

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/05/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/01/2014
NAME OF PROVIDER OR SUPPLIER LEWIS MEMORIAL CHRISTIAN VLG			STREET ADDRESS, CITY, STATE, ZIP CODE 3400 WEST WASHINGTON SPRINGFIELD, IL 62702		
(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) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 323 SS=G	<p>Complaint #1445261/IL73330 and #1445300/IL73374: F323</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to identify hazards and risks and provide supervision to prevent avoidable accidents for one of four residents (R4)with a history of falls in a total sample of six. This failure resulted in R4 sustaining a right temporal acute subdural hematoma, small intraparenchymal hemorrhage to the right front lobe and large right scalp hematoma.</p> <p>Findings include:</p> <p>R4's Physicians Order Sheet (POS) dated 11/1/2014 to 11/30/2014, documented R4's diagnoses to include, Osteoporosis, Muscle Weakness, Personal History of Fall and Subdural Hemorrhage.</p> <p>R4's Minimum Data Set (MDS) dated 8/25/2014, documented R4's Brief Interview for Mental Status (BIMS) as 11 (Score 8-12: moderately</p>	F 323			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	<p>Continued From page 1</p> <p>impaired cognition). R4's MDS documented R4's needs extensive assistance with one person physical assist for transfers. The MDS documents R4 needs extensive assistance of two person physical assist for toileting.</p> <p>R4's Care Plan, date initiated 5/15/13, Revision date 6/3/13, documented, follow facility fall protocol/falling star program.</p> <p>The facility's Falling Star Protocol, not dated, documented, "The falling star protocol is a center based portion of the Fall Management Program. Purpose: To identify residents who are at risk for falling. To ensure residents benefit from participation. To distinguish residents with a visual identifier 'Falling Star' To include staff and families in fall prevention strategies. Protocol: A resident qualifies for the Falling Star Program if: They have fallen within 30 days prior to admission. Experience a change in condition or decline in Activities of Daily Living. Fallen in the facility. The resident is identified by a star on their name plate outside their door and on their wheelchair/walker."</p> <p>The facility's Incident Log for September documented R4 had fallen on 9/9/14 and 9/11/14. The Incident Log documented R4 did not fall in October. In November R4 fell on 11/15/14 which resulted in a hematoma to R4's forehead. On 11/16/14 R4 fell which resulted in a hematoma to R4's forehead and subdural hematoma.</p> <p>Nurse's Notes dated 11/16/14 at 2:45 PM, documented, "Writer heard slapping noise in the hallway and went down to residents room. Observed resident lying on the floor on right side with right arm under body and visible blood under</p>	F 323			

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F 323	<p>Continued From page 2</p> <p>her face. Co-nurse was present and immediately placed pillow under head. Co-nurse began first aide and cleansed area and applied cool compress to slow bleeding. Hematoma visible at left upper corner of forehead (3.5 centimeters (cm) x 4 cm), raised by 2 cm with laceration in center of hematoma. New orders were received from Personal Care Physician (PCP) to send (R4) to the Emergency Room for evaluation."</p> <p>The Hospitalization Summary dated 11/19/14, documented, included, R4 was admitted to the hospital on 11/16/14 and discharge back to the facility on 11/19/14. Cat scan of head documented "1. Small right temporal acute subdural hematoma. 2. There is a tiny, 5 millimeter intraparenchymal hemorrhage in the right frontal lobe without significant associated edema/mass effect. 3. Large right scalp hematoma. 4. Volume loss and chronic ischemic microangiopathy."</p> <p>On 11/25/14 at 10:50 AM, R4 was observed sitting in her wheelchair in the middle of 200 hallway. R4 was asking "Where am I?" R4 had a large amount of purple bruising on the top of her nose, on both right and left cheeks and under her chin. Yellowish brown bruising noted to her forehead. R4 was asked what had happened to her and replied "I fell down."</p> <p>On 11/25/14 at 10:50 AM and 3:07 PM, No falling star was observed on R4's door or R4's wheelchair.</p> <p>On 11/25/14 at 3:07 PM, E8, Licensed Practical Nurse (LPN) was asked what does it mean when a star is on one side of the door. E8 said the side of the door where the star is, means that resident</p>	F 323			

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F 323	<p>Continued From page 3</p> <p>is on the falling star program. E8 was asked why there was no star on R4's door or wheelchair. E8 said "There should be a star on R4's door and wheelchair, it must have fallen off."</p> <p>On 11/25/14 at 8:57 AM, Z1, R4's daughter/ Power of Attorney, was asked about R4's fall on 11/16/14. Z1 said, R4 was assisted to the bathroom and on the toilet riser. The staff then gave R4 the call light and left her in the bathroom alone. Z1 said the staff found R4 beside her bed on the floor with her head facing toward the foot of the bed and her pants were half way down. Z1 said she did not know how R4 managed to get from the bathroom to the bed with her pants half way down. Z1 said R4 cannot manage sitting on the toilet by herself. Z1 stated R4 needs someone to stay with her because she will just get up when she is finished and not wait for help.</p> <p>On 11/26/14 at 11:21 AM, E8 was asked if on 11/16/14 prior to R4's fall if R4 had been in the bathroom and walking back to her bed without assistance. E8 said she could have been. E8 was asked if any staff would take R4 to the bathroom and give her the call light and tell her to call for help when she was finished. E8 said, "No one was to leave her alone on the toilet because (R4) was on the falling star program and could not be left alone in the bathroom." E8 said R4 was noncompliant about turning on her call light and asking for help.</p> <p>Nurse's notes dated 9/6/14 at 1:40 PM, documented, "Resident non compliant with transfer and putting herself to bed. Nurse's Noted dated 9/6/14 at 9:29 AM, documents "Resident is non compliant with asking and waiting for help with going to the restroom or getting into bed."</p>	F 323			

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F 323	<p>Continued From page 4</p> <p>R4's Nurse's Note, on 10/26/14 at 11:02 AM, documents "Resident attempting to self transfer from her bed to the bathroom. Resident reminded that she needed assistance with ambulation and transfers." R4's Nurse's Note on 10/27/14 at 1:01 PM, documents "Resident noted to be self ambulating in her room without her walker. Resident states that she was going to the bathroom. Staff assisted resident to the bathroom. Afterwards resident was placed by the nurses station for observation."</p> <p>On 11/16/14 at 9:14 AM, Nurse's Notes documented "Resident non-compliant with waiting for help. Resident will turn her call light on but not wait for someone to help her. Resident has been explained that she really needs to wait for help so she doesn't fall again and get hurt."</p> <p>The facility's Fall Incident/Occurrence witness statement dated 11/16/14 at 2:45 PM, written by E9, Certified Nurse's Assistant (CNA) , documented, R4 was found in her restroom at 2:43 PM. E9 statement documented E9 left R4 in the restroom to see why the resident across the hall was hollering and heard the nurse running down the hall to R4's room.</p> <p>The Fall Incident/Occurrence, witness statement dated 11/16/14 at 2:45 PM, written by, E10, Registered Nurse (RN) documented "Walking by residents room as I was coming into work today and saw staff running to (R4's) room. (R4) was lying on her right side on the floor beside her bed. Her pants were half way up. Resident fell yesterday as well. Direct pressure applied to bleeding hematoma on right forehead. Bleeding stopped. Ice then applied to hematoma. Appears the resident also broke nose as septum deviated,</p>	F 323			

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F 323	Continued From page 5 swollen and bleeding. (E9) said she put R4 in her bathroom, call bell given. Resident instructed to stay there and use call bell when finished. had shoes and socks on, pants halfway up."	F 323		