STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145406	A. BUILDING _____ B. WING _____	C 05/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH COUNTY CARE CENTER	312 WEST BELMONT SPARTA, IL 62286

(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 Complaint #1442070/IL69778	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to follow the plan of care related to ambulation for one of four residents (R1) reviewed for falls in the sample of four. R1 was not being ambulated properly by staff and fell sustaining a hematoma above the eye and two abraisons across the nose . Findings include: 1. R1's Minimum Data Set (MDS) dated 1/28/14 documents R1is extensively dependent on two or more staff for transfers, ambulation, dressing, and tolieting. The MDS further documents R1's balance during transitions and walking as "not steady, only able to stabilize with staff assistance." R1's Brief Interview of Mental Status (BIMS) score was not addressed. R1's Care Plan dated 2/10/12 documents R1's goal is to transfer safely with moderate/HHA (hand held assist) x 2 staff members and to walk	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 323	Continued From page 1	F 323		

150 plus feet with HHA x 2 staff members. The Care Plan further documents R1 had a low bed, mat on floor, personal alarm, and one to one when resident is restless. R1's Care Plan documents falls on 6/23/13, 11/6/14, 11/27/13, and 1/4/14. No progressive interventions for prevention of falls were found in R1's Care Plan.

R1's Fall Risk Assessment with an initial date of 8/03/13 and a re-assessment date of 4/30/14 documents R1's fall risk score a 14 with a score of 10 or above representing high risk for falls.

R1's Functional Area of Needs Assessment with an initial date of 1/28/14 documents R1 ambulates with staff of two. Assessment further documents on 4/30/14 no changes for R1's initial assessment.

Accident/Incident report dated 6/23/13 documents R1 fell in Dining room when R1 stood up and stumbled in chair legs causing R1 to fall and hit head on the floor. R1 sustained a 6 x 7 centimenter (cm) hematoma to the occipital area. Prevention for Reoccurrence: Observe at all times while in Dining room. External Risk Factors: Position alarm in place? NO- Alarm activated? NO. Conclusion: Personal alarm on Dining room Chair

Accident/Incident report dated 11/6/13 documents R1 fell in beauty shop when R1 grabbed the door frame and pulled herself (R1) forward and chair rolled out from under causing R1 to fall and land on her left hip. Personal alarm was sounding, no apparent injuries. Conclusion: Beautician instructed to make sure there is nothing in reach for R1 to assist her up.

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F 323	Continued From page 2	F 323		

Accident/Incident report dated 11/27/13 documents R1 fell in Dining room when R1 removed personal alarm and stood up. Prevention for Reoccurrence: pin personal alarm at mid back so R1 cannot reach to remove, one to one when resident is restless.

Accident/Incident report dated 1/4/14 documents R1 was found lying on floor in Dining Room and noted to have a 5cm hematoma to back of head. Prevention for Reoccurrence: not to be left alone in Dining room. External Risk Factors: Position alarm in place- YES-Alarm activated? YES.

Accident/Incident report dated 4/3/14 documents in part, as follows: Description of Incident and Treatment Administered: "R1 was ambulating with SBA (stand by assist) of one staff member and lost balance falling to floor landing on right side hitting head. Noted bleeding from face and a 5 x 3.5 cm hematoma above right eye and 0.3 cm abrasion to center with 2 abrasions 0.1 cm and 0.2 cm to bridge of nose. Residents account of what happened: staff ambulated R1 alone. Area Accident Occurred: East Hallway. Primary Injuries: head involved, hematoma and abrasion." Incident Questionnaire documents E4, Certified Nurse Aid (CNA)and E5, CNA stood R1 up out of recliner and noticed R1 was incontinent. E5 left R1 with E4 to go get dry clothes and E4 started ambulating R1 to the bathroom when R1 stumbled and fell.

On 5/20/14 at 10:15 AM, E3 (Director of Nursing) DON, stated that E4 and E5 were walking R1 when E5 left to get R1 dry clothes and left E4 walking alone with R1. E3 stated "there should have been two staff to ambulate R1, she has had previous falls and staff must stay with her. That's

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F 323	Continued From page 3 where the breakdown was right there, you need to send a third person for undergarments." On 5/20/14 at 11:42 AM, during an interview, E4 stated "E4 had went to get dry clothes for R1 and I asked R1 to walk to the bathroom, R1 stumbled, and I tried to hold her but couldn't and that's when R1 fell and hit her head on the floor." E4 further stated that R1 had previous falls and required assistance from 2 staff members at all times and that another CNA could have went to get R1's clothes. On 5/20/14 at 11:50 AM, during an interview, E5 stated "I went to get clothes for R1 while E4 walked R1, I was was coming up hall and saw R1 on the floor." On 5/21/14 at 10:36 AM, during an interview with E6, (Care Plan Registered Nurse) RN, stated that there were no further progressive interventions to prevent R1's falls except to talk with staff and look at R1's environment when falls occurred. On 5/21/14 at 10:40 AM, E2 stated that R1 had a personal alarm in place and it was ineffective and did not sound at times and the facility's progressive interventions to prevent R1 from falling was to place R1's personal alarm in a different area on R1's body. On 5/21/14 at 2:00 PM, E2 stated the Facility did not have a fall policy/procedure and staff followed residents Care Plan.	F 323		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514		

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F 514	Continued From page 4	F 514		

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility failed to maintain complete clinical records that reflect accurate documentation of resident status for one of four residents (R1) in the sample of four.

Findings include:

1. R1's Nursing Notes document an entry on 1/20/14 and the next dated entry is 4/6/14. There is no further documentation found in R1's clinical record on R1's condition status or change in conditions from 1/20/14 through 4/6/14.

On 5/21/14 at 1:10 PM, during an interview with E2, Director of Nursing (DON) stated there is no documentation on R1 from 1/20/14 through 4/6/14. E2 stated R1's Nurses' Notes from that time frame are missing. E2 further stated that there is no policy on documentation for the Facility.