

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001028	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2013
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NAME OF PROVIDER OR SUPPLIER BLU-FOUNTAIN MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1623 29 WEST DELMAR GODFREY, IL 62035
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S9999	<p>Final Observations</p> <p>STATEMENT OF LICENSURE VIOLATIONS 300.610a) 300.696a) 300.696c)2)7) 300.1210b) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>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.</p> <p>Section 300.696 Infection Control</p> <p>a) Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed.</p> <p>c) Each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention,</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>United States Public Health Service, Department of Health and Human Services (see Section 300.340):</p> <p>2) Guideline for Hand Hygiene in Health-Care Settings</p> <p>7) Guidelines for Infection Control in Health Care Personnel</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>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> <p>Based on observation, interview, and record review, the facility failed to follow standard and contact isolation precautions/ protocols when caring for residents with infections, failed to clean and disinfect medical equipment, failed to implement ongoing surveillance of employee isolation practices for residents with Clostridium difficile (C-diff) and failed to track and trend an outbreak of upper respiratory infections (URI). This has the potential to affect all of the 56</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>residents living in the facility.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The facility's policy and procedure entitled, Gastrointestinal Tract Infections, dated 4/01/07, documents, in part, "The facility is committed to providing a safe and healthy environment for residents and to minimize or prevent the spread if infections. PURPOSE To minimize the risk of gastrointestinal tract infections to residents by: Surveillance for signs and symptoms; diagnosis; hygiene and precautions. PREVENTION Stress hand washing (even if gloves are worn) for employees and residents after touching feces or items soiled with feces, or after providing personal care for the infected resident." 2. The facility's policy and procedure dated 4/01/07 and entitled, 'Initiating Isolation' documents, in part, "Isolation precautions are required for certain infected residents to prevent the spread of disease to other residents, employees and visitors. PROCEDURE Place necessary equipment and supplies in the room that will be needed during isolation. Maintain isolation precautions until no longer indicated." 3. The Center for Disease Control, CDC, guidelines documents under 11.1 Environmental Measures "Certain pathogens (e.g.....C. difficile) may be resistant to some routinely used hospital disinfectants. Also, since C. difficile may display increased levels of spore production when exposed to non-chlorine based cleaning agents, and the spores are more resistant than vegetative cells to commonly used surface disinfectants, some investigators have recommended the use of 1:10 dilution of 5/25%...hypochlorite 	S9999		

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S9999	<p>Continued From page 3</p> <p>(household bleach) and water for routine environmental disinfection of rooms and with patients with C. difficile when there is continued transmission."</p> <p>4. The facility policy entitled, 'Hand washing' documents, in part, "PURPOSE-Medical asepsis to control infection. To reduce transmission of organisms from resident to resident. To reduce transmission from nursing staff to resident. To reduce transmission of organisms from resident to nursing staff. Wash hands before and after resident contact. Wash hands when soiled."</p> <p>5. The facility policy and procedure dated 4/01/07 and entitled, 'Standard Precautions' documents, in part, "All employees are expected to practice standard precautions. Purpose-To reduce both the risk of transmitting infections and the likelihood of exposure to blood-borne pathogens. Wash hands after touching or coming in contact with blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn. Wash hands immediately after gloves are removed, before and after resident contacts, and when otherwise indicated to avoid transfer of microorganisms to other residents or environments. Gloves: Change gloves between tasks and procedures on the same resident and after contact with material that may contain a high concentration of microorganisms. Remove gloves and discard properly after use, and wash hands immediately before touching non-contaminated items and environmental surfaces, and before going to another resident."</p> <p>6. In an interview on 10/29/13 at 8:50 AM, during the initial tour of the facility, E17, Minimum Data Set (MDS)/ Care Plan Coordinator, stated R6 and</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>R7 are a married couple rooming together. R6 is on isolation for C-diff.</p> <p>R7's Physician's Progress Note, dated 10/16/13 documents, in part, the diagnoses Multiple Sclerosis, Quadriplegia, Diabetes, Pressure Ulcers, Neurogenic Bladder with Indwelling Catheter, and Intestinal Perforation with Colostomy.</p> <p>An interview was conducted on 10/30/13 at 1:05 PM with R6, R7, and Z5 (R6's grandson). R6 and R7 both agreed they did not want to be separated, and they wanted to stay in the same room together. R6 said the nurses have talked to them about C-diff. Z5 said he took his grandparents to the doctor yesterday. Z5 stated, "No one has given me any education about C-diff except for my grandma."</p> <p>7. On 10/29/13 at 1:32 PM, E11, Certified Nurses Aide (CNA) had on gloves and was assisting R6 while toileting. E11 was not wearing an isolation gown. R6 had a loose bowel movement (BM) on the toilet. At that time, R6 stated she (R6) is incontinent of bowel at times since having C-diff. R6 stood up from the toilet while E11 used disposable wipes to clean R6's rectal area. E11 had on the same soiled gloves as she touched the tube of barrier cream and applied the cream to R6's buttocks. In an interview on 10/29/13 at 1:32 PM, E2, Director of Nursing (DON) stated, "I expect them to use gown and gloves if they are doing anything to do with BM for (R6)."</p> <p>8. On 10/30/13 at 8:16 AM, E15, Licensed Practical Nurse (LPN), used a glucometer from his medication cart to check R6's blood sugar. E15 placed the glucometer directly on R6's over</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>administration on 10/30/13, at 3:40 PM, E13, LPN removed a glucometer from the top drawer of her medication cart and set it on top of the cart. E13 applied gloves, picked up the glucometer and entered R15's room to obtain a blood sample. After obtaining the blood sample and the results, E13 left R15's room and used the same gloves to unlock the medication cart. E13 used a wet bleach wipe to cleanse the glucometer for less than 15 seconds, then placed it directly on the top of the medication cart to dry. The glucometer remained wet for less than 15 seconds. After E13 drew up insulin into a syringe, she applied gloves and administered it to R15 at 3:15 PM. E13 removed her gloves and then touched R33's (R15's roommate) wheelchair to pull her backward without cleansing or washing her hands.</p> <p>At 3:50 PM, E13 cleansed her hands with sanitizer, took the same glucometer, used previously on R15 from the top of the cart and placed a testing strip into the glucometer. E13 applied gloves and re-entered the room to obtain a blood sample from R33 at 3:53 PM. E13 placed the glucometer on the top of the cart, removed her gloves and cleansed her hands. After administering insulin by injection to R33 at 3:55 PM, E13 removed her gloves, unlocked the medication cart, then cleansed her hands. E13 failed to cleanse or disinfect the glucometer after use on R33.</p> <p>At 4:00 PM, E13 prepared a medicated inhalation solution for R16 and used a stethoscope to check R16's pulse, then placed the stethoscope on her neck. E13 attached the face mask and receptacle containing the medication on R16's face and turned on the nebulizer machine without wearing gloves. E13 then left R16's room. E13 did not</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>cleanse her hands.</p> <p>At 4:05 PM, E13 obtained a different glucometer that had been sitting on top of the medication cart, prepared the testing strip and applied gloves. E13 entered R6's room and lanced her forefinger to obtain a blood sample. E13 did not wear a protective gown. A small red sign on the outer left door frame of R6's room read, "STOP See nurse for instructions". PPE was located in a container outside R6's room. In an interview at that time, E13 reported R6 was on contact isolation for the bacteria C-diff in her stool. E13 removed her gloves and brought the glucometer from R6's room and placed it directly on the medication cart without cleansing or disinfecting it. E13 failed to cleanse her hands before unlocking and opening the cart to prepare an insulin syringe for R6. E13 then briefly wiped the glucometer with a bleach wipe and placed the wet glucometer directly on the top of the cart. The glucometer remained wet for less than 15 seconds. E13 gloved, entered R6's room and administered the insulin to R6's right forearm. At 4:12 PM, E13 then removed her gloves and disposed of them in R6's room, left the room, unlocked the medication cart and cleansed her hands with sanitizer.</p> <p>At 4:15 PM, E13 applied gloves and picked up the glucometer and entered R6's isolation room to obtain a blood sample from R7. E13 removed her gloves and carried the contaminated glucometer out of the room, placing it directly on top of the medication cart. E13 prepared the insulin for R7 while wearing gloves, then entered R7's room to administer it at 4:18 PM. E13 then removed her gloves, left R6 and R7's room and disposed of them in the receptacle on the medication cart. E13 unlocked the medication</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>cart then cleansed her hands with sanitizer. E13 then cleansed the glucometer with a bleach wipe for less than 10 seconds and placed it directly on the top of the cart to dry. The glucometer remained wet for less than 15 seconds.</p> <p>At 4:20 PM, R16 came up to E13 and reported she had completed the nebulizer inhalation therapy treatment. E13 then entered R16's room and picked up the face mask, opened the base from the mask and rinsed them with water in R16's bathroom without wearing gloves. E13 place the wet mask and base into a plastic bag before washing her hands.</p> <p>At 4:25 PM, E13 placed the stethoscope from around her neck and placed it onto the top of the medication cart without sanitizing the diaphragm and bell. E13 gloved and then used the second glucometer (previously used on R6) to obtain a blood sample for R35. E13 left R35's room placing the used glucometer directly on the medication cart next to the stethoscope. E13 removed her gloves and cleansed the glucometer with a bleach wipe for less than 10 seconds, then cleansed her hands with sanitizer. The glucometer remained wet for less than 15 seconds. E13 then wiped the diaphragm and bell of the stethoscope with an alcohol wipe and placed it back on the cart.</p> <p>At no time, from 3:40 PM to 4:25 PM did E13 appropriately sanitize this glucometer to prevent the spread of infection.</p> <p>12. On 10/31/13 at 8:25 AM, E7, LPN exited R7's room (an isolation room) carrying a glucometer in her gloved hands. E7 continued to wear the soiled gloves as she touched the medication cart, opened the drawer, and placed the glucometer into the drawer. E7 did not clean the glucometer.</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>E7 stated, "No, I hadn't cleaned the glucometer after I used it." E7 removed the glucometer from the drawer, placed the glucometer directly on top of the medication cart, and wiped the front and sides of the glucometer with a bleach wipe. The glucometer remained visibly wet for 2 minutes.</p> <p>13. On 10/30/13, at 9:40 AM, E6, CNA was interviewed related to infection control policy and procedures. E6 stated she was unaware if any resident in the facility had C-diff. E6 reported information about residents with infection or in isolation is provided in morning report by the nurse on that hall.</p> <p>14. On 10/30/13, at 9:50 AM, E5 was interviewed related to infection control policy and procedures. E5 could not identify if anyone in the facility was on isolation. E5 reported no resident in the facility had an infection and the nurse would have informed her.</p> <p>15. On 10/30/13, at 10:00 AM, E7, LPN was interviewed about infection control policies at the facility. E7 incorrectly identified R6 as having Vancomycin Resistant Enterococcus (VRE) with ESBL (Extended Spectrum Beta Lactamase). E7 reported the staff are responsible for reading the 24 hour Communication Log for current information related to residents with infections and informing the CNA staff.</p> <p>16. In an interview on 10/30/13 at 10:04 AM, E34, Housekeeper explained that her manager tells her when there is anyone on isolation, but she hadn't been told about anyone on isolation at this time.</p> <p>17. In an interview on 10/30/13 at 10:31 AM, E8, CNA, stated, "if toileting (R6) need to wear</p>	S9999		

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S9999	<p>Continued From page 10</p> <p>gloves. We don't need to wear anything else. Protocol is that (R6) has her own thermometer, blood pressure cuff, and stethoscope."</p> <p>18. In an interview on 10/30/13 at 10:44 AM, E20, CNA stated after using the mechanical lift in an isolation room, "We would wipe it down with alcohol pads or sanitizing wipes that are used for pericare."</p> <p>19. In an interview on 10/30/13 at 11:00 AM, E15 stated, "I have never seen them (CNA's) gown going into (R6's) room. There should be gowns in (the isolation cart)." E15 looked in the isolation cart, but did not find any gowns. E15 stated, there were "none available. I would say they haven't been using them since they are not available."</p> <p>20. On 11/13/13, the facility provided a list of the residents that use the mechanical lift on the 100 hall as follows: R7, R11, R40, R41.</p> <p>21. On 10/30/13, at 8:50 AM, E36, Housekeeper, was cleaning R6's and R7's room. R6's was on contact isolation for C-diff. After cleansing the room, E36 removed a broom from her cart which was outside the room. E36 swept the floor and placed the broom back on the cleaning cart. E36 stated she was going to mop the floor with a floor cleaner. E36 did not mop the floor with a 1:10 ratio of bleach disinfecting solution. After mopping the floor, E36 placed the mop back into the mop bucket. She pushed the cleaning cart to the other side of the facility. E36 entered into the housekeeping room, then emptied her mop bucket water into the sink. She refilled the mop bucket with water and floor cleaner. At no time, did she disinfect the bucket or remove the broom which was used to clean R6's room. At 9:20 AM, E36 pushed her cleaning cart down the hallway.</p>	S9999		

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S9999	<p>Continued From page 11</p> <p>E36 stated she was going to continue to clean other residents' rooms.</p> <p>The Material Safety Data Sheet for the above floor cleaner used on 10/30/13 was reviewed. This cleaner did not contain bleach.</p> <p>22. On 10/29/13 at 11:40 AM, E15 used a glucometer to check R35's blood sugar. E15 placed the glucometer directly on the medication cart prior to cleaning the glucometer. E15 then wiped the glucometer with a (bleach wipe). The glucometer air dried remaining wet for less than 30 seconds. E15 did not clean the top of medication cart where the glucometer had been.</p> <p>23. The bleach wipe's label documents, in part, "Active ingredient: Sodium hypochlorite. Directions for use: Allow treated surfaces to remain wet for 5 minutes."</p> <p>24. On 11/13/13, E1, Administrator reported the following residents use the glucometers from the medication cart shared for use for the 100 hall and a portion of the 300 hall. The residents included are: R6, R7, R15, R33, and R35.</p> <p>25. The Physicians Order Sheet (POS) for 10/2013 documents R8 has diagnoses in part, of History of Septicemia with Escherichia coli and Urinary Tract Infection.</p> <p>On 10/29/13, at 1:03 PM, E8 and E9, CNA put on gloves to transfer R8 from his wheelchair using a sit to stand mechanical lift. After positioning R8 in bed, E8 and E9 used the same gloves to use the sit to stand lift to transfer R8's roommate, R9 from his wheelchair to his bed. E8 and E9 failed to change gloves, cleanse or wash their hands after care for R8, before moving on to provide care for R9.</p>	S9999		

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S9999	<p>Continued From page 12</p> <p>26. On 10/30/13, at 10:20 AM, E7, LPN prepared to do a treatment for Stage II pressure ulcers to R8's coccyx. E7 washed her hands and applied gloves. E7 removed R8's pants and the closure tabs of the incontinent brief before pulling the brief down to expose R8's buttocks. E7 pulled R8's buttocks apart with the same gloves to expose the wounds to R8's coccyx. E7 used the same soiled gloves to pick up a clean wash cloth and enter the bathroom to wet the wash cloth. E7 cleansed R8's buttocks and wounds with the cloth, removed her gloves and dried R8's buttocks and coccyx area with a clean towel. At that time, E7 stated, "I probably should have gloves on."</p> <p>On 10/30/13, at 10:25 AM, E7 washed her hands and applied gloves. E7 opened the tube of barrier cream, applied some onto her hands and applied the cream to both pressure areas. E7 used the same gloves to apply a protective barrier wipe around the cream before removing her gloves. E7 disposed of the gloves in a plastic bag, then pulled R8's brief and pants up without washing her hands.</p> <p>On 10/30/2013 at 10:27 AM, E7 washed her hands and without applying gloves, turned R8 onto his left side, removed the tabs of his incontinent brief to expose R8's right hip to check his skin condition. E7 then reapplied the tabs to the brief, pulled up his pants and repositioned R8 to his right side with a draw sheet. E7 then did the following without wearing gloves or washing her hands: placed a pillow behind R8's back, gave him the call light, placed the bed in the low position, moved the bed next to the wall, pulled back the privacy curtain, went into the hall to obtain a sheet and a blanket from the linen cart,</p>	S9999		

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S9999	<p>Continued From page 13</p> <p>folded the blanket and placed it between his feet while touching his legs, pulled the privacy curtain again, touched her clothing with both ungloved hands, touched a pillow and placed it under R8's feet, covered R8, raised up the bed with the remote control panel, picked up a towel, turned off the light and left R8's room without washing her hands.</p> <p>On 10/30/13, at 10:41 AM, after exiting R8's room, E7 opened the shower room door with her unwashed hands to dispose of the soiled linen bag. E7 then washed her hands in the shower room.</p> <p>27. The POS for 10/2013 documents a diagnosis for R3, in part, of Recurrent Urinary Tract Infection.</p> <p>On 10/29/13, at 1:05 PM, R3 stood up from her dining room chair. The chair was soaked with urine. The back of R3's pants and the inside of the right leg were soaked with urine. E14, CNA assisted R3 to sit on the toilet and removed R3's disposal incontinent brief and pants while wearing gloves. R3's pants and incontinent brief were heavily soaked with urine. E14 disposed of the wet brief. With the same soiled gloves, E14 then touched R3's soiled pants, removed R3's shoes and applied a clean brief to R3. E14 began pulling up R3's soiled and wet pants when R3 stated, "Are these the dirty ones?" E14 replied, "No", pulled up the soiled pants and put R3's shoes back on using the same soiled gloves. R3 asked E14 for wet toilet paper as she was standing holding onto a wheeled walker. E14 touched the faucet with soiled gloves to turn on and off the water, and gave R3 toilet paper that had been soaked with water. R3 wiped her front perineal area with the wet toilet paper to cleanse herself.</p>	S9999		

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S9999	<p>Continued From page 14</p> <p>E14 used the soiled gloves to give R3 some dry toilet paper.</p> <p>On 10/20/13, at 1:30 PM, E14 removed her soiled gloves and pulled up R3's clean brief and soiled pants after touching the gait belt without washing her hands. R3 propelled herself to the sink to wash her hands with E14 holding onto the gait belt. R3 then ambulated from the bathroom wearing the wet pants and sat down in her wheelchair as E14 was holding the gait belt. E14 then washed her hands and left the room.</p> <p>28. On 10/29/13, at 11:50 AM, E30, CNA, used gloves as he provided perineal care to R1. R1's adult incontinent brief was soiled with both urine and stool. E30 used the same soiled gloves to apply barrier cream. E30 continued to use the same soiled gloves as he pulled up R1's clean incontinent brief and pants, and transferred R1 into the wheelchair. E30 then removed the soiled gloves and washed his hands.</p> <p>29. On 10/30/13, the facility's Nosocomial Infection Log from 10/2012 through 10/30/13 was reviewed.</p> <p>The January 2013 Nosocomial Infection Log documents the following 18 residents had upper respiratory infections (URI's) : R1, R18, R20, R24, R38, R42, R43, R46, R47, R48, R49, R50, R51, R52, R53, R54, R55 and R56. The Log failed to document any diagnostic test were completed to determine the causative organisms of these URI's.</p> <p>On 10/31/13, at 8:50 AM, an interview was conducted with E35, Infection Control Nurse/Registered Nurse (RN). E35 stated she only gathers and documents information on the log for infection control purposes. E35 stated she</p>	S9999		

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S9999	<p>Continued From page 15</p> <p>is not responsible for tracking or trending this information. E35 stated E2, DON, is responsible for analyzing this information. When questioned why there were a large number of residents with URI's in January 2013, E35 stated at that time of year there was a lot of flu, but she was not sure what was going on during that time.</p> <p>On 11/6/13 at 1:05 PM, an interview was conducted with E2. E2 stated she and E35 were responsible for the infection control program. E2 stated she goes through the Infection Control Log and looks for patterns and trends to identify where the infections may have originated. E2 stated if they find the problem with infection control, they fix it, inservice staff and re-evaluate the system. E2 stated she thought there was a flu-type virus in the building in January 2013. E2 stated she was not sure if staff were educated on infection control procedures during this time. E2 stated she was not sure if the County Health Department were informed of the outbreak.</p> <p>On 11/7/13, at 11:00 AM, an interview was conducted with E2. E2 stated she called the County Health Department and they did not receive any notice regarding an URI outbreak in the facility in January 2013. E2 stated she could not find any documentation that inservices regarding infection control were conducted in January 2013.</p> <p>30. The facility's Inservice documentation for the past year was reviewed on 11/7/13. There is no documentation of any inservices on Infection Control or C-diff for direct care staff prior to the current survey. Housekeeping staff was inserviced for: Contaminated Isolation Rooms on 2/28/13, C-diff on 3/18/13, Infection Control on 3/29/13, PPE (Personal Protective Equipment) on</p>	S9999		

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S9999	<p>Continued From page 16</p> <p>3/29/13, Procedures for Infection Control and Introduction to Infection Control on 6/13/13.</p> <p>31. The Resident Census and Conditions of Residents, CMS 672, dated 10/29/13 documents that the facility has 56 residents living in the facility.</p> <p>(B)</p> <p>300.1210b)5) 300.1210d)6) 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.</p> <p>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.</p> <p>d) Pursuant to subsection (a), general nursing</p>	S9999		

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S9999	<p>Continued From page 17</p> <p>care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</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 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These requirements were not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to assess, identify causative factors contributing to falls; implement, monitor and modify interventions to prevent falls; provide adequate supervision to prevent falls ; and provide safe transport and transfer procedures to prevent injury for 4 of 7 residents (R3, R8, R10 and R12) reviewed for falls and injuries in the sample of 14. This failure resulted in R3 falling and sustaining a right wrist fracture.</p> <p>Findings include:</p>	S9999		

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S9999	<p>Continued From page 18</p> <p>1. R3's Physician's Order Sheet (POS) dated October 2013 documented she had partial diagnoses of Rheumatoid Arthritis, Alzheimer's Dementia, Degenerative Disc Disease, Spinal Stenosis and Osteoarthritis.</p> <p>R3' Minimum Data Set (MDS), dated 9/5/13 and 6/6/13 documents she was moderately impaired cognitively. The MDS, dated 9/5/13, documents she required extensive assistance of one staff person for transfers, ambulation and toileting. The MDS documents she was not steady and only able to stabilize with human assistance when moving from the seated to standing position, turning around, moving on and off toilet and surface-to-surface transfers.</p> <p>On 10/29/13, at 1:05 PM. E14, Certified Nurse's Aide, CNA, asked R3 to stand up from the dining room table. R3 stood, grabbed her walker and began to walk down the hallway toward her room. R3's gait was steady. At 1:20 PM, E14 assisted R3 onto the toilet. E14 exited the bathroom, closed the bathroom door and left R3 alone on the toilet unsupervised. E14 left R3 alone on the toilet for two to three minutes while gathering R3's clothes.</p> <p>On 10/31/13, at 3:05 PM, an interview was conducted with R3. R3 stated she was able to transfer herself to the toilet and from her wheelchair. R3 stated "They don't want me to, but I can."</p> <p>The facility's Occurrence Report, dated 11/8/12, documents at 11:30 AM, R3 was found sitting on the floor in Room 40. The Occurrence Report documents "Has history of transferring self and ambulating short distances without assist. Has</p>	S9999		

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S9999	<p>Continued From page 19</p> <p>unrealistic views of limitations. Resident said she wanted to sit in the library and read. She said she did this. When trying to sit back in her wheelchair, she got her footing wrong and landed on the floor. Noted resident ambulating in the hallway shortly after with assist of walker. " The Recommendation documents "Refer to restorative therapy."</p> <p>The facility's Occurrence Report, dated 1/8/13, documents at 4:20 PM, R3 was found in her room on the floor. The Occurrence Report documents "She stated that she was on the commode and slipped self to floor and scooted self to bedside to attempt to get self up off floor." The Occurrence Report documents she had been toileted at 3:45 PM. The Recommendation documents "Educate Resident regarding refusing toileting."</p> <p>R3's Care Plan was revised on 1/9/13 "Bruise noted on coccyx. Had been in B/R (Bathroom) on commode et (and) scooted to bed. Did not use B/R call light prior to fall on 1/8/13." The Care Plan documents "Notify SS (Social Service) if res (resident) refusing toileting schedule. One on ones as needed re: toileting."</p> <p>The facility's Occurrence Report, dated 5/5/13, documents at 7:35 PM, "Visitor came up to nurses station and notified me that the resident was on the floor in her bathroom. " The Report documents "When encouraged to use her call light, the resident states ' I know I should, but I don't want to bother you girls.' " The Occurrence Report documents R3 had been toileted at 7:00 PM.</p> <p>R3's Care Plan, revised on 5/6/13 documents "Reviewed care plan for falls (and) no recommendations noted at this time."</p>	S9999		

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S9999	<p>Continued From page 20</p> <p>The facility's Occurrence Report, dated 5/10/13, documents at 7:12 PM, "I was notified by CNA staff that the resident was on the floor in her room. Upon entering the room, I visually observed the resident sitting upright on the floor on her buttocks. She was close to the entry door of the room with her back facing the door." The Report documents "Had her pants and undergarment around her ankles. Noted that she was incontinent of stool. Her wheelchair was in the bathroom with wheels locked. Water was running in sink." The Report documents " Resident has history of frequent falls which often occur when she is attempting to toilet herself. Despite frequent reminders to use her call light for assistance and toileting schedule, the resident continues to transfer herself without assistance." The Occurrence Report documents she had been toileted at 6:40 PM. R3's Care Plan was not revised after this fall to implement any new interventions to prevent her from falling in the future.</p> <p>R3's Care Plan, dated 6/18/13, documents "Resident requires assistance with ambulation, transfers, dressing, personal hygiene. She has diagnosis of Alzheimer's disease. She needs verbal cueing and set up and assistance with ADLs. Currently receiving PT for strengthening following multiple falls."</p> <p>The facility's Occurrence Report, dated 6/30/13 documents "Resident noted on floor face down with blood noted on the floor. Resident remain alert and oriented times three." The Report documents "Resident noted w/o (without) shoes, socks only, disposable undergarment noted on floor. Believed to be on her way to bathroom. Noted resident on floor face down in Resident's</p>	S9999		

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S9999	<p>Continued From page 21</p> <p>own blood." The Report documents R3 was sent to the hospital.</p> <p>R3's X-ray report dated 6/30/13 documents R3 fractured her right wrist.</p> <p>R3's Fall Risk Plan of Care was revised on 6/30/13 and documents staff were to encourage R3 to wear slipper socks when up, ensure her walker was within reach when in her wheelchair or in her bed and to encourage her to call for assistance when toileting.</p> <p>The Physician's Order Sheet, dated 7/3/13, documents R3 should continue Physical Therapy and Occupational Therapy after she sustained her fracture.</p> <p>R3's Nurse's/Physician's Communication Record, dated 9/23/13, documents "Resident tried to ambulate down hall to obtain wash cloth, she stated she go woozy and fell on her right hip." R3's Narrative Nursing Notes, dated 9/23/13 at 7:30 PM, documents "Resident was ambulating down hall (without) walker and lost her balance and fell on her right hip. Another resident's family member saw her fall, denied hitting her head." The Note documents "Encouraged resident to please use her call light for assistance."</p> <p>R3's Progress Note, dated 9/24/13, documents R3 complained of right hip pain. The Note documents Z3, R3's Physician was notified and ordered an x-ray of her right hip. R3's Radiology Report, dated 9/24/13 documents she had no fracture. R3's Care Plan was not revised at this time with progressive interventions to prevent her from future falls.</p> <p>R3's Nurse/Physician's Communication dated</p>	S9999		

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S9999	<p>Continued From page 22</p> <p>11/1/13 documents at 8:00 PM, R3 fell while going from her bedroom to the bathroom. R3 did not use her call light or her walker. The report documents that staff would monitor R3 and educate her to use the call light.</p> <p>R3's Care Plan, revision dated 11/1/13, documents "Encourage resident to use call light and to use walker when up in room with assistance or may use w/c (wheelchair)." The Care Plan was not updated with any new/progressive interventions to prevent her from future falls.</p> <p>On 11/5/13, at 9:55 AM, an interview was conducted with E2, Director of Nurse's (DON). E2 stated R3 was a challenge. E2 stated R3 has been in therapy since May 2013 for strengthening. E2 stated as R3 gets stronger "there we go again." E2 stated R3 has no safety awareness. E2 stated they have not implemented any new interventions but are attempting to reinforce the old interventions.</p> <p>2. R12's Physician's Order Sheet, dated November 2013, documents he had a partial diagnosis of Stroke.</p> <p>The facility's Occurrence Report, dated 10/26/13 at 3:15 AM documents "Noted resident lying on the floor on stomach. Had been incontinent of B & B (Bowel and Bladder)."</p> <p>R12's Care Plan, revision dated 10/26/13, documents "Observed on floor attempting to take himself to bathroom. No injury." The Care Plan revision dated 10/28/13 documents "Scoop mattress, hi-low bed, mat on the floor."</p>	S9999		

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S9999	<p>Continued From page 23</p> <p>On 11/1/3, from 1:30 PM until 3:00 PM, R12 was lying in his bed. There was no mat on his floor.</p> <p>3. The Physician's Order Sheet (POS) for 10/13/2013 documents R8 has a diagnosis, in part of Cerebral Vascular Accident with Right Side Hemiparesis. The Minimum Data Set, dated 9/26/13, documents R8 requires extensive assistance for transfers and bed mobility.</p> <p>On 10/29/13, at 1:38 PM, R8 was seated in the dining room in his wheelchair. Multiple wound closure strips were on his right elbow covering a large skin tear with red/purple discolorations. At that time when asked, R8 stated, "The girls (Certified Nurses Aides) lost control of my wheelchair and ran me into the wall's guardrail last Friday."</p> <p>The Nurse/Physician Communication Record, dated 10/16/13, documents the incident with R8 sustaining two skin tears to his elbow, measuring 3.0 centimeters (cm) X 2.5 cm and 3 cm X 1.3 cm.</p> <p>The Nurse/Physician Communication Record, dated 10/16/13, documents, in part, "(R8) was being transported out of the cafe by staff (unidentified) in his wheelchair, resident's right arm hit a rail in the hall on side of cafe. There are 2 skin tears just below the right elbow. The area was cleansed with wound spray and (wound closure strips) are in place."</p> <p>The Occurrence Report, dated 10/16/13, at 12:00 PM, for R8 documents, in part, "Resident was being pushed by staff from the cafe and was bumped into the side rail in the hall. (E14, CNA) said the hall was very congested and she bumped the wall with (R8)".</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001028	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2013
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NAME OF PROVIDER OR SUPPLIER BLU-FOUNTAIN MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1623 29 WEST DELMAR GODFREY, IL 62035
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 24</p> <p>R8's Care Plan, dated 10/08/13, fails to document the incident including the skin tears and the treatment ordered by the physician.</p> <p>On 10/30/13, at 10:30 AM, E7, Licensed Practical Nurse (LPN) was interviewed about the skin tears to R8's right elbow. E7 stated, "I think he was being pushed in his chair, and they bumped him into the handrail. We did a change in condition for it."</p> <p>On 11/01/13, at 9:55 AM E10, Registered Nurse (RN) was interviewed about R8's skin tears to his right elbow. E10 stated, "He got it a while ago. It happened during a transfer. I heard he bumped it."</p> <p>The POS for 10/2013 and 11/2013 were reviewed on 11/01/13. There were no physician orders documented for treatment to R8's right elbow.</p> <p>On 10/29/13, at 1:03 PM, E8 and E9, CNA's transferred R8 from his wheelchair to bed with a sit to stand lift. R8's shins to both lower extremities were resting against the lift during the transfer.</p> <p>On 10/30/13, at 1:30 PM, after completing a treatment for R8's pressure ulcers a complete skin check was completed with E7. A scabbed area to R8's left shin was noted with no dressing. At that time, when asked what caused the injury to the left shin, E7 stated, "He bumped it on something."</p> <p>POS, dated 9/9/13, documented "Cleanse left lower leg with wound cleanser, apply Optifoam, dressing every 3 days and PRN till healed."</p>	S9999		

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S9999	<p>Continued From page 25</p> <p>On 11/01/13, at 9:55 AM, E12, RN was interviewed about the cause of the wound to R8's left shin. E10 stated, "It's from leaning into the sit to stand lift. I remember making sure it was clean with a (foam dressing). Now we just observe for signs and symptoms of infection."</p> <p>The Occurrence Report for R8, dated 7/17/13, at 6:30 PM, documents, in part, "Abrasion to left lower leg. Noted area coincides with rubber area on lift. Recommendation-Inservice staff on placement of legs on lift. Noted resident kicks leg out. Also apply a barrier between his legs and the lift."</p> <p>The Post Incident 72 hour Follow Up form for R8, dated 7/19/13 documents a "abrasion 4 cm X 3 cm to left lower leg." The Weekly Skin Condition Evaluation, dated 9/11/13, documents, "abrasion left lower leg." The Weekly Skin Condition Evaluation form, dated 10/02/13 documents, "scabs and abrasion in left leg." The Weekly Skin Condition Evaluation form, dated, 10/09/13, documents "scabs left leg."</p> <p>4. On 10/31/13 at 3:30 PM, R10 was sitting in his wheelchair during an activity in the dining room. R10's wheelchair did not have auto-lock brakes.</p> <p>R10's Care Plan for Fall preventions documents an intervention, dated 10/22/13, for auto-lock brakes on R10's wheelchair,</p> <p>In an interview on 11/1/13 at 10:25 AM with E17, Care Plan Coordinator, she observed and verified R10 did not have the auto-lock brakes his wheelchair.</p> <p>On 11/1/13 at 10:30 AM, E28, Maintenance</p>	S9999		

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S9999	Continued From page 26 Director, stated he did not remember getting a request to put the auto-lock brakes on R10's wheelchair. (B)	S9999		