STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145225	A. BUILDING _____ B. WING _____	03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOSPITAL LTC UNIT	800 EAST CARPENTER, 11TH FLOOR 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 Annual Recertification Survey	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 interviews and record review, the facility failed to provide proper assistance during toileting for 1 (R10) of 5 residents sampled at risk for falls in the sample of 10. This failure resulted in R10 sustaining a subcapital fracture of the right femoral neck with displacement and angulation that required surgical intervention. Findings include: The clinical record indicates R10 was admitted to the facility on 1/4/11 from the hospital following a below the knee amputation on her right leg. According to the FALL RISK ASSESSMENT dated 1/4/11, R10 was at a moderate risk for falls. The History and Physical indicate R10 had a prior shoulder fracture. Mandatory Fall Prevention interventions on the FALL RISK ASSESSMENT, indicate staff was to "stay c/Pt (with patient) in bathroom." Individualized interventions indicate R10 used a bedside commode, and a walker/gait belt for ambulation.	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	Continued From page 1 The fall report indicates R10 could use call light. R10's Physical Therapy note dated 1/5/11 indicated that R10 demonstrates deficits in balance, endurance, strength, bed mobility, transfers, and gait. The report indicates R10's static sitting balance was good; dynamic sitting fair; static standing poor. According to the physician's orders, R10 had Morphine 2mg every 2 hours PRN (as needed) for pain along with Tramadol. Physician's notes dated 12/30/10 state "appears quite confused - most likely secondary to pain meds." On 12/31/10, the physician writes "was confused some about where she was - knew about BKA (below knee amputation)" and "alert, mild delirium rel (related) analgesics." On 1/3/11, the physician wrote "more alert, still somewhat confused" and at 8:45am, "Apparently she is still disoriented at x's (times), especially when walking, most likely related to morphine for pain.... Delirium should resolve once Morphine use decreases ..." R10's increased confusion following analgesic use is not identified or addressed in the falls prevention program in terms of increasing her risk of falling. The Incident/accident log indicates R10 fell on 1/7/11 at 1:54am. The note states "patient rang call light (staff) answered the light. He then assisted her to the commode using the gait belt. Call light at hand he instructed her to call then stood at the door to give her privacy and she says that she leaned over to get paper off of the table and fell off the commode and landed on her right hip and shoulder. The right hip has a bruise on it and the shoulder shows no sign of injury and she says shoulder is okay." Manager comments state "had extra NT (Nursing tech) doing 1:1 with another patient who was asleep, he went to assist this patient (R10)." R10	F 323		

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F 323	Continued From page 2 complained on right hip pain and x-rays done showed a "subcapital fracture involving the right femoral neck with displacement and angulation" which required surgical intervention. The staff member failed to follow R10's care plan and stay with her as she was on the commode. The Incident/Accident report fails to identify that R10 received Morphine shortly before her fall. According to the Medication Administration Record, R10 had no Morphine on 1/6/11 but had just had 2mg given at 1:03pm, 51 minutes prior to her fall. Interview with E2, Registered Nurse, Nurse Manager, on 3/3/11 at 2pm indicates that the staff member was doing a 1:1 with another resident when he answered R10's call light and then stood at the door of her room to afford her privacy. E2 agreed that the staff person should have remained with R10 while she was on the commode as indicated in the Mandatory Interventions of the care plan. R10 fell toward the side of her amputation. The FALL PREVENTION PROGRAM policy dated 7/7/10 indicates each resident will be assessed for their risk of falling upon admission, and at least every 12 hours in conjunction with routine nursing assessments and that the "mandatory interventions should be implemented, initiated and documented in the medical record."	F 323		