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
	IL6000723	A. BUILDING: _____ B. WING _____	06/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-CARLINVILLE	1200 UNIVERSITY AVENUE CARLINVILLE, IL 62626

(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) 300.1210b) 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 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: d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,	S9999		

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S9999	Continued From page 1 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 These requirements were not met as evidenced by: Based on interviews, observations and record review, the facility failed to provide adequate supervision and assistance to prevent falls for 2 of 6 residents (R10 and R11) in the sample of 15. This failure resulted in R10 falling within 24 hours of readmission following a fractured right hip repair and sustaining a fracture on the left hip 4/27/14. Findings include: 1. The Minimum Data Set (MDS) dated 4/11/14 identifies R10 to have severe cognitive impairment and independent in all activities of daily living including ambulation. According to an Occurrence Report dated 4/22/14 at 17:55 (5:55pm), R10 was found laying on her left side holding her right leg. The Occurrence Report documented that R10 was transferred to the emergency room at 6:10pm and according to a Hospital Operative Report dated 4/24/14, R10 had a right femoral neck fracture which required	S9999		

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S9999	Continued From page 2 surgical intervention. Nurses Notes written by E15, Licensed Practical Nurse (LPN) dated 4/26/14 at 1815 (6:15pm) documents that R10 returned to the facility accompanied by Z2, R10's daughter. The Nurses Notes, with no date or time, written by E15, documented "continuation: low bed + pressure pad in place", provided no explanation as to why an alarm or low bed was placed the evening on R10's readmission. There are no other nurses notes written on 4/26/14. Nurses Notes written by E16 Registered Nurse (RN) dated 4/27/14 at 2am documents "resident up to bathroom c (with) walker and 2 person extensive assist . Slow gait." The note further documented R10 "education provided on safety and call light usage." No further notes until 4:55am when the notes documents R10 "observed lying supine on floor c head near closet doors and feet near foot of bed, yelling out in pain." The physician (Z1) was notified and R10 was transferred again to the emergency room where, according to discharge records dated 4/30/14, she was diagnosed with left hip fracture. E15, LPN, on 6/12/14 at 12:10pm, stated in interview that she was the nurse who readmitted R10 from the hospital on 4/26/14 and that R10 didn't understand why she couldn't get up and walk or why she needed to use the call light to call for help. E15 stated they placed the pressure alarm and low bed due to R10 repeatedly trying to get up unassisted and that the Certified Nurses Aides (CNA) were constantly going back into her room. E15 stated they showed her how to use the call light but she "just didn't seem to understand" the purpose of the button or call light. E15 stated the daughter was here that evening	S9999		

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S9999	Continued From page 3	S9999		

and also knew R10 was trying to get up on her own. Asked how often R10 attempted to get up, E15 replied multiple times per hour. E10 stated she left work at 10pm and passed the information to the oncoming nurse.

There is no evidence the facility further assessed R10 for additional safety measures given that R10 continued to attempt to get out of bed except the alarm. On 6/12/14 at 2pm, it was noted that R10's room was not by the Nurse Station and was 2/3rds of the way down the hall. There is no evidence the facility moved R10 closer to the nurses station for closer observation. There is also no indication the facility got her up and set her in a higher traffic area for better monitoring.

On 6/12/14 at 1pm, Z1 Physician agreed that R10 would be unable to use the call light or call for help to get up due to her cognitive impairment. Z1 stated the hospital had 1:1 on her due to her constantly trying to get up and thought the hospital actually discharged her early due to that fact. Z1 also agreed that the alarm would not be a reminder for R10 to call for help also due to her cognitive impairment and that her history when she was at home was to be up a lot at night. Z1 agreed that the facility could have put a sitter with her and/or move her closer to the desk to increase monitoring.

On 6/12/14 at 3:15pm, Z2, R10's daughter stated she was at the facility the night R10 returned from the first hospitalization for the right hip fracture. Z2 stated R10 was confused and didn't understand why she couldn't get up and was unable to use her call light due to cognitive impairment. Z2 stated the hospital had trouble keeping her in bed and had actually used restraints. Z2 stated R10 repeatedly attempted to

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S9999	Continued From page 4 get up out of bed setting off the alarm and that when she left that evening, before 10pm, she told the nurse that her mother continued to constantly try to get up on her own. On 6/13/14 at 9:10am, E16 RN stated in interview that she was the only nurse in the building along with at least 4 aides the evening R10 returned from the hospital the first time. E16 stated she was told that R10 by E15 during report that R10 repeatedly tried to get up and that a low bed and bed alarm had been placed. E16 stated R10 would be unable to use the call light due to her cognitive impairment. According to the facility's policy entitled "Fall Assessment, Risk Identification and Management Policy", it is the policy of the facility to "assess each residents fall risk on admission." The Fall Assessment may address assessment of factors listed but not limited to the following: general state of health, age, sensory deficits related to hearing and vision, mobility, medications, mental status, wandering tendencies, previous falls." Interventions are based on the resident assessment and the circumstances surrounding the risk for injury or actual injury or fall and include falls related to confusion, gait/balance deficits and poor judgement or knowledge deficit among others. 2. R12's Care Plan of 5/26/14 documents R12 is a Fall Risk related to Dementia and Left hip fracture with repair. Care Plan documents R12 is a recent re-admit status post fracture from a fall. Facility Fall Details Report of 5/19/14 documents R12 lost her balance and fell on 5/19/14 and was sent to the hospital. Hospital History and Physical of 5/20/14 documents R12 was	S9999		

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S9999	Continued From page 5 ambulatory without assistance prior to the fall and fell at the Nursing Home and sustained a fractured left hip. Facility Fall Details Report of 5/30/14 documents R12 was observed sitting on the floor between bed and wall. Report documents R12's alarm was not sounding. On 6/12/14 at 4PM, E2, Director of Nursing (DON), stated that the alarm was not working due to a dead battery. (A)	S9999		

Heritage Health of Carlinville

Plan of Correction

June 30, 2014

Cycle Date: June 13, 2014

Survey Date: June 13, 2014

Provider: 145456/0048850

Preparation and submission of this plan of correction does not constitute an admission or agreement of the provider of the truth of the alleged or of the correctness of the conclusion set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirements under state and federal law.

F323:

Heritage Health of Carlinville strives to ensure that the residents' environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

1. Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice.
   A. R10 has been reassessed by therapy and is currently receiving therapy services. She remains in a low bed with a curved mattress, mat on the floor and a pressure alarm. Pain is controlled by medications. Is encouraged to remain in high traffic areas for close observation when up. Her care plan has been reviewed and updated. (F323 Attachment 27)
   B. R12 has been reassessed and is currently receiving therapy. Batteries were changed in the alarm system and alarms are checked weekly. (F323 Attachment 28)

2. How will the facility identify other residents having the potential to be affected by the same deficient practice?
   A. All residents with battery operated personal/pressure alarms are at risk.

3. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. The facility must look at the existing system and determine if a change is necessary to correct the deficiency. If a system does not exist or is a revision to an existing system is necessary then the facility must develop one.
   A. The facility currently monitors alarm function with ADL's and Repositioning of residents, this process will be continued.
   B. All new admissions will have a fall assessment done within 24 hours. (F323 Attachment 29) The Restorative Nurse and/or designee will review the assessment the first business day after which the admission took place.
   C. An in-service was provided to all licensed staff regarding resident assessment and fall interventions. (F323 Attachment 30)

4. Quality Assurance Plans to monitor facility performance to ensure corrections are achieved and are permanent.
   A. The Director of Nursing and/or Fall Team will conduct investigation of individual resident occurrence of falls in order to determine the root cause and develop resident specific recommendations for implementation toward minimizing risk of recurrence. (F323 Attachment 31)
   B. The facility has a Quality Assurance action plan to reduce the number of falls within the facility and this shall continue and be reviewed quarterly at the Quality Assurance and Assessment Committee meeting. (F323 Attachment 32)

5. Dates when corrective action will be completed 7/02/14