STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002679	A. BUILDING: _____ B. WING _____	12/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN VILLAGE CARE CENTER	400 SOUTH STATION ROAD GLEN CARBON, IL 62034

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S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) 300.3240a) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and	S9999		

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provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

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

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:

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Based on observation, interview and record review, the facility failed to assess, identify causative factors contributing to falls, implement individualized interventions, and modify interventions when falls continued for 3 of 16 residents (R1, R2 and R4) who were reviewed for falls, in the sample of 20. This failure resulted in R4 falling and sustaining a fracture of the thoracic vertebra.

Findings include:

1. Review of Incident Report Detail for R4 documents falls on 6/3/13, 6/10/13, 7/25/13, 8/7/13 10/10/13 and 11/24/13. Incidents were documented on R4's care plan of 4/5/13 with no new interventions implemented except for incident 10/10/13 when facility implemented an alarm on bed and wheel chair. Incident Log documented R4 fell on 11/24/13. Investigation Summary of 11/27/13 documents E8, Certified Nurse Aide (CNA) lifted R4's legs on his bed to elevate his legs and the wheelchair tipped backwards. Report documents R4 struck his head on the dresser. R4's November 2013 Physician Order Sheet (POS) documents an order to transfer R4 to the hospital for possible head injury. Hospital Physician Discharge Summary of 11/26/13 documents a diagnosis of fracture of T1 (thoracic spine) and neck collar was ordered.

Review of untitled document dated 11/27/13 done by E3 Assisted Director of Nursing (ADON) interview with E8 states she often puts R4's feet up on his bed per his request. E9 Liscenced Practical Nurse (LPN) stated R4 requests his legs put up on bed when sitting in wheelchair. E3 ADON discussed and explained to them that if R4

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request to put feet up on the bed that facility should provide a foot stool. This information is not documented on R4 care plan. An undated Fall Prevention Approaches check list form documents, "12/23/12 Patient protector, 12/14/13 Dycem and 10/10/13 Smart pad w/c (wheelchair) and bed".

Facility POLICY: FALL PREVENTION PROGRAM with reversion dated 5/8/01 documents OBJECTIVES: 2. Incorporate fall risk prevention interventions within the resident's plan of care. 3. Reduce the risk of resident falls and possible injury. PROCEDURE: 6. Any resident experiencing a pattern to fall incidents or an injury as a result of a fall shall have a Post Fall Assessment completed by a member of the safety committee.

On 12/12/13 at 12:45PM, E3 stated there is no assessment of causal factors for falls or individualized approaches. E3 stated interventions should be on R4's Care Plan.

2. The POS, dated 12/01/13, documented R2 as having the following diagnoses, in part as, Dementia and Psychosis. The Minimum Data Set (MDS), dated 11/29/13, documented R2 is moderately cognitively impaired displaying disorganized thinking requiring extensive assist of at least 2 staff for bed mobility, transfers, dressing, toilet use, hygiene and bathing. It also documented R2 has a supra-pubic catheter for the bladder and is frequently incontinent of bowel. The Fall Risk Assessment, dated 08/30/13, documented R2 as being at risk for falls with a score of 27. The Care Plan, dated 12/05/13, documented R2 as being at risk for falls "due to cognitive loss, poor safety awareness and weakness secondary to disease processes and

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taking antidepressant and antipsychotic daily." It also documented R2 is unable to use the call light effectively and unable to voice needs. It also documented approaches, in part as, "anticipate needs, assess and evaluate cause of falls, smart pad in wheelchair and bed at all times, mat on floor at bedside, monitor for any signs or symptoms of acute problems or situations that could contribute to falls."

On 05/28/13 at 7:20 PM, an incident report documented R2 was found by staff sitting on the floor next to his bed with his shirt off and trying to remove his pants. No documentation of the chair alarm sounding. The measures to prevent falls documented to do hourly checks and put R2 to bed earlier. This was not incorporated into the care plan. On 06/22/13 at 6:15 PM, an incident report documented R2 slid from wheelchair attempting to transfer himself to a dining room chair. It documented the chair alarm was sounding and staff present. The measures to prevent falls documented monitor closely, when restless offer walking or toileting. This was not incorporated into the care plan. On 07/07/13 at 1:40 AM, an incident report documented R2 was found sitting on the floor next to his bed. It documented the bed alarm was sounding. The measures to prevent fall documented "continue current care plan." This was not incorporated into the care plan. On 07/23/13 at 10:30 PM, an incident report documented R2 was found on the floor on the mat next to his bed. It documented the bed alarm was sounding. The measures to prevent falls documented frequent visual checks. On 08/27/13 at 10:40 PM, an incident report documented R2 was found on the floor in the doorway of his room. It documented the bed alarm was sounding. The measures to prevent falls documented place on hourly visual checks.

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S9999	Continued From page 5 On 09/09/13 at 7:00 AM, an incident report documented R2 was found lying on the floor with socks on. It documented that the alarm was not sounding and not on the bed. The measures to prevent falls documented staff educated regarding use of alarms. In all of these falls, there was no documentation of the causative factors or assessments and interventions put into place after each incident. On 12/10/13 at 12:45 PM, R2 was observed in the TV area of the 100 and 200 unit. R2 was attempting to propel himself out into the hall and staff brought him back to the TV area and tilted his chair back so that his feet were approximately 4 inches off the floor. R2 was then observed trying to push his bottom forward to touch the floor with his feet. Then E4, CNA took R2 to his room. At 1:05 PM, E4 was observed to tilt R2's wheelchair back due to him trying push his bottom forward out of the chair. Even after tilting the chair back, R2 continued to push his bottom forward to the edge of the chair. E4 stated that they (staff) has to tilt his chair back when he's restless sometimes or he'll fall out of his chair. E4 used a sit to stand mechanical lift to transfer R2 to the toilet. At 1:25 PM, E4 stepped out of the bathroom, leaving R2 sitting on the toilet alone for approximately 3 minutes. On 12/12/13 at 12:45 PM, E3, DON (Director of Nursing) stated that staff are not assessing for alarm effectiveness when a resident falls. She stated that staff are putting alarms on those residents after they fall the first time without assessing the causative factors first. She stated that staff are applying alarms to notify staff when a resident is moving around. She also stated that falls are still occurring despite the alarms.	S9999		

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S9999	Continued From page 6 3. R1's Minimum Data Set, dated 10-13-13, documented severe cognitive impairment and total dependence of one to two person's physical assistance with mobility and transfer. R1's Care Plan, start date 7-10-13, documented, in part, that R1 was at risk for falling related to poor safety awareness and history of falls. R1's Incident Report Detail, dated 9-12-13, documented R1 was observed lying on the floor in her room. R1 was not documented as incurring an injury; however, the Incident Report documented "staff educated re safety with geri chairs." R1's Care Plan, entry date 9-12-13, documented "Staff re-educated to be sure chair is reclined and that she is not in room alone." R1's Event Report, dated 11-4-13, documented R1 slid out of her chair onto her right side. It was also noted that R1 was crying in pain/fear resulting in a reduction of range of motion in her right shoulder. R1's Event Report also documented, "staff notified to make sure tilt-recliner chair is in tilt position. not full erect, with Dysom pad." R1's Care Plan, dated 11-4-13, documented "fell 8:15a.m. in studio from w/c (wheel chair)". R1's Care Plan, dated 9-12-13 and 11-4-13, and chart documented that both R1's falls occurred as a result of improper chair placement. R1's chart did not document fall assessments nor causative factors of R1's falls in relationship potential interventions to prevent further falls from her chair. (B)	S9999		