Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001010	A. BUILDING: _____ B. WING _____	05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER OF BLOOMINGTN	1509 NORTH CALHOUN STREET BLOOMINGTON, IL 61701

(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	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1210a) 300.1210b) 300.1210d)6) 300.1220b)3) 300.2210a) 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	S9999		

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S9999	Continued From page 1 practicable level of independent functioning, and 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. 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. 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 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	S9999		

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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.

Section 300.2210 Maintenance
a) Every facility shall have an effective written plan for maintenance, including sufficient staff, appropriate equipment, and adequate supplies.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements are not met as evidenced by:

A. Based on interview and record review, the facility failed to ensure direct supervision while dressing, failed to maintain the functioning of safety alarms, and failed to implement post fall interventions for one (R19) of eight residents reviewed for falls in the sample of 22. These failures resulted in R19 falling on two separate incidents, sustaining a fractured right hip and a subarachnoid hemorrhage respectfully.

Findings include:

The Physician Order Sheet dated May 2014 for R19 documents the following diagnoses: Dementia with Behaviors, Glaucoma, Weakness and Anxiety State.

The Minimum Data Set (MDS) dated 2/7/14 documents R19 as cognitively impaired, poor

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decision making, needing cueing and supervision with decision making tasks. The same MDS documents R19 as not steady and only able to stabilize with staff assistance while walking, turning around, moving from seated to standing position, moving on and off toilet seat and surface to surface transfers. The MDS documents that R19 needs assistance of one when dressing.

R19's Interim Plan of Care dated 1/31/14 documents R19 needing the assistance of staff while dressing, during ambulation and transfers.

A facility document titled "Fall Risk Evaluation" and dated 1/31/14, 2/12/14 and 5/5/14 assesses R19 as being high risk for falls.

R19's Nursing Notes dated 2/2/14 document that R19 has behaviors and when agitated is known to tear off her safety alarms.

The facility's Accident and Incident log documents R19 falling on the following dates: 2/10/14, 2/24/14, 3/6/14, 3/20/14 and 4/20/14.

A Fall Investigation Report dated 2/10/14 (no documented time) documents that E5, Certified Nursing Assistant left R19 sitting on the edge of her bed putting socks on. E5 then heard R19 yelling for help. E5 went back to R19's room and found R19 lying on the floor. The Investigation Report states R19's bed safety alarm was not sounding. The same report documents R19 being sent to the emergency room at 9:30 am due to a shortened and rotated right leg. The investigation report states R19 was admitted to the hospital for surgical repair of a fractured right hip per the same fall investigation.

The facility's Fall Investigation Report dated

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S9999	Continued From page 4 2/24/14 at 5:45 pm documents R19 was found sitting on the floor by her bed. The investigation documents that R19 often tries to transfer herself and is frequently confused. The same report documents to continue all interventions. There were no post fall interventions documented on the investigation report. The Care Plan dated 2/24/14 for R19 documents a fall on 2/24/14 and directs staff to continue all previous interventions. The facility's Fall Investigation Report dated 3/6/14 for R19 documents at 12:19 pm that R19 was found lying on the floor by her door with a large hematoma to the right side of her head. The report documents that R19's bed alarm failed to sound. The same report documents that R19 was transported to the emergency room via ambulance at 12:30 pm for evaluation. A facility report to the State Agency dated 3/6/14 documents that R19 was admitted to the hospital on 3/6/14 with a diagnosis of Subdural Hematoma with Subarachnoid Hemorrhage. On 5/14/14 at 10:20 am E2, Director of Nursing stated the facility had no Policy or Procedure concerning safety alarms. E2 stated there was no system in place for checking the working status of alarms. E2 acknowledged that anytime an alarm fails staff should be finding out why and correcting the problem. E2 stated that to her knowledge this had not been done on R19's falls of 2/10/14 and 3/6/14. E2 stated "I guess we find out after a resident gets up or falls if the alarm is working, staff will usually come and ask for new batteries." E2 acknowledged that R19 had a history of taking her alarms off.	S9999		

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B. Based on record review and interview, the facility failed to ensure that an effective assistance device was implemented. The facility failed to provide a safe wheelchair for one (R20) of eight residents reviewed for falls in the sample of 22.

Findings include:

The Physician Order Sheet dated May 2014 for R20 documents the following diagnoses: Depression, Alcoholic Dementia with Behaviors.

R20's Minimum Data Set (MDS) dated May 2013 documents R20 with severe cognitive impairment. R20 is unable to stabilize without staff assistance during walking, turning around, and during transfers. The same MDS documents R20 at 73 inches tall (6 foot one inch).

A facility report titled "Incident and Accident Report" documents that R20 fell backward in his wheelchair on 6/18/13 at 6:30 pm. The report documents that R20 received a small hematoma to the back of his head. The investigation tool for this incident also dated 6/18/13 documents that R20 was in the wrong wheelchair.

On 5/14/14 at 3:05 pm E2, Director of Nursing stated R20 was in a different wheelchair because his regular one was broke. E2 stated the temporary wheelchair that R20 was placed in did not have anti-tippers on it. E2 stated R20 tipped back in his wheelchair and fell, striking his head and receiving a small hematoma to the back of his head.

On 5/21/14 at 11:05 am E12, Care Plan Coordinator stated that R20 has had anti-tippers on his wheelchair since she started employment

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a year ago at the facility. E12 stated "(R 20) becomes agitated and has behaviors and needs the anti-tippers because (R20) tries to stand pushing back on his wheelchair."

C. Based on observation, interview, and record review, the facility failed to ensure that R32 was provided with supervision measures to ensure safety. The facility failed to ensure that 30 minute checks were completed and documented for one of one residents (R32) reviewed for exit seeking behavior in the sample of 22.

Findings include:

R32's Physician Order Sheet (POS) dated 5/2014 documents diagnoses of Dementia with Paranoia and Bipolar Disorder. R32's Elopement Risk Assessment dated 3/23/14 documents that R32 is at high risk for elopement.

On 5/14/14 at 8:27am, R32 exited the 100 Hall door. On 5/15/14 at 8:20am and 1:25pm, R32 exited the building.

R32's Nurse's Notes dated 3/24/14, 3/31/14, 4/6/14, 4/8/14, 4/19/14, 4/23/14, 4/24/14, 4/25/14, 4/26/14, 4/27/14, 4/28/14, and 5/2/14 document R32's exit seeking behavior. R32's Physician Progress Note dated 4/9/14 documents "She (R32) wanders constantly. She (R32) is also exit seeking."

R32's Elopement Care Plan dated 3/23/14 documents that staff must "Every 30 minutes check on resident location and chart on elopement sheet."

On 5/20/14 at 8:55am, E16, Licensed Practical

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S9999	Continued From page 7 Nurse, stated that the facility has no residents currently receiving 30 minute checks. On 5/20/14 at 9:02am, E30, Certified Nursing Assistant (CNA), stated that they are not using the 30 minute check elopement sheets. On 5/20/14 at 9:50am, E2, Director of Nursing, stated that 30 minute checks are not being done or documented because R32 rarely stays in one place for 30 minutes. D. Based on observation and interview, the facility failed to ensure that one resident toilet did not leak and that nonskid strips were intact for one of 22 residents (R24) reviewed during resident room review in the sample of 22. Findings include: R24's Minimum Data Set dated 4/22/14 documents that R24 is totally dependent on staff for transfers and toileting. R24's Care Plan dated 4/22/14 documents that R24 requires a mechanical lift to transfer to the toilet. R24's Fall Risk Assessment dated 4/22/14 documents that R24 is at high risk for falls. On 5/12/14 at 7:15am and 2:00pm, and 5/13/14 at 8:00am R24's resident toilet flush mechanism permitted a constant flow of water and a large puddle of water surrounded the toilet. The water extended from the toilet to both walls, approximately eight inches on each side and 12 inches in front of the toilet. Nonskid strips were peeling up from the floor in front of the toilet. On 5/13/14 at 12:15pm, E29, Assistant Maintenance Supervisor, stated that he had not	S9999		

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S9999	Continued From page 8 been notified of R24's leaking toilet. E29 stated that he had to rebuild the tank mechanism in order to stop the leak. E29 stated that staff are supposed to complete a work order when repairs are needed. (A) 300.1230 k) Section 300.1230 Direct Care Staffing k) Effective September 12, 2012, a minimum of 25% of nursing and personal care time shall be provided by licensed nurses, with at least 10% of nursing and personal care time provided by registered nurses. Registered nurses and licensed practical nurses employed by a facility in excess of these requirements may be used to satisfy the remaining 75% of the nursing and personal care time requirements. This requirement is not met, Based on record review and interview the facility failed to meet staffing requirements for nursing and personal care for eight of 25 consecutive days reviewed. This failure has the potential to affect all 106 residents in the facility. Findings include: 1. On 5/5/14 at 1:00 pm E1, Administrator, provided a staffing spreadsheet dated 4/17/14 through 4/30/14. The spreadsheet documents the average daily census for that period of 7.64 skilled care residents and 97.86 intermediate care residents. The calculations totaled 273.65 hours of minimum direct care staff and 68.4	S9999		

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hours of licensed nurses required per 24 hours. The staffing spreadsheets and actual working schedules document the following staffing failures:

4/19/14:64 hours of licensed nurses and 256 hours of direct care staff;
4/20/14: 64 hours of licensed nurses and 250.4 hours of direct care staff;
4/26/14: 256.5 hours of direct care staff;
4/27/14:64 hours of licensed nurses and 250.5 hours of direct care staff.

2. On 5/12/14 at 12:30 pm E1, Administrator, provided staffing spreadsheets for 4/28/14 through 5/11/14. The spreadsheet documents the average daily census for that period of 7.7 skilled care residents and 97.2 intermediate care residents. The calculations totaled 272.26 hours of minimum direct care staff and 68.0 hours of licensed nurses required per 24 hours. The staffing spreadsheets and actual working schedules document the following staffing failures:

5/3/14: 261 hours of direct care staff;
5/4/14: 64 hours of licensed nurses and 256 hours of direct care staff;
5/10/14:64 hours of licensed nurses and 247.4 hours of direct care staff;
5/11/14:64 hours of licensed nurses and 224 hours of direct care staff.

On 5/5/14 at 2:20 pm and 5/14/14 at 10:00 am E1 and E2, Director of Nursing confirmed the staffing hours were accurate.

On 5/5/14 and 5/15/14 E2 submitted a written statement of how she determines staffing. E2's statement documents, "I follow the Illinois staffing

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S9999	Continued From page 10 requirements for my scheduling of staff." The Resident Census and Conditions of Resident Form dated 5/12/14 documents that 106 residents reside in the facility. (AW)	S9999		

F 323 (page 42)

1. Corrective Action Taken For Residents Affected By Deficient Practice

The facility has adopted a safety alarm policy that requires nursing staff to test safety alarms when the resident is placed in bed to verify that the alarm is working and nursing staff have been inserviced on this new policy. R 19's care plan has been revised as needed to address the resident's behavior of attempting to tear off the safety alarm including frequent checks on the safety alarm to ensure it has not been removed. Nursing staff have been inserviced on the resident's care plan for fall prevention and the need to follow the care plan.

R 20 is in a wheel chair with Anti Tippers. Nursing staff have been inserviced on the requirement that when a resident is placed in a temporary wheelchair, nursing staff must make certain that the wheel chair fits the resident and that any protective devices for the resident are present as required.

Nursing staff have been inserviced on the elopement plan for R 32 and on the need to follow that elopement plan.

The toilet in R 24's room has been repaired and the nonskid strips have been reattached to the bathroomfloor.

2. Identification of Other Residents Having Potential To Be Affected By Same Deficient Practice

The DON, Administrator and Charge Nurses have observed resident care to ensure that fall prevention care plans are being followed, that safety alarms are in place, that staff are checking safety alarms to ensure that they are functioning before putting a safety alarm in use, that residents who are using a temporary wheel chair fit the chair and that all safety devices are in place, that residents who are at risk of eloping are being checked in accordance with their elopement plan with appropriate documentation, that all toilets are properly functioning and are not leaking, and that all nonskid strips are in good repair and are in place.

3. Measures Taken to Ensure that Deficient Practice Does Not Reoccur

The facility has adopted a safety alarm policy that requires nursing staff to test safety alarms when the resident is placed in bed to verify that the alarm is working and nursing staff have been inserviced on this new policy. Nursing staff have been inserviced on the need to be familiar with each resident's fall prevention care plan and on the requirement that it must be followed with safety alarms tested and in place, that temporary wheel chairs fit the residents and have safety devices in place, that residents who are at risk of elopement are being checked in accordance with their elopement plan with appropriate documentation, that all toilets are in repair and not leaking and that all nonskid strips are in place, and that any item requiring repair must be reported to the Maintenance Supervisor in a written work order. The DON, Administrator,

Charge Nurses and QA Committee will observe resident care during regular rounds to assure that each of the above items are being followed.

4. Quality Assurance

The facility has adopted a safety alarm policy that requires nursing staff to test safety alarms when the resident is placed in bed to verify that the alarm is working and nursing staff have been inserviced on this new policy. Nursing staff have been inserviced on the need to be familiar with each resident's fall prevention care plan and on the requirement that it must be followed with safety alarms tested and in place, that temporary wheel chairs fit the residents and have safety devices in place, that residents who are at risk of elopement are being checked in accordance with their elopement plan with appropriate documentation, that all toilets are in repair and not leaking and that all nonskid strips are in place, and that any item requiring repair must be reported to the Maintenance Supervisor in a written work order. The DON, Administrator, Charge Nurses and QA Committee will observe resident care during regular rounds to assure that each of the above items are being followed.

Completion Date: 6-20-14