STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146154	A. BUILDING ______ B. WING ______	09/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA VILLAGE CARE CENTER	**4101 WEST ILES AVENUE SPRINGFIELD, IL 62711**

(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 Certification Annual Survey	F 000		
F 323 SS=E	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: A. Based on observation, interview and record review the facility failed to provide effective interventions to prevent falls for 1 of 7 residents (R11) reviewed for falls in the sample of 15. Findings include: 1. R11's Admitting face sheet dated 5/8/14 documents diagnoses that include; Cerebral Vascular Accident, Expressive Aphasia,Symbolic Dysfunction and general weakness. A nurses note written by E14 Licensed Practical Nurse, (LPN), dated 9/9/14 documents that R11 is disoriented to time and place unable to follow a one step command, is restless and demonstrates repetitive actions. It also states R11 has poor balance, is incapable of safety judgement, attempts to climb out of bed and get up from wheelchair unassisted, is unable to express self clearly, and is unable to learn.	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 Minimum Data Set dated 7/31/14 documents that R11 is severely cognitively impaired, and incontinent of bowel and bladder. A Fall Risk Assessment dated 9/6/14 documents that R11 is at high risk for falls. Review of the Facility accident /incident log documents that R11 has had 17 falls between 5/28/14 and 9/6/14. Initial interventions after the 5/28 fall included a low bed and fall mats on the floor. This did not deter R11 and he continued to attempt to get up during the night and fall. Per E3 Registered Nurse, (RN) Director of Nurses, (DON) on 9/10/14 at 2 PM, "we do not like to use restraints or alarms. We have a flat call light that we put on the bed at night and if it is hit by the resident the call light goes on and we respond." This call light was attempted, but was not effective in preventing continued falls. R11 also fell from the wheelchair and regular chair in the dining room. Anti tipping devices were added to the wheelchair as well as a wheelchair pad, but because the root cause as to why R11 continued to attempt to get up from bed or his wheelchair were never assessed, effective interventions were never determined. On 7/30/14 R11's fall, in his room, resulted in a hematoma to the back of his head. Fifteen minute checks were initiated, but per E3 DON, "can't be continued forever, and they didn't always work." On 9/5/14, R11's fall resulted in a head laceration, no new interventions were attempted and on 9/6/14 R11 fell once again. Per the Facility Fall Investigations and R11's plan of care which was last updated 8/31/14 different interventions have been attempted, including ongoing Physical Therapy. Despite the	F 323		

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F 323	Continued From page 2	F 323		

interventions put in place, R11 continues to have multiple falls.

On 9/9/14 at 3:10 PM, R11 was noted to be agitated and attempting to get out of his wheelchair. When staff attempted to intervene R11 swatted at them with his hand.

On 9/10/14 at 10:30 AM, R11 was noted to be getting assistance of Z1 and Z2, two Certified Nurses Aid students to transfer from a shower chair to his wheelchair. R11 was unsteady and could not straighten out his legs fully during the transfer. R11 was unable to follow simple requests.

Z1 stated at 11:10 AM, " I have been with (R11) all week and I can tell you, you can't take your eyes off of him for a minute. He moves so fast and keeps trying to get up by himself no matter what we are doing."

E14 stated on 9/10/14, "He can get very agitated and anxious and just moves all the time, we have tried many interventions, sometimes I think it is not consistent on all shifts. You have to keep trying different things."

E3 Director of Nurses (DON) stated on 9/10/14 at 3:20 PM, "we have discussed his falls and tried different things, but his attention span is very limited, nothing seems to keep him busy for long, we are not sure why he can go for a while without a fall and at a loss of what else to try, he is a challenge. He did have a one-on-one caregiver when he first was admitted, to help him get used to the change in his environment. We might need to look at that again."

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B. Based on observation, interview and record review, the facility failed to keep resident pathways free of trip hazards and failed to keep hazardous chemicals in a locked storage for for 4 of 15 residents,(R5, R6, R8, R11) reviewed for independent, cognitively-impaired ambulation in the sample of 15, and 20 residents (R16, 17, R18-35) in the supplemental sample.

Findings include:
2. On 9/8/14 at 1:45 PM, on the Winter household, E5 (CNA) and E6 (CNA) were ambulating R6 to the bathroom, with a walker, to toilet her. In the center of R6's room a 4 X 6 foot X 1 inch thick rug was in the center of the room and located near the pathway from R6's bed to the bathroom. This area rug had had places around the edges rolled up off of the floor.

Fall investigations were reviewed on 9/10/14, they documented R6 had fallen on 1/15/14, 1/27/14, 2/17/14, 3/30/14 and 6/11/14.

The care plan for R6 for fall risk with a start date on 12/9/13, documented under problem, fall risk, and includes under approach "keep my room and hallways free of clutter please", "please monitor room for clutter while I am up and about and arrange in such a way that I will not trip."

3. On 9/8/14 during the initial tour of the facility, on Winter household, an enclosed screened in porch, was unlocked. In the center of the porch on the floor was a large cloth woven area rug.

On 9/11/14 at 10:20 AM, E4 (LPN) was asked which residents in Winter household have access to the enclosed porch. E4 said "all of the residents on Winter household have access to

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the enclosed porch." These residents are R5, R6, R18 through R31.

4. The facility's policy and procedure for fall prevention documented #1 At move in, Neighborhood team members will assist the resident and family in ensuring the resident's bedroom is free from hazards that could cause a fall. #1 d. Resident and family will be educated about tripping hazards such as small rugs, electrical cords, unsteady furniture and placing items in the path of travel to the bathroom and bedroom door. Team member will notify Neighborhood nurse about any hazards identified. Neighborhood nurse will discuss issues with resident and family.

5. On 9/9/14 at 9:50 AM, CNA closet door on the Summer Breeze Household was found to be unlocked. Inside this closet there was a cabinet with a handwashing sink. A large container of (disinfectant) wipes was on the counter closest to the entry door next to the handwashing sink. On the (disinfectant) container a warning label documented, "Warning keep out of reach of children." Also inside the unlocked cabinet above the handwashing sink was a plastic container with fingernail polish containers inside and an 8 ounce bottle of Acetone finger nail polish remover.

Review of "Cognitive Impaired Residents who are ambulatory or wheelchair ambulatory" list provided by E3 Director of Nursing (DON) at 9:30 a.m. on 9/11/14 confirms R11, R32-R35 are cognitively impaired.
5. At 11:40 a.m. on 9/8/14 a CNA closet door was found to be unlocked on the Spring Hill Household. Inside the closet there was a cabinet with a handwashing sink. A large container of

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F 323	Continued From page 5 (disinfectant) wipes was next to the handwashing sink. On the (disinfectant) wipe container a warning label documented, "Warning keep out of reach of children." Also inside the unlocked cabinet above the handwashing sink was a plastic container with fingernail polish containers inside and an 8 ounce bottle of Acetone finger nail polish remover. Interview with E11 (CNA) at 9:15 a.m. on 9/11/14, E11 stated that R17 is confused and is wheelchair ambulatory resident. Review of "Cognitive Impaired Residents who are ambulatory or wheelchair ambulatory" list provided by E3 Director of Nursing (DON) at 9:30 a.m. on 9/11/14 confirms R17 is cognitively impaired. Findings include: 6. On 9/9/14 during a walk through of the Reach Household the Certified Nursing Assistant(CNA) closet door was unlocked. Inside the closet were unlocked cabinets containing a bottle of acetone polish remover and a container of (disinfectant) wipes. An interview with E7, licensed practical nurse (LPN) on 9/9/14 at 8:10 AM, E7 stated that the CNA closet should be locked and that some chemicals were kept there. E7 also stated that they do have ambulatory cognitively impaired residents, that could get into the unlocked closet. Review of the List of Cognitive Impaired Residents Who Are Ambulatory or Wheelchair Ambulatory dated 9/10/14 list R8 and R16 as residents on the Reach Household.	F 323		

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

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F 323	Continued From page 6 8. Review of policy and procedure for "Safe Use of Chemicals", dated 11/14/11, documents "...All chemicals will be stored in a locked cabinet when not in use...Containers of chemicals will not be left on tables or countertops unsupervised..."	F 323		