURSING CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 1901 13TH STREET HERRIN, IL 62948
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S9999	<p>Final Observations</p> <p>Statement of Licensure Violations</p> <p>300.1210b) 300.1210d)3)6) 300.1220b)3) 300.3240a)</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. Restorative measures shall include, at a minimum, the following procedures:</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>3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for</p>	S9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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S9999	<p>Continued From page 1</p> <p>further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record</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>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 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>resident. (Section 2-107 of the Act)</p> <p>THESE REGULATIONS WERE NOT MET AS EVIDENCED BY:</p> <p>Based on observation, record review and interview the facility failed to collect accurate data regarding falls, identify trends and risk factors regarding the circumstances surrounding falls, failed to implement fall interventions, and monitor and modify the effectiveness of interventions that are established for residents who continued to experience multiple falls for 2 residents (R3 and R4) reviewed for falls.</p> <p>These failures resulted in R3, who receives Coumadin and Aspirin daily, falling 8 times from 08/9/13 to 10/6/13 with two of the falls resulting in an Intracranial Bleed. On 10/06/13, R3 fell out of a chair and was hospitalized in the Intensive Care Unit with an Intracranial Bleed. At the time of this survey, R3 remains hospitalized under the care of Hospice and is not expected to live, according to an interview with Z2, (Hospitalist/ Registered Nurse) on 10/17/13 at 8:50 AM.</p> <p>On 10/09/13 at 4:15 PM , E3 (Registered Nurse) provided a Resident Census Sheet dated 10/08/13 that indicated the facility has 87 of 122 residents who are considered to be at high risk to fall. E3 stated residents are considered to be at a high risk for falling if they score 10 points or higher on the facility fall risk assessment form. The Incident Logs for October 2013, September 2013 and August 2013, note R3 and R4 are the only residents who sustained multiple falls with</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>injuries.</p> <p>Findings include:</p> <p>1. R3's Physicians Order Sheet (POS) dated 10/01/13, note R3 was admitted to the facility from home on 07/26/13 with the following diagnoses: Abnormal Gait, Muscle Weakness, Difficulty Walking, Dementia with Behaviors and Atrial Fibrillation. R3's October, 2013, Physician's Order Sheet documents that since 07/26/13, R3 has been receiving Coumadin and Aspirin, blood thinning medications, daily.</p> <p>A Progress Report dated 09/26/13 notes R3 scored a 17 on the Fall Risk Assessment. The facility Fall Assessment form documents a score of 10 or above is considered to be at high risk for falls to occur.</p> <p>According to R3's Incident/Accident Reports, R3 has fallen eight times between 08/09/13 and 10/5/13, with six of those falls occurring between 4:30 PM and 9:30 PM and R3 fell from a chair during five of these six falls. All of the falls have been unwitnessed according to these Incident/Accident Reports.</p> <p>There is no evidence in the facility fall investigations, that the facility analyzed R3's falls for patterns and trends when developing interventions to prevent reoccurrence of falls. E1 (Administrator) stated on 10-10-13 at 2 PM that falls are looked at each morning for those occurring the day before and they only look at that fall and interventions to be added to the care plan.</p> <p>The falls are as follows.</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>A. The Fall reports document on 08/09/13 at 1:45 PM , R3 fell from a wheel chair in his room. The fall was unwitnessed. R3's Care Plan notes on 08/09 /13 a new intervention that staff will not leave R3 unattended while up in the wheel chair.</p> <p>B. An Incident and Accident Report dated 08/14/13 at 4:30 PM documents R3 fell from a wheel chair in his room and the fall was unwitnessed. A pressure pad alarm was sounding and alerted staff of this fall.</p> <p>The Fall Report contradicts the Incident and Accident Report regarding this same fall. This report notes R3 fell on 08/14/13 at 4:30 PM , this report does not specify if R3 was in bed or in a chair. The Fall Report notes E12 (Certified Nurse Aide) and E13 (Certified Nurse Aide) witnessed the fall. An undated Investigation Conclusion relating to the 08/14/13 fall notes, R3 was in a wheel chair in his room and staff found him laying on the floor with the pressure alarm sounding, The plan of Action notes R3 will be toileted before and after meals.</p> <p>C. The Incident/Accident Report dated 08/14/13 at 5:40 PM documents R3 was alone in his room in a wheel chair. Staff heard the pressure pad alarm sound and found R3 standing in the doorway. Fall Report notes dated 08-14-13 at 5:40 PM indicate as staff approached R3 he fell before E11 could reach him. R3 was laying on the floor unresponsive. R3 was sent to the hospital and admitted with Intracranial Bleeding.</p> <p>The Fall report contradicts the Incident and Accident Report regarding this same fall. This report dated 08/14/13 at 5:40 PM notes E12</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>(Certified Nurse Aide) heard an alarm going off, saw R3 in the doorway of his room and he fell over onto floor in the hallway and was unresponsive. The Post Fall Investigation for R3's 08/14/13 fall at 5:40 PM indicates R3 tripped while ambulating in the hall way. Page two of this report notes R3 was laying in bed watching television at 5:30 PM when staff last saw R3. The Investigation Summary dated 08/14/13 notes R3 was sitting in his room watching television when a CNA (not specified who) last saw R3. The recommended interventions noted, on the undated, Post Fall Management form regarding the fall R3 sustained on 08/14/13 at 5:40 PM, is to increase activities with supervision,. The Care Plan initiated on 08/02/13 that was revised on 10/07/13 does not include an intervention to increase activities with supervision. The undated MDS Kardex Report, that hangs on R3's closet door, does not include an intervention to increase activities with supervision for R3,</p> <p>D. According to the facility Incident/Accident Report dated 09/06/13 at 6:45 PM, R3 fell from bed. E3 walked past the room and saw R3 on the floor. R3 was not injured according to this incident report. R3's Care Plan dated 08-02-13 does not address a plan with interventions to keep R3 from self-transferring nor is there an assessment to determine if there are common factors with R3's falls. No new interventions were added to this Care Plan.</p> <p>E. According to the facility Incident/Accident Report dated 09/12/13 at 6:00 PM, R3 fell from the wheel chair in the dining room. Staff heard the alarm sound and saw R3 stand up and fall backwards. R3 was not injured according to this incident report. R3's Care Plan dated 08-02-13</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>does not address a plan with interventions to keep R3 from self-transferring nor is there an assessment to determine if there are common factors with R3's falls. No new interventions were added to this Care Plan</p> <p>F. According to the facility Incident/Accident Report dated 09/24/13 at 9:30 PM, R3 was alone in his room and fell out of a reclining chair, and the pressure alarm was sounding. R3 was not injured according to this incident report. R3's Care Plan dated 08-02-13 does not address a plan with interventions to keep R3 from self-transferring nor is there an assessment to determine if there are common factors with R3's falls. No new interventions were added to this Care Plan</p> <p>G. According to the facility Incident/Accident Report dated 09/27/13 R3 fell from bed at 5:30 AM. R3 was not injured according to this incident report. R3's Care Plan dated 08-02-13 does not address a plan with interventions to keep R3 from falling out of bed nor is there an assessment to determine if there are common factors with R3's falls. No new interventions were added to this Care Plan.</p> <p>H. An Incident and Accident report dated 10/05/13 at 7:00 PM notes R3 fell from a chair, hit his head and was admitted to the hospital's Intensive Care Unit with Intracranial Bleeding. The 10/05/13 Fall Report notes the fall was unwitnessed and occurred in the Activity Room. The same report also notes that the fall occurred in R3's room. During an interview with E6 (Licensed Practical Nurse) at 2:30 PM on</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>10/09/13 , E6 confirmed R3 was sitting in a high backed chair in the Activity room asleep after supper. E6 said she could not see R3 from where she was sitting, working on a computer ,at the nurses station. E6 said she heard the pressure alarm sound, when she got to where R3 was, in the Activity Room , R3 was on his hands and knees,on the floor, trying to stand up.</p> <p>E6 stated no other staff were present in the activity room at this time. E6 said two residents with Dementia (No recall of identify of residents) were sitting on the couch, beside R3's chair, when the fall occurred. E6 stated she noticed a red area to the back of R3's head. E6 said she and E7 (Licensed Practical Nurse) began to evaluate R3's Neurological Responses and when R3's Blood Pressure rose and they noticed one of R3's eyes was blood shot they sent R3 to the hospital. E6 said R3 was admitted to the hospital's intensive care unit, with a diagnosis of Intracranial Bleeding. During an observation on 10/09/13 at 1:08 PM , the nurses station computer, is approximately 25 feet away ,from the chair, in the activity area, where R3 was sitting. E6 said the chair R3 was sitting in was facing the hallway and staff could see R3 when they walked by. E6 also said R3 was on 15 minute checks.</p> <p>A Preliminary Report History and Physical dated 10/06/13, notes R3 had Intracranial bleeding causing significant mass effect in the range of 10 millimeters. Supertherapeutic anticoagulation was corrected due to the Intracranial Bleed, with Vitamin K. An Operative Report dated 10/06/13 notes R3 had a large chronic Subdural Hematoma causing midline shift. A Bur Hole Craniotomy for evacuation of chronic Subdural Hematoma and a Titanium Cranioplasty.</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>During an interview with Z2 (Hospitalist Registered Nurse) at 8:50 AM on 10/17/13, Z2 said R3 sustained a severe Intracranial Bleed that is expected to cause death. Z2 said R3 was admitted to the Hospice Care program on 10/07/13, and is currently in the hospital on the medical floor. Z2 said R3 was anticipated to die within one week of the Injury.</p> <p>R3's Care Plan with fall interventions initiated on 08/02/13 and revised 10/07/13 do not identify 15 minute checks as an intervention for R3's falls. The Care Plan does indicate that R3 should not be unattended while in a wheel chair. During an interview on 10/09/13 at 12:45 PM E8 (Certified Nurse Aide) stated R3 needed some one to watch him at all times 24/7 and that R3 needs one on one care. E8 said her partner had gone to lunch when R3 fell on 10/05/13 and she was helping E7,(Licensed Practical Nurse), they were in the process of sending another resident to the hospital. E8 stated they heard the chair alarm sound around 7:00 PM. E8 said she saw R3 kneeling on the floor and E 6 was assisting him.</p> <p>During an interview with E7 (Licensed Practical Nurse) at 12:45 PM on 10/09/13 she stated they kept R3 out where some one could see him at all times. E7 said R3 needed to be redirected, assisted to walk or occupied in some way at all times unless he was asleep. E7 said R3 has a very unsteady gait and is unbalanced. E7 stated on 10/05/13, R3 had been in the wheel chair but he wanted to sit in the high back chair and read the newspaper. E7 said they put him in the chair and put the pad alarm in place. E7 said the last time she saw him it was around 6:45 PM and he was looking at a newspaper.</p>	S9999		
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S9999	<p>Continued From page 9</p> <p>When asked what interventions are to be used with R3, E9 (Certified Nurse Aide) at 9:00 AM on 10/10/13, stated R3 needed to be in view of staff at all times. E9 said R3 required staff to assist him to walk, offer snacks, books, newspapers and busy boxes. E9 said they would try to wear him out by walking him in the evenings. E9 said she has worked at the facility for six months and when working with R3 the longer the day goes on the more active R3 gets.</p> <p>During an interview with E2 (Director of Nursing) at 3:00 PM on 10/09/13 she stated R3 is very impulsive, and not steady on his feet. R3 is not safe to to walk without assistance from staff. E2 stated if R3 is in a chair or wheel chair he should be in view at all times unless he was in bed asleep.</p> <p>On 10/10/13 at 2:55 PM, E1 (Administrator) and E2 (DON) stated the nurse on duty at the time the fall occurs completes an assessment of the resident and the circumstances surrounding the fall. The nurse fills out a post fall assessment. The Inter-Disciplinary Team comprised of the Director of Nursing , Administrator, Social Service Designee, Activity Director, Physical Therapist, and Restorative Aide, review the assessments for patterns and root cause analysis. The Inter Disciplinary Team determines what interventions to put in place after the fall occurs and they convey it to the Nurse Aides by updating the Kardex in residents rooms.</p> <p>During an interview with E14 (Licensed Practical Nurse) on 10/08/13 at 12:40 PM E14 said fall interventions are posted on the inside of resident closet doors so all staff can have easy access to the current fall interventions used to prevent falls for residents who are in the Falling Star Program.</p>	S9999		
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S9999	<p>Continued From page 10</p> <p>The MDS Kardex Report that was hanging on R3's closet door listed the following fall interventions; 08/10/13 staff are not to leave R3 unattended in the wheel chair. On 08/14/13 Resident will be toileted after meals and as needed. 09/06/13 fifteen minute checks. 09/12/13 leg rest to be removed while resident is self propelling to avoid tripping. 09/24/13 pressure pad alarm to reclining chair place resident in bed when drowsy. 09/26/13 up and dressed in wheel chair upon awakening to prevent resident from getting up unassisted. 10/05/13 resident must be in view at all times due to impulsiveness/safety.</p> <p>R3's Care Plan initiated on 08/02/13 and revised on 10/07/13 notes R3 is at high risk for falls due to impaired safety awareness, unsteady gait, impaired balance and daily use of medications that could cause dizziness. The 10/01/13 Physician Order Sheet notes R3 takes Exelon, Namenda, Lipitor, Pletal, Aspirin, and Remeron. According to the Drug Information Handbook for Nursing, 8th Edition from Lexi-Comp, these medications can cause weakness and dizziness.</p> <p>The only interventions noted on R3's Care Plan are; 08/02/13 offer and assist to the toilet frequently and as needed, 08/02/13 assist of 1 for transfers, 08/02/13 keep call light in reach, 08/02/13 monitor for side effects of medication that could cause dizziness, drowsiness, 08/09/13 remind staff not to leave resident unattended while in wheel chair, 08/13/13 elevate foot pedals while in wheel chair and alarming pressure pad to wheel chair, 08/14/13 resident will be taken to the toilet before and after meals and as needed, 09/13/13 remove wheel chair pedals while resident self propels to avoid tripping , 09/24/13 pressure pad alarm to reclining chair, place</p>	S9999		

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S9999	<p>Continued From page 11</p> <p>resident in bed when drowsy, 09/24/13, pressure pad to bed, 09/26/13 up and dressed in wheel chair upon awakening, 09/26/13 monitor neuro checks, 10/05/13 resident must be in view at all times due to impulsiveness/ safety.</p> <p>The Care Plan also notes R3 is on Anticoagulant (blood thinning) therapy due to the Atrial Fibrillation with interventions in place for staff to monitor for signs of complications of Anticoagulant therapy. The facilities fall post fall assessment do not identify R3's Anticoagulant therapy.</p> <p>2. R4's Care Plan for falls dated 04-30-13 document that R4 is high risk for falls, has balance problems while standing and walking, utilizes assistive device, has decreased muscle coordination, has change in gait pattern, has vertigo, and uses narcotics and psychotropic medications. The Physician's Order Sheet dated October, 2013 documents that R4 has Cardiovascular Disease, Dizziness, and Hemiplegia.</p> <p>R4 has been assessed as high risk for falls since 04-30-13 according to the facility fall risk assessment. According to R4's Care Plan dated 07-01-13, R4 had falls on 04-26-13 (2 falls), 06-22-13, 08-14-13 and on 09-09-13 (2 falls).</p> <p>The falls are as follows.</p> <p>A. The facility Incident/Accident Report for 04-26-13 documents, that at 7:15 PM on 04-26-13, R4 tried to get up from her wheel chair in the front lobby, the wheel chair rolled and R4 was found on the floor. The Post Fall Investigation documents that the brakes were unlocked, the chair alarm sounded during this</p>	S9999		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008528	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/18/2013	
NAME OF PROVIDER OR SUPPLIER SHAWNEE CHRISTIAN NURSING CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 13TH STREET HERRIN, IL 62948		
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S9999	<p>Continued From page 12</p> <p>incident, no injuries noted, and R4 could not indicate what had happened.</p> <p>R4's Care Plan for falls dated 04-30-13 was not updated to include a plan with interventions on the Care Plan to address R4's self transfer from her wheel chair.</p> <p>B. The second fall for R4 on 04-26-13 with no time given, indicates on the facility Investigation Conclusion documents that R4 was taken to her room by staff, the staff left the room and R4 attempted to self transfer from wheel chair to bed after the supper meal. The facility Post Fall Management Form dated 04-26-13 with no time given documents the root cause as attempted to self transfer and wanted to lie down after the supper meal. The intervention was to offer to lay R4 down after the supper meal.</p> <p>R4's Care Plan for falls dated 04-30-13 was not updated after this fall to include a plan with interventions to address how soon after the supper meal R3 is to be put to bed and R3's unsafe self- transfers after the evening meal on 04-26-13.</p> <p>C. The Investigation Conclusion to the Incident Report for R4's fall at 7:15 PM on 06-22-13 documents R4 was in her room and found to have slid out of R4's wheel chair to the floor in her room. This report documents that the root cause was that R4 slid out of the wheel chair. The intervention given was to put a non-skid fabric in her chair. There was no evaluation of what R4 was doing before the fall and/or if R4 was trying to transfer herself. R4's Care Plan for falls dated 04-30-13 does not include interventions to increase supervision after having another unobserved fall nor is there any indication that</p>	S9999		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008528	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/18/2013
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S9999	<p>Continued From page 13</p> <p>R4's medications were reviewed at that time.</p> <p>D. The facility Investigation Conclusion dated 08-14-13 documents that at 9:35 am on 08-14-13, R4 was found by staff laying on the floor after attempting to self ambulate. This report lists weakness/fainted as a predisposing physiological factor and again documents that R4 had an unobserved fall.</p> <p>Review of R4's X-ray report dated 08-14-13 documents that R4 sustained an "Acute nondisplaced fracture of medial malleolus with adjacent soft tissue swelling. In comparison to prior study, findings are new."</p> <p>The facility Post Fall Management Form for the 08-14-13 at 9:35 am fall documents a root cause determination as "Res (Resident) attempted to get self up for either toilet/bed." New interventions to be implemented were to toilet R4 every 2 hours and to lay R4 down for naps when fatigued.</p> <p>R4's Care Plan dated 07-01-13 has a problem of "Resident is High risk for falls r/t (related to) Paralysis, Poor communication/comprehension, balance problems. Interventions on this Care Plan up-dated due to the 08-14-13 fall are toilet frequently, and lay down for naps when fatigued.</p> <p>There is no plan to increase supervision to prevent R4 from self transferring nor is there any comprehensive assessment of these falls to determine if there are common factors.</p> <p>E. The facility Incident Investigation report documents a fall on 09-09-13 at 6:45 am. This report documents that R4 was found on the floor</p>	S9999		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008528	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/18/2013
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S9999	Continued From page 14 mat next to bed on the right side of the bed. No injuries were noted and R4's brace was in place to the right lower extremity according to this report. The Investigation Conclusion for this 09-09-13 fall stated, "It is believed due to the weight on the leg with the brace, she put her leg over the bed and by gravity kept moving until she landed on the mat." There is no assessment of the leg brace used since the 08-14-13 fall as an environmental hazard for R4 or any measures put in place to keep the leg in bed to prevent a reoccurrence nor is there any comprehensive assessment of these falls to determine if there are common factors. F. The facility Incident Investigation report dated 09-09-13 at 5:35 PM documents that R4 was found lying flat on her back in the short hall and R4's right leg was bent in toward her body. The root cause was determined to be that R4 was self propelling wheel chair down a slight incline. An X-ray dated 09-09-13 has findings of "A complete oblique fracture is identified involving the distal third of the right femur. Posterior medial displacement of the distal fracture fragment is noted." R4's Care Plan dated 07-01-13 has a problem of being high risk for falls. The interventions added after the 09-09-13 falls were to encourage to attend activities, offer assistance to and from meals, provide for resident needs. There is no comprehensive assessment of R4's falls to determine if there are common factors and/ issues/changes in condition that might contribute to falls nor was there a plan initiated to address R4's non-compliance with not self transferring.	S9999		

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S9999	<p>Continued From page 15</p> <p>R4's Physician's Order Sheet documents that R4 has been receiving Sonata 5mg as needed, Xanax 0.25 mg twice a day and Celexa 40 mg daily since 07-17-13. According to the Drug Information Handbook for Nursing, 8th Edition from Lexi-Comp, Sonata can have the side effect of Dizziness, Vertigo, Light Headedness; Celexa can have the side effect of Dizziness; and Xanax can have the side effect and "has been associated with falls and traumatic injury and should be used with extreme caution in patients who are at risk of these events (especially the elderly)". The facility failed to take this information into consideration as a possible contributing factor in R4's falls. E2 on 10-10-13 at 10:30 PM stated that she did not know if there were any pharmacy recommendations on these specific medications pertaining to R4's falls.</p> <p>E2, Director of Nurses, verified on 10-15-13 at 8:30 am that R4 had falls on 04-26-13, 06-22-13, 08-14-13, and 09-09-13. E2 also stated during this interview that all interventions are listed on the care plan.</p> <p>(A)</p>	S9999		