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
	IL6000814	A. BUILDING: ______ B. WING ______	C 01/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEDDINGTON OAKS	2223 WEST HEDDING AVENUE PEORIA, IL 61604

(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

Statement of Licensure Violations

Complaint Investigation
2020376/IL119243

S9999 Final Observations — S9999

300.1210b)
300.1210d)6)
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.

Section 300.1210 General Requirements for Nursing and Personal Care

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.

Attachment A
Statement of Licensure Violations

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Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Regulations were not met as evidenced by:

Based on interview and record review the facility failed to transfer a resident from the bed to the chair with the assist of two persons for one of three residents (R1) reviewed for falls in the sample of four. This failure resulted in R1 falling during a transfer and sustaining a right femur fracture.

Findings include:

The facility's "Falls and Fall Risk, Managing", revised March 2018, states, "Policy Statement: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling."

The facility's "Goals and Objectives, Care Plans" policy, revised April 2009, states, "1. Care plan goals and objectives are defined as the desired outcome for a specific resident problem. 4. Goals and objectives are entered on the resident's care plan so that all disciplines have access to such information and are able to report whether or not the desired outcomes are being achieved. 5. Goals and objectives are reviewed and/or revised: a. When there has been a significant change in the resident's condition; b. When the desired outcome has not been achieved..."

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R1's Minimum Data Set, dated 1/1/20, Section G Functional Status, G0110. Activities of Daily Living (ADL) Assistance documents R1 as needing extensive assistance of two plus persons physical assist for transfers. Section G0400 Functional Limitation in Range of Motion documents R1 as having impairments in both lower extremities.

R1's Quarterly Balance Score Sheet, dated 1/6/20, documents, "Analysis: Resident requires staff assistance to transfer d/t (due to) generalized weakness and balance impairment.

R1's Quarterly Restorative/Rehabilitation Evaluation, dated 1/6/20, states, "Observation Details: Resident requires staff assistance to complete ADLs d/t (due to) generalized weakness and her unwillingness to participate as much as she is able. She is alert and able to voice her needs. She can follow cuing well but doesn't always participate in cares as much as she is able. She needs encouragement to participate. She is needing two assist or sit to stand lift PRN (as needed) with transfers. This same form under "Transfers" documents, "Needing two assist or sit to stand as needed."

R1's Quarterly Fall Risk Assessment, dated 1/6/20, documents R1 with a fall risk score of 13. This assessment states any score of 10 or higher represents a high risk for falls.

The facility's fall log documents R1 had a fall in which R1 was "lowered to the ground" on 1/13/20 at 7:09 A.M.

R1's fall investigation contains a witness statement signed and dated by V4 (Certified

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Nursing Assistant/CNA) on 1/14/20, stating, "Jan. (January) 13, 20 on a Monday, I was transferring a res (resident/R1) with a gait belt off the bed, having her hold onto the chair in standing position next to the bed. As we was standing, she (R1) was holding on the wheelchair saying her legs hurt. I notice she was losing her balance so I put my leg behind her bottom, lowering to the ground because she was falling and her legs start to buckle, while her right leg slightly above the left foot. So I went and got my nurse (V6/Licensed Practical Nurse) around 7:00 AM. She asset (assessed) her, we put a gait belt back on her to lift her on the bed. Then I got the sitting stand (sit to stand), me and the nurse hook her on the sitting stand, and she was sliding because she said she couldn't stand on it. But we manage to get her in the wheelchair."

On 1/17/20 at 11:43 A.M., V4 stated, "On 1/13/20 around 7:00 AM, I was transferring (R1) with the gait belt from the bed. She was holding onto the arms of the wheelchair to help me. (R1's) legs began to buckle, so that's when I lowered her down to the floor. She was saying "Oh my leg, oh my leg." I put my leg behind her to ease her fall to the ground. I was trying to catch her as she was lowering to the ground. I was able to guide her down with my leg. She was complaining of right leg pain as soon as she stood up. I notified the nurse (V6). I was transferring (R1) by myself at the time she was lowered to the ground. I told the nurse right away. I did not hear a pop or anything like that. (R1's) leg was bent out to the side. R1 kept complaining of pain. I would say it was increased from her normal complaints of pain. She was saying her right leg hurt repeatedly. When we used the sit to stand, her legs were buckling on that."

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R1's fall investigation contains a witness statement signed and dated by V6 (Licensed Practical Nurse) on 1/13/20 stating, "This nurse was called to res (Resident/R1) room after the CNA who was getting (R1) out of bed had to be lowered to the ground. CNA stated that when (R1's) legs gave out while transferring her to w/c (wheelchair), she had to sit her on the ground. When this nurse entered the room, res was sitting on the ground, back leaned up against bed with legs out in front of her. This nurse assessed (R1) ROM (Range of Motion) et were WNL (within normal limits). (R1) assisted up onto her bed with a gait belt and assist x 3 (of three people). (R1) then began to slide off edge of bed and had to be lifted again. (Sit to Stand) then used to move (R1) into her w/c. BLE (bilateral lower extremities) very weak per usual..."

R1's current Care Plan documents, "Transfer: I have impaired mobility as evidenced by being unable to transfer independently. I require MOD A (moderate assist) of one using GB (gait belt), w/w (wheeled walker), or grab bars to transfer r/t (related to) generalized weakness. Requires sit to stand lift at times."

R1's Final Investigation Report to the local state agency documents, "Conclusion: (R1) received a fracture of the right distal femoral oblique during her transfer. Staff transferred resident per her care plan."

On 1/21/20 at 8:53 A.M., V5 verified care plans are what staff members use to determine how a resident would transfer.

On 1/21/20 at 9:50 AM, V5 (Restorative Nurse) stated, "I get how the forms (I completed for R1) and what is written on the care plan is different

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and confusing. The care plan is wrong. It should have been updated to show transfer with assist of two. Based on the assessments I completed on (R1), (R1) should have had two people to transfer the day she fell."

R1's SBAR (Situation, Backgroung, Assessment, Response) Communication Form, dated 1/13/20, states, "Situation: (R1) was lowered to the floor due to losing her balance. (R1) right knee is swollen 2x (two times) the normal size. (R1) also has bruising on the L/R (left and right) sides of her tongue. (R1) is on dialysis 5x/week (five times a week). (R1) complains of severe pain in her Rt (right) knee."

R1's Radiology Report of the right knee on 1/14/20 states, "Impressions: Distal femoral oblique fracture. Osteopenia."

(B)