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
	IL6008866	A. BUILDING: ______ B. WING ______	C 01/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY'S NRSG & REHAB CENTER	767 30TH STREET ROCK ISLAND, IL 61201

(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
S 000	Initial Comments	S 000		

Complaint Investigation

2020326/IL119178
2020412/IL119280

S9999	Final Observations	S9999		

Statement of Licensure Violations

300.1210b)
300.1210c)
300.1210d)6)
300.1220b)3)
300.3240a)

Section 300.1210 General Requirements for Nursing and Personal Care
b) The facility shall provide the necessary care 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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 02/13/20

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S9999	Continued From page 1	S9999		

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:

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 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 as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that care planned interventions of floor mats and a specialty bed were followed, new interventions added to a care plan after a fall, and the correct mechanical lift device was used for three (R5, R24, R27) of seven residents reviewed for falls in

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S9999	Continued From page 2	S9999		

a sample of 29. This failure resulted in R27 being transferred to the hospital and receiving stitches to the right eye.

Findings include:

1. The facility's (undated) fall policy documents "Policy: To provide the investigation of all falls. To provide a safe environment for resident." This same policy documents "Procedure: IDT (interdisciplinary team) to review fall during morning meeting. New interventions will be added to the care plan."

On 1/21/20 at 11:35 AM, R27 was sitting in a chair in the dining room. R27 was pleasantly confused with conversation and had a reddened area containing stitches to her right eyebrow.

R27's current care plan, dated 1/1/20, documents "I have a history of falls with injury related. I have risk factors that require monitoring and interventions to reduce risk for falls." This care plan also documents the latest intervention was added on 1/1/20 to include "mats on floor."

R27's Incident Investigation Quality Improvement Process form, dated 1/14/20, documents at 3:50 PM "(R27) was attempting to get out of bed and fell to the floor." This same form documents R27 suffered a "Major Injury as a result of the fall. Laceration to right outer eyebrow. Sent to the emergency room for evaluation and treatment."

R27's Incident Investigation Quality Improvement Process form, dated 1/16/20, documents at 4:20 AM "(R27) removed bolster from bed, threw it on the floor and rolled out of bed."

On 1/22/20 at 10:45 AM, V2 (Director of Nursing)

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stated, "When someone has a high/low bed, the bed goes to the floor. Usually they're accompanied by floor mats. (R27's) fall on 1/14/20 resulted in a laceration and stitches to her eyebrow because staff working that day forgot to put down (R27's) floor mats. (R27) didn't have floor mats in place so she hit her eye on the floor." V2 confirmed that the care plan for R27 has not been updated and new interventions were not added after the falls in January. V2 stated, "Nursing assistants and nurses should look at the care plan to know how to care for a resident."

On 1/22/19 at 12:15 PM, V16 (Minimum Data Set assessment coordinator) confirmed R27's care plan has not been updated after two falls in January. V16 stated, "We have not added any interventions after she fell 1/14/20 and 1/16/20 due to our team has not met to discuss the fall."

2. R24's current care plan, dated 1/22/20, documents "(R24) has risk factors that require monitoring and interventions to reduce risk for falls." This same care plan documents an intervention of "high/low bed."

R24's current physician order sheet, dated 1/15/20, documents "(R24) needs a high/low bed (bed that lowers to ground level) with floor mats due to numerous falls."

On 1/21/20 at 10:50 AM, R24 was sleeping in bed in his room. R24 was not in a high/low bed. R24 did not have floor mats in the room.

On 1/21/20 at 11:25 AM, V18 (Licensed Practical Nurse) stated, "(R24) does not have a high/low bed but his bed is in the low position."

On 1/22/20 at 12:20 PM, V2 (Director of Nursing)

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stated, "Orders for a high/low bed should be communicated to me and I then let maintenance know and the bed would be delivered within the same day. I have not seen this order (high/low bed) for (R24). I didn't know it was an order in his chart because the nurse did not tell me. He should've had the high/low bed on the day it was ordered 1/15/20."

3. Facility "Policy and Procedure for lift equipment," dated 2013, documents "To be transferred with a sit to stand lift, the resident must be able to partially bear weight and hold on to the hand grips."

R5's Minimum Data Set (MDS), dated 9/20/19 and 12/20/10, documents R5 is totally dependent on two people for transfers.

R5's "carecard," no date, in R5's room documents R5 is a "two person mechanical lift."

R5's Physical Therapy notes, dated 11/14/19, documents "Transfers = Total Dependence without attempts to initiate."

V5's (Certified Nurse Aid/CNA) incident investigation written statement, dated 11/26/19, documents "I was helping (V15) CNA with (R5) and we put him in the sit to stand and he slid out of the sit to stand."

V15's (CNA) incident investigation written statement, dated 11/26/19, documents "Me and (V5) were transferring (R5) in the lift. He fell straight down out the lift and we got the nurse."

On 1/16/20 at 1:05pm, V15 stated "When he (R5) fell in November (2019) we were using a sit to stand, he let go of the bars and he fell straight

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down out of the sit to stand. He was up and we told him to push up and use his knees and at times he was weak when using the sit to stand."

On 1/16/20 at 1:15pm, V16 (Licensed Practical Nurse/MDS - Minimum Data Set Coordinator) verified there was no assessment performed on (R5) for the use of a sit to stand.

(B)