

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006852	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/10/2014
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NAME OF PROVIDER OR SUPPLIER ASTA CARE CENTER OF COLFAX	STREET ADDRESS, CITY, STATE, ZIP CODE 402 SOUTH HARRISON COLFAX, IL 61728
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S9999	<p>Final Observations</p> <p>STATEMENT OF LICENSURE VIOLATIONS:</p> <p>300.610a) 300.1210b) 300.1220b)10) 300.3240a) 300.3240b) 300.3240f)</p> <p>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.</p> <p>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.</p>	S9999		
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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>Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 10) Participating in the screening of prospective residents and their placement in terms of services they need and nursing competencies available.</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. b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility.</p> <p>These requirements are not met as evidenced by: A. Based on interview, observation and record review the facility failed to develop and implement adequate interventions to protect a resident (R1) after witnessed physical and verbal resident to resident abuse by R2, failed to operationalize their policies Abuse Prevention Program and Qualifications for Admissions, and failed to ensure the administrator was immediately informed of a suspected abusive incident and a</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>bruise of unknown origin, resulting in R2 having continued unsupervised access to R1. These failures affect two of nine residents (R1, R2) reviewed for abuse in the sample of nine.</p> <p>Findings Include:</p> <p>Physician's Order Sheets (POS) dated 6/2/14 document R1 and R2 were admitted to the facility on 4/23/14. The POS documents that R1 has diagnoses of Aphasia, Parkinsonism, Depressive Psychosis and Depression. R1's Minimum Data Set (MDS) dated 5/1/14 documents she is moderately cognitively impaired with memory problems and requires extensive assistance of one person with transfers and wheelchair mobility. On 7/8/14 at 2:25 E4 Certified Nurses Aide stated that 90 % of the time when she asks R1 a question R1 will not answer and when R1 does respond to questions it is usually by shaking her head yes or no.</p> <p>R2's MDS dated 5/1/14 documents that R2 is cognitively intact and requires only supervision for ambulation and transfers. Z3's Nurse Practitioner Progress Note dated 6/4/14 documents R2 has diagnoses of Alzheimer's Dementia with Psychosis and Depression.</p> <p>The Resident to Resident Physical Abuse Investigation Report dated 5/29/14 documents that on that date R2 was seen by staff members hitting R1 because R1 would not pick her feet up to be wheeled back into the facility. Social Service Notes dated 5/29/14 document "(R2) became angry when {R1} would not pick her feet up, so he began hitting her on the arm. Staff members tried to separate them and resident (R2) became angry.....Resident was put on 15 minute checks." On 7/3/14 at 1:10 PM E7 Social</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>Services Director stated R2 was upset and crying after being hit by R2 on 5/29/14 and they were separated long enough for them to calm down. At that time E7 stated R1 and R2's Power of Attorney Z4 did not want the two to be moved to separate rooms after the 5/29/14 incident. E7 stated that after the 5/29/14 incident they required the door of R1 and R2's shared room to remain open. The Physician's Order dated 5/29/14 documents a Psychiatric consult was ordered for R2 on that date.</p> <p>The Fax Cover sheet dated 5/29/14 documents that R2 became upset with R1 again at suppertime that day and shook her. The Social Service Note dated 5/29/14 documents, "(R1) and (R2) were waiting in line for the doors to open, when they opened R1 did not let go of the hand rail and R2 became angry and started shaking R1. Staff tried to intervene but R2 started to get angry. R2 would not let staff take R1 to check her out, she was crying. R2 started swinging and hitting staff. Director of Nurses took both residents to their table in the dining room and sat with them.....R1 stopped crying and finally calmed down..... (R2)called (R1) an 'a**hole'." The Physicians Orders dated 5/30/14 document R2's Seroquel (antipsychotic) dosage was increased. The progress note dated 6/4/14 documents that R2 was seen by the Psychiatric Nurse Practitioner on that date and R2's Seroquel was again increased.</p> <p>The Social Service Note dated 6/13/14 documents "(R2) taking (R1) into their room and shutting door, staff went to open door, (R1) started yelling, cursing.....staff stated they were just looking out for (R1) and (R2) stated '(R1) is a h*ll of a problem' and started cursing. Nurse came in and (R2) told her he would 'kick her a**',</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>both residents were separated until everyone calmed down....."</p> <p>The Social Service Note dated 6/27/14 documents "(R2) went to see podiatrist..... (R2) became very angry, (R2) stood up, face, lips turning blue from anger, called podiatrist 'a son of a b**ch'. Got in podiatrist's face and punched him in the face. (R2) walked out of the room and down the hallway to his room. Staff went to check on (R2), R2 shoved staff."</p> <p>On 7/3/14 at 1:00 PM E4 Certified Nurses Aide (CNA) stated she noticed a new bruise on R1's right shoulder on 7/1/14. E4 stated that she reported the bruise to E5 Nurse at 6:15 am that morning. On 7/3/14 at 1:30 PM E2 Director of Nurses stated that no one reported to E2 that R1 had a new bruise on her right shoulder. At that time E2 stated the bruise should have been immediately reported to her and investigated as an injury of unknown origin. E2 confirmed that there were no nurses notes related to R1's right shoulder bruise. On 7/3/14 at 2:20 PM E1 Administrator stated R1's right shoulder bruise was not reported to her by facility staff.</p> <p>On 7/3/14 at 1:30 PM E2 Director of Nurses confirmed that R2 hit R1 on 5/29/14 but stated she thinks R1 is safe unsupervised in the shared room with R2. E2 further stated that the door to the shared room must remain open. If staff notice that R2 is getting upset they remove R1 from the room.</p> <p>On 7/3/14 at 3:40 PM E8 Licensed Practical Nurse (LPN) stated to protect R1 from R2 they leave the door open and check on them every 15-30 minutes. On 7/3/14 at 1:30 PM E4 CNA stated they leave the door to R1 and R2's room</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>open and check on the couple about once an hour.</p> <p>On 7/3/14 at 11:10 AM R1 and R2 were in their shared resident room. At that time no staff were present in the room or hallway. On 7/3/14 at 12:55 PM R1 and R2 were seated in the day room. At that time no staff were present in the day room.</p> <p>The Behavior tracking Sheet dated 7/4/14 documents "(R2) was in the dining room for lunch and (R1) began coughing continuously and (R2) began telling (R1) to shut up multiple times with (R2's) hand in (R1's) face. (R2) said 'shut the hell up don't you get it.' Staff removed R1 from the table but she went back." The Resident to Resident Verbal Abuse Report dated 7/7/14 documents that the residents were placed on 15 minute checks.</p> <p>The Physician's Order Sheet dated 7/4/14 documents that E5 Nurse obtained an order from Z1 Physician for R2 to have Ativan 0.5 mg every 8 hours as needed for increased agitation. On 7/7/14 at 12:00 PM Z1 Physician stated that when she gave the order for R2 to have Ativan on 7/4/14 that she told the nurse that R1 and R2 should be moved to separate rooms. At that time Z1 stated the nurse told her that R1 and R2's Power of Attorney Z4 did not want the couple to be separated.</p> <p>E10's (CNA) written statement dated 7/5/14 documents "R2 came out of his room.....seemed really mad.....raised hand threateningly at E10.....we went to check on (R1) she was laying in bed bed crying, we asked if she was ok. She shook her head no. We decided to ask if she wanted to be in a different room than with (R2)</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>she shook her head yes. We asked again 'do you want to be in a different room' she again said yes." E4's written statement dated 7/5/14 documents "R2 came down hall from his room looking angry..... (R2) stated (R1) was a 'G** d**n spook'." E9's (CNA) written statement dated 7/5/14 documents, "As (R2) walked past the nurses station he threatened to hit E10.....(R2) was blue in the face."</p> <p>On 7/7/14 at 10:10 AM E11 Nurse stated that at approximately 2:00 PM on 7/5/14 the CNA's reported to her that R2 came out of his room and threatened a CNA so they went to check on R1 and found her crying in her room asking for a room change. At that time E11 stated that R1 was brought out to the nurses station. E11 stated R1 was sobbing but did not indicate that R1 had abused her. E11 stated that R1 and R2 had dinner together in the dining room that evening and were not moved to separate rooms because R1 indicated she did not want to move at bedtime. E11 went on to state that at approximately 7 PM the CNA's reported to her that they had found a new golf ball sized hematoma like bruise on R1's left shoulder. R1's Nurses Note dated 7/6/14 at 12:30 PM documents "Shoulders asymmetrical - left shoulder has bruising posteriorly and swelling. Z1's (Physician) call service notified. Resident crying - when asked why, she starts crying harder. Denies discomfort or pain."</p> <p>On 7/7/14 at 9:20 AM E1 stated that facility staff called her on 7/4/14 to tell her about the incident between R1 and R2 in the dining room. At that time E1 stated that staff told her that R2 was angry on 7/5/14 and R1 was sitting at the nurses station upset. But stated that staff did not tell her about the bruise found on R1's left shoulder or</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>that R1 had requested to move. At that time E1 stated that if she had been given all of the information regarding the 7/5/14 incident between R1 and R2 she would have instructed staff to move R1 and R2 to separate rooms. E1 further stated that staff did not follow the facility policy on reporting abuse.</p> <p>On 7/7/14 at 9:50 AM E9 stated she could not believe it when she came to work on 7/7/14 and found that R1 and R2 were still sharing a room. At that time E9 stated that R1 and R2 remained on 15 minute checks but stated "anything can happen in 15 minutes". E9 went on to state that she "did not know how bad it was until this weekend." E9 stated that R1 only speaks when R2 tells her to. E11 stated if they ask R1 if she wants fish or chicken for lunch R1 won't answer until R2 says its ok to answer.</p> <p>On 7/8/14 at 9:25 am E4 CNA stated that on 7/5/13 she called E1 and told her about the bruise on R1's left shoulder. On 7/8/14 at 9:35 am E1 stated that E4 told her about the bruise on R1's left shoulder on 7/5/13 and stated she had R1's bruises confused. E1 stated again that staff did not give her all of the information regarding the incident on 7/5/14 and again stated staff did not tell her that R1 had requested a room change.</p> <p>The Behavioral Healthcare Center Discharge Summary dated 11/20/13 prior to admission to the facility documents, "(R2) was accusing the staff of not letting him see (R1).....(R2) was also increasingly verbally and physically aggressive towards (R1). (R2) actually struck (R1) in the face knocking her to the floor at one point causing a contusion. (R2) would then argue with staff, saying he had not seen(R1) for years."</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>On 7/8/14 10:10 AM E1 Administrator stated she assumes the 11/20/13 Discharge Summary was included in the admission information when R2 was admitted to the facility. At that time E1 stated she did not know if R2 was identified as being potentially abusive towards R1 on admission. On 7/8/14 at 2:25 PM E1 could not provide an assessment of R2's abuse potential done when R2 was admitted to the facility.</p> <p>The facility policy Qualifications for Admission dated 10/29/10 states "Each potential resident is evaluated prior to admission to determine if any conditions exist that would require denial of admission." The policy further states "The following conditions/situations require denial of admission: Any person exhibiting violent behavior that is a danger to self or others."</p> <p>The Abuse Prevention Program Facility Policy states "The facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. This facility prohibits mistreatment, neglect or abuse of its residents" and "The facility is committed to protecting our residents from abuse by anyone including but not limited to facility staff, other residents.....or any other individuals." The policy further states that "Employees are required to report any incident, allegation or suspicion of potential abuse.....they observe hear about or suspect to the administrator."</p> <p>B. Based on interview and record review the facility failed to ensure an injury of unknown origin was reported immediately to the administrator for one (R6) of nine residents reviewed for abuse in the sample of nine.</p>	S9999		
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S9999	<p>Continued From page 9</p> <p>Findings include:</p> <p>2. The Report of Injury of Unknown origin dated 7/7/14 documents that on 7/5/14 at 7:30 PM R6 was found to have a bruise on her left arm that extended from her wrist to her elbow. On 7/7/14 at 2:30 PM E1 stated that she found statements written by her staff regarding the discovery of R6's bruise under her door when she arrived at work on 7/7/14. At that time E1 stated the staff should have called her on 7/5/14 when the bruise was identified.</p> <p style="text-align: center;">(A)</p>	S9999		
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Imposed

ALLEGATION OF COMPLIANCE: Please accept this plan of correction as an allegation of compliance as of July 30, 2014

F 225 (page 1)

1. Corrective Action Taken For Residents Affected By Deficient Conduct

R 2 has been discharged from the facility. R 1 now shares a room with a resident who exhibits no violent behavior.

2. Identification of Other Residents Having Potential For Being Affected By The Same Deficient Practice

For each resident who has been assessed for having the potential for physical or verbal abusive conduct, the facility has (a) reviewed the care plan for each such resident to ensure that each care plan contains appropriate interventions and approaches to address that potential behavior, (b) that staff have been inserviced on the care plans and interventions and approaches and are following the care plants, (c) that were appropriate psychiatric consults have occurred and that the orders and recommendations have been implemented, (d) that appropriate roommates have been selected for each such resident, and (e) that the required level of supervision is taking place and is being documented as required. The facility has further reviewed each residents chart for the last 60 days to verify that each injury noted was reviewed, investigated, and reported as required to ensure that no possible instance of abuse did not occur without an appropriate investigation.

3. Measures Taken To Ensure That The Deficient Practice Will Not Reoccur

In addition to the steps outlined in the Statement of Deficiencies that were taken by the facility during the course of the survey, the facility has taken the following additional steps:

- a. The facility has reviewed the Behavioral Healthcare Discharge Summary for each resident and has identified any resident who has the potential for physical or verbally abusive conduct. The care plan for each such resident has been reviewed to ensure that appropriate interventions, approaches and supervision is in place. Nursing staff have been inserviced on the care plans for any such resident.
- b. The DON and Care Plan Supervisor have been inserviced on the requirement that she/he will review the Behavioral Healthcare Discharge Summary for each resident at time of admission to ensure that any resident who is identified as having the potential for physical or verbally abusive conduct should be admitted to the facility and if admitted, have a proper care plan in place to prevent abuse from occurring.

Imposed

- c. The DON has been inserviced on the Qualifications for Admission and the requirement that she/he is not to allow any potential resident to be admitted without an assessment for abusive conduct.
- d. The DON has been inserviced on the involuntary discharge procedures and the need to implement an involuntary discharge where a resident's abusive conduct toward other residents or staff members cannot be controlled. The DON was further inserviced on the need to use the involuntary discharge procedure where directions from a guardian, power of attorney, family member or resident make the prevention of abusive conduct impossible.
- e. Nursing staff have been inserviced on the requirement that any incident, allegation, or suspicion of potential verbal or physical abusive or injury from abusive conduct must be appropriately documented and immediately reported to the Administrator and or DON.
- f. The DON and nursing staff have been inserviced on the requirement that where supervisory checks are to be conducted for a resident to prevent abusive conduct, the schedule for the checks must be documented, nursing staff must be knowledgeable as to the frequency of the required checks, and documentation must be made demonstrating that the checks are occurring as required.
- g. The inservices will be repeated on a monthly basis for the next three months and thereafter each quarter.

4. Quality Assurance

The Administrator, DON, Care Plan Coordinator, QA Committee and Admissions Coordinator will meet on a monthly basis or more often as needed to ensure that (a) no resident is admitted who exhibits violent behavior or who is a danger to others, (b) that each new resident has been assessed for potentially abusive behavior, (3) that each care plan properly addresses each residents potential for abusive conduct with appropriate interventions, supervision and approaches, (4) that proper reporting and documentation of instances of possible abuse have occurred, and (5) that nursing staff are knowledgeable about the required procedures to follow and are following those procedures.

Completion Date: July 25, 2014