STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008528	A. BUILDING: _____ B. WING _____	C 12/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAWNEE CHRISTIAN NURSING CTR	1901 13TH STREET HERRIN, IL 62948

(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: 300.1210b) 300.1210d)6) 300.1220b)3) 300.3240a) 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, 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	S9999		

attachment a statement of licensure violation

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S9999	Continued From page 1 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 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 300.3240 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) These Regulations were not met as evidenced by: Based on record review and interview, the facility failed to provide adequate supervision during periods of restlessness/drowsiness and failed to implement established interventions to prevent a fall for one resident (R2) reviewed for falls.	S9999		

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S9999	Continued From page 2	S9999		

This failure resulted when R2 fell from her wheelchair on 09/30/14 and sustained Subdural Hematomas which resulted in her death on 10/04/14. From this fall, R2 also sustained bilateral fractured clavicles. (See Post Fall Investigation, Diagnostic Imaging Report and History and Physical, all dated 09/30/14, and Death Certificate dated 10/04/14.)

On 10/01/14 the facility screened all residents with a form titled Assessment Scoring Report that identified 28 residents living at the facility that are at high risk for falls.

Findings include:

R2 was admitted to the facility on 01/29/14 according to the Admission Record face sheet. R2's diagnoses, according to an October 2014 Physicians Order Report, included Dementia without Behavioral Disturbance, Pressure Ulcer, Personal History of Falls, Hyperlipidemia, Atrial Fibrillation, Hypertension, and History of Hip Fracture. This same Report showed an order for "Alarming pressure pad to wheelchair while up" with an initiation date of 08/21/14.

R2's Care Plan with a review date of 09/30/14 showed a problem area of "High risk for falls related to gait/balance problems, general weakness, dementia, use of psych(iatric) med(ications) and diuretic, poor safety awareness, history of fall with hip fracture in April of 2013, and falls on 02/04/14, 05/27/14, 06/06/14, 06/24/14, 07/15/14, 08/02/14, 09/09/14 and 09/30/14." Corresponding interventions included "alarming pressure pad to wheelchair when up out of bed", which was added 08/21/14,

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S9999	Continued From page 3	S9999		

and "gripper socks at all times" which was added 09/09/14.

A Progress Note dated 09/29/14 stated that at 11:57 pm, R2 was restless and trying to climb out of bed, and at that time she was given Tramadol 50mg for complaints of pain. This Progress Note stated that at 1:00 am on 09/30/14 she was gotten up to her wheelchair and placed at the nurses station with a snack. The Progress Note stated that at 1:30 am the resident was found near the nurses station laying on her right side beside her wheelchair after having an unwitnessed fall. According to an Incident Report dated 09/30/14, R2 was noted to have a swollen right eye and stated she couldnt remember what had happened. This Incident Report stated R2 was sent to the emergency room at a local hospital for evaluation and treatment. This report stated that the " IDT (Interdisciplinary Team) met and an investigation was initiated. Environmental assessment was completed. (Wheel)chair alarm not in place. Resident had inadequate footwear on." A 10/6/14 statement from E5 CNA (Certified Nursing Assistant) included in the Incident Report stated that at the time of the fall "Her (R2's) wheelchair did not have a chair alarm in place." Also included in the Incident Report was a 09/30/14 written statement from E7, Licensed Practical Nurse, "There was no alarm present to wheelchair", and a statement from E7 that R2 "had been sitting in wheelchair talking and was given cookies and a drink, and resident had dozed off some". A 09/30/14 History and Physical completed by Z1, Emergency Room Physician stated the following: " Assessment: Fall injury with Intracerebral and Subdural Hemorrhage.She is at high risk of death because of her intracerebral hemorrhage leading to Encephalopathy. There is also an unexpected finding of bilateral clavicle

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fractures." A Diagnostic Imaging Report dated 09/30/14 stated: "There is a intraparenchymal hematoma in the right frontal lobe measuring up to 3.5cm x 3.6cm x 3.6cm craniocaudad with extension into the adjacent right frontal extra-axial space and along the anterior falx. There is a right frontoparietal temporal subdural hematoma measuring up to 12mm transverse, There is a left frontal parietal temporal subdural hematoma measuring up to 4mm transverse." Certification of Death Record dated 10/04/14 listed the Cause of Death as: A)Subdural Hemorrhage, due to, or as a consequence of: B) A Fall.

On 11/26/14 at 1:00 pm, E2, Director of Nurses, stated that when R2 fell on 09/30/14, a wheelchair alarm was not in place, and the fall was unwitnessed as R2 was at the nurses station without staff present. E2 stated R2 had a long history of falls including a fall with hip fracture. E2 stated that, according to the Incident Report dated 09/30/14, R2 "was wearing inadequate footwear- I'm not sure what that means exactly but my interpretation is that she was not wearing gripper socks." On 12/09/14 at 9:05 am, E8, CNA stated R2 was restless and trying to climb out of bed in spite of being toileted twice, so she got R2 up to the wheelchair around 1:00 am on 09/30/14 and did not utilize a wheelchair alarm as there were " none available which were not already in use, and we had been told not to use other residents wheelchair alarms and not to use a bed alarm in place of a wheelchair alarm." On 11/26/14 at 2:20 pm, E5, CNA, stated when R2 fell, she did not have a wheelchair alarm in place, and that she had been left unsupervised at the Nurses Station. E5 stated another CNA had gotten R2 up because she was restless and wanted to get out of the bed. E5 stated at the time of the fall, she was doing bedchecks down

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S9999	Continued From page 5 the hall with E4. On 12/03/14 at 2:20 pm, E4, CNA stated that R2 was at the nurses station without staff present with another confused resident present, and did not have a wheelchair alarm in place at the time of the fall. E4 stated she had last visually observed R2 at 1:20 am, and R2 fell at 1:30 am. On 12/09/14 at 9:15 am, E8, CNA, stated she had not witnessed the fall because she was on break and not on the unit at that time. E8 stated she had gotten R2 up to the wheelchair because she kept attempting to get out of bed and her bed alarm kept going off. E8 stated she had given the resident a snack and fluids and placed her wheelchair by the nurses station, where E7 was at the time. (AA)	S9999		

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

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Shawnee Christian Nursing Center

Imposed Plan of Correction

300.1210b) 300.1210d)6)
300.1220b)3)
300.3240a)

A. Resident assessments were reviewed to ensure that those residents who are at risk for falls have appropriate interventions on their care plans.

B. Daily audits were conducted by the DON to determine which residents were at risk for falls, to continue for a period of four weeks, and then three times weekly until the facility has sustained compliance.

C. Nursing staff were re educated on where safety equipment was located, process on when equipment is not available, process on how to maintain resident safety until correct safety equipment is available, and on the facility's Fall Policy, including preventative measures, implementing interventions after a fall, and identifying the root cause of the fall. Staff are not permitted to work until after receiving this re-education.

D. The facility reviewed residents who sustain a fall at the morning IDT meeting to determine if appropriate interventions had been implemented as well as the weekly At Risk meeting. Findings will be presented to the Quality Assurance Committee monthly for three months for review and recommendations.

E. The Maintenance Director performed audits of available safety devices, chair and bed alarms, and checked for operational ability.

F. Walking rounds were and continue to be completed by CNA's at the change of shift with visual and physical verification that correct safety tools are in place and functioning. CNA's report findings of room checks at report and nurses document on the Treatment Administration Record.

Completion date: 20 Days from Receipt of Notice

attachment B Imposed Plan of Correction