

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002711	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/28/2014
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NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE UNIVERSITY DRIVE EDWARDSVILLE, IL 62025
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S9999	<p>Final Observations</p> <p>STATEMENT OF LICENSURE VIOLATIONS:</p> <p>300.610a) 300.1210b) 300.1210d)6) 300.1220b)2) 300.1220b)3) 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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.</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</p>	S9999		

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>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>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>2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.</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</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>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 resident. (Section 2-107 of the Act)</p> <p>THESE REGULATIONS WERE NOT MET AS EVIDENCED BY:</p> <p>Based on record review, observation and interview, the facility failed to provide effective fall interventions, measures and supervision for 4 residents (R6, R10, R16 and R15) reviewed for falls. This failure resulted in R15 incurring a fractured wrist and R10 incurring a fractured nose after repetitive falls.</p> <p>Findings include:</p> <p>1. R10's Minimum Data Set (MDS), dated 10-1-13, documented diagnoses, in part, of Alzheimer's Disease and Dementia, incontinent of urine, extensive assistance of one person physical assistance with mobility, transfer and toileting and no falls since admission.</p> <p>R10's Care Plan, created on 6-5-13, documented R10 was at a high fall risk due to, in part, weakness, impaired balance, impaired memory, decreased endurance, decreased safety</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>awareness and incontinence.</p> <p>R10's Incident/Accident Reports, dated 9-27-13 to 12-22-13, documented R10 had 8 falls. On 9-27-13, R10 was found on the floor in her room and her body alarm was not attached; On 10-8-13, R10 was found on the floor in her room in front of her wheelchair. R10's alarm was attached and sounding; On 10-23-13, R10 was found on the floor in her room. R10's alarm was on attached and sounding; On 11-15-13, R10 was found on the floor beside her bed sitting in urine. R10's alarm was attached and sounding; On 12-11-13, R10 slid down the edge of her bed and was found sitting on the floor. R10's alarm was attached and sounding; On 12-15-13 at 3:30a.m., R10 was found on the floor bedside. R10's alarm was attached and sounding; On 12-15-13, R10 leaned forward in her wheelchair and fell incurred a 3 cm laceration to the bridge of her nose and bilateral nasal bone fractures; and, On 12-22-13, R10 was found lying on her right side from a fall from her wheelchair incurred a 7 cm x 5 cm hematoma to the right side of her forehead and a 3 cm x 2 cm hematoma to her left index finger. R10's alarm was attached and sounding.</p> <p>Interview of E1, (Administrator) and E2, (Director of Nursing, DON), on 1-28-14 at 2:00p.m., E1 and E2 stated that R10 was provided interventions after her falls. E1 and E2 provided a list of her falls and documentation of interventions after each fall.</p> <p>R10's interventions did not document reassessments of the effectiveness of R10's alarm in fall prevention, a change in the type of alarms until after R10's 12-22-13 fall or addressed additional supervision needs of R10.</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>In addition, R10 was not placed on scheduled toileting until after her 12-11-13 fall.</p> <p>2. R15's MDS, dated November 2013, documented R15 required extensive assistance for transfers and a Cognitive score of 9 with range 1 -15. The Care Plan, dated 11/26/13, documented R15 as high fall risk. Fall Risk Assessment, dated 9/25/13, is scored at 15 with score of 10 or above represents HIGH RISK.</p> <p>The Accident/incident report, dated 7/29/13, documented R15 was found laying on his back on the floor in his room. R15 sustained bilateral elbow skin tears. The Accident/incident reports documents R15 was last seen in bed approximately ten minutes prior to finding R15 on the floor. According to the Accident/incident form interventions were to prevent resident from falling again is staff is to bring R15 up to nurses station and remind him he is not able to walk.</p> <p>On 8/9/13 at 8:30AM, R15 had an unwitnessed fall. The Accident/incident report for R15 documents he was last observed in a high back wheelchair in tilt back position in hall just a few minutes prior finding R15 in his room on the floor laying, flat on back. R15 sustained a 3 corner 1cm (centimeter) by 1cm skin tear with bruised area approximately 3cm by 2cm to right elbow. Incident/accident form documents interventions for R15 is to not leave him up in high back wheelchair in his room or down the hall out of staff's eyesight. Personal alarm placed r/t (related to) second fall in less than 2 weeks.</p> <p>On 9/24/13 at 11:15pm, accident/incident report documents R15 was found on the floor with back to the bathroom door and alarms sounding Left hand/wrist swollen, discolored and pain noted.</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>R15 had been in bed prior to the fall. R15's Accident/incident Form documents interventions of staff educated on promptly responding to alarms. R15 sustained a fracture of the left distal radius.</p> <p>In an interview on 1/28/14 at 2:05PM with E5 (LPN), (Licensed Practical Nurse) stated the bed alarm did go off but it took her and a CNA a few minutes to get there as they were using a mechanical lift on another resident. The Nurse was already in R15's room when E5 arrived.</p> <p>In an interview with E6 Registered Nurse (RN) on 1/28/14 at 2:10PM she stated the call light wasn't on. The bed alarm was going off. She was at the Nurses Station and didn't make it in time before R15 fell. E6 stated she was there seconds before the CNA.</p> <p>In an interview with R7, roommate to R15, on 1/28/14 at 1:00PM, he stated he was in bed and turned to look over to the door and saw R15 stand halfway from bed to bathroom and saw R15 falling backwards against the bathroom door. R7 stated he yelled for help and help took just couple of seconds to minutes to get there. R15 didn't remember if R15's bed alarm was sounding or not.</p> <p>3. R16's MDS, dated 12-17-13, documented cognitive impairment, incontinent of bowel and bladder and extensive assistance of one person physical assistance with mobility, transfer and toileting.</p> <p>R16's Incident/Accident Reports, dated 8-30-13 to 1-9-14, documented the following falls: On 8-30-13, R16 slid down her door and incurred a right elbow skin tear. R16's alarm was sounding;</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>On 10-16-13, R16 attempted to stand up from her wheel chair and slid and fell; On 10-25-13, R16 slid from her wheel chair and sat on her buttocks; On 10-28-13, R 16, attempted to get up from her wheel chair, leaned forward, moved a treatment cart, fell forward and hit the left side of her head on the wall; On 11-23-13, R16 was found on the floor against her wheel chair in the hallway with her alarm sounding; On 12-5-13, R16 was found sitting on her bottom with her back against wall. R16 had been in her wheelchair; On 12-7-13, R16 was found in the dinning room on the floor with her alarm sounding after attempting to stand up from her wheel chair; and, on 1-9-14, R16 fell from bed even with her side rails up. R16's alarm was sounding.</p> <p>Interview of E1 (Administrator) and E2 (DON), on 1-28-14 at 2:00p.m., stated, that R16 was provided interventions after her fall. E1 and E2 provided a list of interventions after each fall; R16's 11-23-13 and 1-9-14 falls. It was also noted R16's alarm was not assessed for effectiveness to prevent falls or alternative interventions after assistance wheel chair devices were attempted and were discontinued to to R16's agitation.</p> <p>4. On 01/22/14 at 9:40 AM, during tour of the facility R6 was observed sitting in a wheelchair in her room sleeping. R6 was observed to have a velcro shoulder strap harness and a chair alarm.</p> <p>The Physician Order Sheet, POS, dated January 2014, documented R6 has the following diagnoses, in part, as Alzheimer's Disease, Abnormality of Gait, Degenerative Disc Disease, Pain in Shoulder and Dementia with Behaviors. The MDS, dated 12/17/13, documented R6 as</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>having moderate cognitive impairment requiring extensive assist of at least one staff for bed mobility, transfers, ambulation, dressing, hygiene, toileting and bathing. It also documented R6 is frequently incontinent of bladder and is unable to balance self without human assist. The Fall Risk Assessment, dated 01/08/14, documented R6 was a high risk for falls. The Care Plan, dated 12/27/13, identified R6, in part, as having cognitive loss and high risk for falls due to decreased safety awareness, impaired balance, impaired memory and incontinence.</p> <p>An Incident Report, dated 05/17/13, documented R6 fell from her wheelchair and was found on the floor and transferred to the Emergency Department for evaluation for lethargy.</p> <p>An Incident Report, dated 07/04/13, documented R6 fell from her wheelchair and was found on the floor near the bathroom door in her room. The report documented R6 complained of right knee and right hip pain, however X-rays obtained were negative for fracture. The intervention listed was for R6 to not be left alone in wheelchair, body alarm to wheelchair, pull alarm to bed and lay down when sleepy.</p> <p>On 09/23/13, an Incident Report documented R6 fell from wheelchair in the dining room. R6 sustained a 3 cm hematoma to right side of forehead. The report documented the body alarm was not sounding due to R6 removing it. Interventions were listed as monitor body alarm placement and lay resident down when sleepy.</p> <p>On 10/22/13, an Incident Report documented R6 fell from her wheelchair and was found on the floor in her room near the bathroom door. The report documented R6 sustained an 11 cm</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>abrasion to her back, a 2 cm abrasion to her mid-back and skin tear to posterior lower left leg. The report also documented R6's alarm was not sounding due to the clipped string being too long and the call light was on. The intervention was to shorten the alarm string.</p> <p>On 12/27/13, an Incident Report documented R6 fell from her wheelchair and was found on the floor. The report documented R6's body alarm was not sounding due to staff not turning it on. The report documented R6 sustained two skin tears to the left hand. The interventions listed was to re-educate staff about proper use and function of the body alarm.</p> <p>On 12/30/13, a physician's order for R6 documented "Ok for shoulder harness (velcro release) to enable proper alignment in the wheelchair."</p> <p>On 01/07/14, an Incident Report documented R6 fell from her wheelchair in the dining room. The report documented the body alarm was sounding. The report documented two skin tears. The report also documented steps to prevent further incidents as shoulder strap harness to wheelchair secondary to resident leaning forward. There were no new interventions to prevent R6 from further falls.</p> <p>5. The facility's Falls Management System policy and procedure, not dated, documented, in part, "It is the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if fall occurs. Each resident is assisted in attaining or maintain their highest practicable level of function through providing the resident adequate supervision, assistance</p>	S9999		

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S9999	Continued From page 9 devices and functional programs as appropriate to prevent accidents." <p style="text-align: center;">(B)</p>	S9999		