Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005300	A. BUILDING: ______ B. WING ______	08/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS MEMORIAL CHRISTIAN VLG	3400 WEST WASHINGTON SPRINGFIELD, IL 62702

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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations ; 300.610a) 300.1210b) 300.1210d)6) 300.1220b)2)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting Section 300.1210 General Requirements for Nursing and Personal Care b)The facility shall provide the necessary care	S9999	Attachment A Statement of Licensure Violations	

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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.
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 Services

b)The DON shall supervise and oversee the nursing services of the facility, including:
2)Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.
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

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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 requirements were not met evidencded by:

Based on observation, interview, and record review the facility failed to provide supervision to prevent falls, failed to assess for root cause analysis of falls and implement interventions based on this assessment for 3 of 13 residents (R125, R127, R142) reviewed for falls in the sample of 46. This failure resulted in R125 falling and sustaining a fractured distal fibula (one of two bones that support the ankle joint).

Findings include:

1. R125's Admission Record, dated 08/01/19, documents R125 was admitted on 07/01/19 with diagnoses which included Psoriatic Arthritis, Morbid Obesity, and Encounter for Specified Surgical Aftercare.

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R125's Fall Risk Assessment Tool, dated 07/01/19, documents that R125's Fall Risk Score was 4, indicating R125 was at high risk for falling.

R125's Fall Risk Questionnaire, dated 07/01/19, documents R125 documents that R125 stated that her knees give out on her and that she gets dizzy sometimes.

R125's Care Plan, under the at risk for falls section, with an initiation date of 07/01/19, has an intervention which states, "Be sure call light is within reach and encourage to use it for assistance as needed. Needs prompt response to all requests for assistance." There is no intervention in this Care Plan which details, in any way, how direct care staff members should attend to, or supervise, R125 while she is on the toilet, even with her statements about her knees giving out and her tendency to get dizzy within R125's initial Fall Risk Questionnaire dated 07/01/19.

R125's Minimum Data Set (MDS), dated 7/15/19, documents R125's Brief Interview of Mental Status (BIMS) score is 15, meaning R125 is cognitively intact. This MDS documents R125 requires extensive assistance of 2 staff members for bed mobility, transfers, locomotion on the unit, locomotion off the unit, and toilet use. The MDS also documents that R125 requires supervision with support of 1 staff member for walking in her room. Regarding balance status, the MDS documents R125 is not steady and is only able to stabilize with staff assistance when moving from seated to standing position, when moving on, and off the toilet, and during a transfer between bed and chair or wheelchair.

R125's Progress Notes, dated 07/08/19, states that resident is educated about her "increased

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risk for dehydration" due to her Ileostomy and that common side effects of dehydration include increased weakness and dizziness.

R125's Progress Notes, written by V15, Licensed Practical Nurse (LPN), dated 07/09/2019 at 5:35 PM, documents, "CNA (Certified Nurse's Aide) yelled for writer to come to resident's rm (room). Upon entering residents bathroom noted resident lying on her left side with her head in the shower and legs outstretched in front of her in front of toilet. Non-skid socks noted on feet. CNA stated she just came back into the room as resident stood up and couldn't get to her before she fell. Resident stated she stood up to pull up her pants and her left leg gave out on her and she fell. Resident assessed for injury." This note continues, "new orders received to obtain 2 view x-ray of (left) foot."

The facility's Incident/Accident Report, dated 07/15/2019, documents that R125's fell on 07/09/2019 in front of her toilet in her bathroom. The report states that upon being assisted up R125 "complained of pain to the top of her left foot upon weight bearing." The report continues, stating that X-ray results showed a "fracture of the distal fibula without significant displacement" and an appointment to a local orthopedic clinic was ordered.

On 08/01/2019, at 10:16 AM, V15, Licensed Practical Nurse, stated that V24, CNA, called to V15 at the time of R125's fall and told her that she had helped R125 to the toilet, but went out of R125's room to help another resident. V15 stated that when V24 came back into R125's room, she saw R125 trying to get up on her own from the toilet. V15 stated that R125 fell before V24 could get to her.

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On 08/01/19, at 11:19 AM, V2, Director of Nurses, stated that the facility does not have a policy on attending to residents in bathroom if they are independent. V2 stated that V24 is no longer employed at the facility. V2 stated that in writing the facility's incident report, she just relied on R125's verbal description of the incident, which was that V24 was in the room when R125 fell but just turned around to give R125's privacy while toileting.

R125's Progress Notes, dated 07/10/2019, document that R125 "slipped out of her wheel chair" while being transported, from an orthopedic appointment, back to the facility in the facility's transport van.

On 08/01/2019, at 10:15 AM, V2 stated that R125 did not have her seat belt on when she slipped out of her wheel chair in the van. She stated that she did not have a CNA attending her when this happened. V2 also stated that the facility does not have a van policy, or a policy related to wearing a seat belt, or restraining device, during transport within the facility's van.

R125's Post Fall Analysis & Intervention Tool, dated 07/11/2019, documents, under the "Predisposing Environmental Factors," that there were "other" factors; however, there is no explanation anywhere in this report what is meant by 'other'. This report even has an "Other Info" section but there is no documentation at all in this 'other' section. This report has no information about R125 not having a seat belt on when she slipped out of her wheel chair during this transport. This report does state that R125 did not have any injuries related to this fall.

2. R127's Admission Record, dated July 30,2019,

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documents R127 was admitted on 4/29/2019 with diagnoses of Cerebral Infarction due to unspecified occlusion or stenosis of right carotid arteries, Hypertension, cognitive communication deficit, Hemiplegia and Hemiparesis following other cerebrovascular disease affecting left dominant size and repeated falls.
R127's MAHC 10 (Fall Risk Assessment Tool), dated 4/29/19, documents R127's Fall Risk Score is a 7 indicating a High Risk for Fall.

R127's MAHC 10 (Fall Risk Assessment Tool), dated 6/20/19, documents R127's Fall Risk Score is an 8 indicating a High Risk for Fall.

R127's Minimum Data Set (MDS), dated 7/9/2019, documents R127 was admitted 4/29/2019. This MDS documents R127 has a Brief Interview of Mental Status of 8 indicating R127 is moderately cognitively impaired. The MDS documents R127 has no hallucinations, delusions, behaviors or rejection of care. This MDS documents requires limited assistance of 1 staff member for bed mobility, walking in room, locomotion on unit. The MDS documents R127 requires extensive assistance of 1 staff member for transfer, dressing and personal hygiene. This MDS documents R127 requires extensive assistance of 2 for toileting.

The MDS documents R127 is not steady, only able to stabilize with staff for moving from seated to standing position, walking, turning around and facing the opposite direction while walking, moving on and off the toilet and surface to surface transfer. The MDS documents R127 may use a walker or a wheelchair. The MDS documents R127 is frequently incontinent. The MDS does not document that R127 uses a trunk restraint.

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R127's MDS, dated 5/28/2019, documents R127 has a Brief Interview of Mental Status of 7 indicating R127 is severely cognitively impaired. The MDS documents requires extensive assistance of 1 staff member for bed mobility, transfers, locomotion on and off unit, toileting and personal hygiene. This MDS documents R127 is not steady, only able to stabilize with staff for moving from seated to standing position, walking, turning around and facing the opposite direction while walking, moving on and off the toilet and surface to surface transfer. The MDS documents R127 may use a walker or a wheelchair. The MDS documents R127 is frequently incontinent of urine and bowel.
R127's Nurses Note, dated 5/7/2019 22:00, documents in part, "CNA (Certified Nurse Aide) observed resident in her room sitting on the floor in front of her wheelchair with her feet straight out. Resident stated, 'I hope the boys are doing the right thing and that there is no trouble with (V8) outside. And I need a drink.' VS (vital signs) and full body check done. Full ROM (range of motion) and neuro (neurological) checks WNL (within normal limits). No complaints of pain or discomfort from resident at this time. No complaints voiced."

R127's Care Plan, undated, documents, in part, "Focus: (R127's) is a high risk for falls related to: CVA (cerebral vascular accident) LT (left) sided weakness. Interventions/Tasks: 5/8/2019 keep in common areas while in w/c (wheelchair)."
R127's Nursing Note, dated 5/16/2019 04:54, documents in part, "resident sitting in her wheelchair at nursing desk. she is very confused and fidgety. she worked her way to the front of her wheelchair and slid out onto the floor onto her buttocks. no changes in cognition. denies pain. assisted back into wheelchair with 2 assist. initial

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b/p (blood pressure) 181/89, pulse 70, temp (temperature) 97.2, respirations 18. follow up b/p 155/92 with pulse 77."

R127's Post Fall Analysis & Intervention Tool, dated 5/16/2019, documents, "Discussion of Event: Guest had been restless in bed until she got up to toilet at 3:00 AM and declined to go back to bed. Was sitting at nurses' station with nurse. Very restless and repeatedly scooting self to edge of w/c. repositioned numerous times. Guest finally wiggled self out of w/c and slid to floor witnessed by nurse. Root Cause Analysis/ Impression: Scooted self out of w/c due to confusion/ disease process. Problem List: scooted self out of chair. Individualized Intervention: melatonin for sleep, non-skid in recliner."
R127's IDT (Intradisciplinary Team) Note, dated 5/16/2019 13:19, documents, "IDT met to discuss incident. New interventions put in place for anti-skid to his wheelchair. Will also contact MD (medical doctor) and inquire about adding melatonin due to not sleeping well at night."

R127's Physician Order, dated 5/17/2019, documents, in part, "Melatonin Tablet 3 mg (milligram) by mouth 1 tablet PRN (as needed) every 24 hours. Indication for use: restless."

R127's Post Fall Analysis & Intervention Tool, dated 6/17/2019, documents, "73 year old female resident found in floor of room. Resident unable to give description of the event. Prior to event resident was in bed sleeping. Root Cause Analysis/ Impression: confusion/ disease process. Resident self transferred in night and fell. Problem List: Restless. Individualized Intervention: Request to schedule Melatonin from PRN (as needed). Beveled mats."

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R127's Nurses Note, dated 6/18/2019 12:12, documents, in part, " Writer spoke with (V9 nurse Practitioner) regarding PRN melatonin. Requesting scheduled due to recent fall while up in middle of night. New orders received as follows: Melatonin 3mg PO (by mouth) Q (every) HS (hour of sleep) for inability to sleep."

R127's Nurses Note, dated 6/20/2019 12:10, documents, in part, "Staff notified that resident had fallen out of her wheelchair, in the dining room. Upon arriving at the table, resident was found laying on her left side with the wheelchair lying on top of the resident, resident's head hit another resident's wheelchair. When nurse assessed resident there were no injuries, redness or bruising at this time. Resident was confused but this is her baseline mentation. Resident, when asked what happened she was unable to tell us what happened. VS taken and they were elevated but resident was quite riled up, the second set of vital signs started coming down."
R127's Post Fall Analysis & Intervention Tool, dated 6/21/2019, documents, "Root Cause Analysis/ Impression: Resident fell from wheelchair while in common dining area waiting to eat. confused at baseline. Attempts to self transfer frequently. Problem List: w/c tipped over. Individualized Intervention: Anti-tippers to wheelchair."

R127's Nurse Note, dated 6/21/2019 05:27, documents, in part, "Resident was sitting in the hallway outside of 318. She repeatedly kept leaning over in her wheelchair, I asked her to sit back. After asking her to sit back for the 3rd time resident leaned too far and fell out of the wheelchair on to her left side. No injuries, no complaints of pain."
R127's Post Fall Analysis & Intervention Tool,

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dated 6/21/19, documents "Root Cause Analysis/Impression: confusion/disease process leaned forward in wheelchair and fell forward. Problem List: leaning too far forward in her w/c. Individualized Interventions: Alarming seat belt to wheelchair."

On 7/30/19 at 1:14 PM, V2 stated, "I don't know what else we could do but put a seatbelt on her to keep her from falling. The other interventions didn't work."

On 7/30/19, at 2:55 PM, V1 Administrator, stated "we do a fall risk evaluation after every fall."
On 7/30/19, at 2:55 PM, V1 Administrator, stated "we do a fall risk evaluation after every fall."

On 7/31/19 at 1:30 PM, V2 stated "I am sure the nurses were doing other interventions, but it was not charted. We determined in team meeting that a seat belt was the best way to keep her from continuing to fall because she is confused, has delusions and has a brain injury."
On 7/30/19, at 2:55 PM, V1 Administrator, stated "we do a fall risk evaluation after every fall."

On 7/31/19 at 1:30 PM, V2 stated "I am sure the nurses were doing other interventions, but it was not charted. We determined in team meeting that a seat belt was the best way to keep her from continuing to fall because she is confused, has delusions and has a brain injury."

The facility's "fall Prevention - Steady Steps" policy, dated 3/1/19, stated that it is their policy "to provide each resident with an appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs." in the "Fall Prevention" section it documents "Residents identified as at frisk for falls, will have clinically

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appropriate interventions put into place to reduce the risk of falls and/or prevent recurrence of falls. The interdisciplinary Team will review and modify the fall risk prevention plan of care at a minimum of quarterly, after each fall, and as clinically indicated. Interventions for the fall prevention plan will be modified following the interdisciplinary review and changes will be made to the plan of care." The policy continues under "Post Fall Intervention: Attempt to determine appropriate fall interventions and implement as soon as possible after the fall. Utilize the Patient Centered Intervention Tool to assist in determining potential interventions with input from appropriate associates. Post Fall Analysis will be completed by the Interdisciplinary Team. The resident will be screen by the Rehab Department after each fall. Care Plan will be reviewed and revised with additional/Modified fall interventions as indicated."

3. R142's Care Plan dated 10/4/16, revised 7/4/19 documents "Resident is high risk for falls related to Gait/balance problems, Diabetes, Anemia. Has decreased safety awareness and takes medication that could have adverse reaction and family has reported she is legally blind in left eye. 8/15/18 resident was noted to self-transfer and ambulate without calling for assist. 12/7/18 resident was noted to self-transfer and ambulate without calling for assist." The Care Plan Interventions documented "Nonskid strips next to bed on floor. 7/11/19 therapy to eval for appropriate wheelchair (w/c) and proper w/c positioning, 8/16/18 Resident to be toileted as immediately upon arising in am for evacuation of bowels. Antibiotic recently changed to cover urinary tract infection (UTI) bacteria resistance, * Be sure call light is within reach and encourage To use it for assistance as needed. Needs prompt response to all requests for assistance. Ensure

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wearing appropriate footwear when ambulating or mobilizing walker. Keep furniture in locked position. Keep needed items, water, etc., in reach. Maintain a clear pathway in room, free of obstacles.

On 07/29/19 at 10:55 AM, V23, R142's Daughter, stated, "(R142) has had falls on, 5/31/19 and 7/10/19." V23 stated, "The fall on the 10th, Mom had just gotten out of the hospital and was very weak, she was on the 500 hall, the CNA (unknown) left her unattended in her wheelchair in the doorway while she went to answer someone's call light. My Mom did not have her call light she was left in the doorway. My Mom fell hard, she had 2 black eyes and a hematoma on her forehead, she had to go to the emergency room (ER) and came back to the facility the next morning."

R142's Progress notes dated 7/10/19 documents in part, "Writer was called to resident's room by CNA. Writer found Resident laying face down in door way. Resident was visually assessed and appeared to be in pain. Vitals taken and doctor and daughter notified. Writer received orders to send resident to Emergency Room (ER) for Evaluation and treatment related to (r/t) head injury due to fall."
R142's Post Analysis & Intervention Tool, dated 7/11/19, documents Root Cause Analysis/Impression "Fell forward out of wheelchair, secondary to poor core strength."

R142's Hospital Computed Tomography Scan (CT) Head Impression, dated 7/10/19 documents "There is a hematoma of the frontal scalp just right of midline".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005300	A. BUILDING: ______ B. WING ______	08/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS MEMORIAL CHRISTIAN VLG	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) COMPLETE DATE
S9999	Continued From page 13	S9999		

B. Based on observation, interview and record review the facility failed to safely transfer residents using a full mechanical lift for 2 of 2 residents (R23, R44) reviewed for full mechanical lift transfers in the sample of 46.

Findings include:
1. On 07/30/19 9:41 AM, V20 Certified Nurse Aide (CNA) and V21 CNA were transferring R44 using a full mechanical lift. R44 was sitting in a high back wheelchair, V20 and V21 attached the machine to the sling and raised her above the chair, moved her over and checked the straps between the chair and the bed above the floor, then over to the bed and lowered her down into the bed. V20 and V21 did not lock R44's high back wheelchair prior to the transfer.

2. On 07/30/19 10:45 AM, V20 and V21 were transferring R23 using a full mechanical lift. R23 was sitting in a high back wheelchair, V20 and V21 attached the machine to the sling and raised her above the chair, moved her over and checked the straps between the chair and the bed above the floor, then over to the bed and lowered her down into the bed. V20 and V21 did not lock R23's high back wheelchair prior to the transfer.

On 8/1/19 at 2:50 PM, V2 stated, "I would expect the brakes on the wheelchair to be locked prior to transferring a resident with a mechanical lift."

The User Manual for the full mechanical lift, not dated, documents in part, Using the Sling WARNING: If the patient is in a wheelchair, secure the wheel locks in place to prevent the chair from moving forwards or backwards. When elevated a few inches off the surface of the stationary object (wheelchair, commode or bed)

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	IL6005300	A. BUILDING: ______ B. WING ______	08/05/2019

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LEWIS MEMORIAL CHRISTIAN VLG	3400 WEST WASHINGTON SPRINGFIELD, IL 62702

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S9999	Continued From page 14 and before moving a patient, check again to make sure the sling is properly connected to the hooks of the hanger bar. If any attachments are not properly in place, lower the patient back onto the stationary object (wheelchair, commode or bed) and correct this problem. (B)	S9999		