

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000970	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/07/2020
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NAME OF PROVIDER OR SUPPLIER CASEY HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 100 N.E. 15TH CASEY, IL 62420
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S 000	Initial Comments Annual Certification Survey	S 000		
S9999	Final Observations LICENSURE VIOLATIONS: 300.610a) 300.1210a)b)5)d)6) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to	S9999	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 03/05/20
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S9999	<p>Continued From page 1</p> <p>meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)</p> <p>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. Restorative measures shall include, at a minimum, the following procedures:</p> <p>5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.</p> <p>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:</p> <p>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</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>and assistance to prevent accidents.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These regulations are not met as evidenced by:</p> <p>Based on record review, interview and observation, the facility failed to identify and implement appropriate fall interventions for a cognitively impaired resident (R25) and failed to supervise a cognitively impaired resident (R50), both with known histories of multiple falls. R25 and R50 are two of four residents reviewed for falls in the sample list of 17. R50 was admitted to a hospital with acute trauma, scalp laceration and a skull fracture after falling on 10/12/19 at the facility.</p> <p>Findings include:</p> <p>1. R50's Minimum Data Sheet (MDS) dated 8/12/19 includes the following diagnoses: Seizure Disorder, Alzheimer's Disease, Anxiety and Asthma. This same MDS documents R50 as being severely cognitively impaired, supervision required when ambulating, is to be supervised when up ambulating and has had multiple falls.</p> <p>A facility report titled "Fall Risk Assessment" dated 8/12/19 documents R50 as being high risk for falls. The facility Fall log dated 1/2019 through 1/2020 documents R50 with the following falls: 2/21/19, 6/15/19, 7/26/19, 8/9/19, 9/9/19, 10/7/19 and 10/12/19.</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>R50's Plan of Care documents that R50 has an identified problem area of Wandering behaviors and to provide supervision and to accompany resident to go where desired. This same Plan of Care identifies R50 with a problem area of falls due to R50 not understanding mobility limits due to cognitive impairment. Interventions of a safety helmet implemented on 7/1/16, keep resident within visuals while ambulating was implemented on 9/21/18. The Plan of Care also documents that R50 was sent to the emergency room on 7/26/19 due to a fall and to continue previous safety interventions. This same intervention of "continue previous safety interventions" are documented in the Plan of Care for falls dated 8/9/19 and 8/18/10.</p> <p>A facility report titled "Final Report" dated 10/18/19 includes the following documentation on R50: "On October 12, 2019 at (9:10pm) (R50) was found lying on the floor in the hallway, (R50) assessed and sent to the Hospital for (Evaluation) and (treatment). (R50 had been walking up and down the hallway as (R50) usually does. Staff stated they went to take a resident to the bathroom and passed (R50) in the hallway walking. Staff heard male resident yelling for help, immediately went to see and observed (R50) lying on the floor with no objects around. Nurse was immediately notified and (R50) assessed, (R50) was sent to the Hospital for (evaluation and treatment)."</p> <p>Staff Interviews: "(V13, Certified Nursing Assistant) works 10-6-I didn't witness the fall. (R50) was up walking when I passed (R50) in the hallway to take another resident to the restroom. I was in the bathroom with another resident when I heard yelling for help from a male resident. I came out and seen a resident on the floor. I</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>called for help from the nurse immediately. I got vitals and (R50) went out to the hospital." "V14, Certified Nursing Assistant works 2-10pm-stated I was in the shower room providing ADL (activities of daily living) care to another resident, didn't witness the incident." "No other staff member witnesses (sic) this incident." V13, Certified Nursing Assistant documents in a written statement (undated) that V13 did not witness the fall due to toileting another resident and was aware R50 was in the hallway ambulating. This statement is signed by V13. There is no signed statement from V14. Neither Certified Nursing Assistant were available for interview.</p> <p>Hospital records dated 10/13/19 at 1:06 am document the following on R50: "(R50 is a 71 year old female that presents as a transfer after a fall. The patient has a history of dementia and non-verbal at baseline. History obtained from (R50's) son. (R50) reportedly stood up to ambulate without assistance at her (facility) and fell. She has had recurrent falls for which she wears a helmet." Electronically signed by V16, Hospital Admitting Physician</p> <p>"CT (Computed Tomography) Brain (10/13/19): Indication : Acute Trauma; Impression: 1. Small hemorrhagic contusions along the floor and anterior aspect of the right frontal lobe. 2. Left occipital skull fracture which is minimally displaced 3. Cerebral and cerebellar atrophy 4. Small vessel ischemic/degenerative changes 5. Posterior scalp hematoma.; Active Hospital Problem: Diagnoses; Principal Problem Fall; Scalp Laceration, posterior; Occipital fracture; Brain contusion with no loss of consciousness; Trauma - Plan: Admit to surgical floor"</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>"CT Brain without contrast (10/14/19)" Findings: "There is redemonstration of trace scattered subarachnoid hemorrhage, which is most pronounced in the right inferior frontal region. This is slightly less conspicuous from prior CT. Trace intraventricular hemorrhage within the occipital horns is more pronounced, which may be related to redistribution. There is redemonstration of bilateral subdural collections, which are increased in size from the prior exam. For reference, the left convexity subdural collection measures 1.5 cm (centimeters in thickness in the right convexity subdural collection measures up to 0.9 cm in thickness (series 2 image 19. On prior CT these collections measured 1.0 and 0.7 cm respectively. The subdural collections are predominately hypodense; although, there is hyperdensity posteriorly on the right (series 2 image 17). There is redemonstration of a non-displaced left occipital calvarial fracture. The middle ear cavities and mastoid air cells reveal no significant opacity." Impression: 1. Increased size of subdural collections along the bilateral cerebral convexities, left greater than right. 2. Slight improvement of trace subarachnoid hemorrhage and increased prominence of trace intraventricular hemorrhage. 3. Non-displaced left occipital calvarial fracture" Electronically signed by V15, Radiologist</p> <p>On 2/5/20 at 1:55 pm, V2 Director of Nursing defined and stated supervision of a resident meant that the resident is within visuals of staff at all times. V2 confirmed that R50 was in the hallway ambulating without supervision, fell and was sent to the hospital on 10/12/19. V2 stated R50 had a soft helmet on, but could not say whether the helmet had been removed prior to</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>the fall.</p> <p>2. R25's Physician's Order Sheet dated February 2020 documents the following diagnoses: Cervical Spine Fracture C2, C3, C4, Chronic Kidney Disease Stage 4, Chronic Obstructive Pulmonary Disease, Hypertension, Neurodegenerative Cognitive Impairment and Toxic Encephalopathy and Fracture Right Hip.</p> <p>The Minimum Data Sheet (MDS) dated 11/29/19 documents R25 as being severely cognitively impaired. The MDS also documents R25 requires one person physical assist for transfers, walking in the room, walking in the corridor and requires two person physical assist for toileting.</p> <p>The facility form titled "Fall Risk Assessment" dated 9/27/10 for R25 documents Fall Risk scores for 8/7/19, 9/20/19 and 11/29/19 at high risk. The form documents R25 to have Occasional Confusion, and Loss of Balance with standing and walking.</p> <p>R25's Care Plan dated 11/22/2019 documents R25 is to have one assist and gait belt for all ambulation. Use additional assist as needed. Personal alarm on while in bed and while up in chair. Check position with cares and functions each shift. R25 is known to unplug and shut off alarm. On 11/8/19 this same Care Plan documents R25 is frequently non-compliant with waiting for staff assistance with ambulation.</p> <p>A facility report titled "Final Report" dated 1/10/20 documents R25 falling on 1/4/2020 and being admitted to the hospital with a Right Intertrochanteric Femur Fracture. The report documents R25 was yelling and the CNA (Certified Nursing Assistant) hearing her yell went</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>into the room and found both R25 and her room mate on the floor.</p> <p>The facility report titled "AIM for Wellness" dated 1/4/20 documents under "Nursing Notes "R25 complaining of right hip pain, unable to move (R25's) right leg. Shortening noted. Orders received from Nurse Practitioner (V12) to send (R25) to emergency room for evaluation and treatment.</p> <p>Hospital records titled "Emergency Department Note Physician Final Report" dated 1/4/2020 documents the following for R25: "Chief Complaint - (R25) in ED (Emergency Department) following fall. (R25) has shortening of the right leg. This patient (R25) is an (sic) 95-year old female presented to the emergency department by EMS (Emergency Medical Service) from (facility) for an evaluation from a fall. From what can be gathered, (R25) was found on the floor and nursing staff observed shortened right lower extremity. (R25) is complaining of right hip pain and there is obvious shortening of the right lower extremity. " X-Ray of the right hip: Impression: "Right Intertrochanteric Femur Fracture."</p> <p>On 2/5/20 at 2:05 pm, V2 Director of Nursing confirmed that on 1/4/20, R25 had gotten up from the recliner in the room to help R25's roommate. V2, also confirmed R25's Plan of Care for fall interventions prior to 1/4/20 included pressure alarms while in recliner and bed, with frequent checks. V2 stated R25 has previously had therapy and was instructed to use the call light and wait for assistance. V2 confirmed there were no alarms being used for R25 the night she fell 1/4/2020.</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>The facility policy titled "Fall Prevention" dated 11/10/18 documents the following: "1. Conduct fall assessments on the day of admission, quarterly, and with a change in condition. 2. All staff must observe residents for safety. If a residents (sic) with a high risk code are observed up or getting up, help must be summoned or assistance must be provided to the resident. 5. Immediately after any resident fall the unit nurse will assess the resident and provide any care or treatment needed for resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions. 7. Report all falls during the morning Quality Assurance meetings Monday through Friday. All falls will be discussed in morning Quality Assurance meeting and any new interventions will be written on the Care Plan."</p> <p>Fall Prevention Interventions: "Keep in visual when out of bed." "Instructions for resident not cognitively impaired to use call light and wait for assistance."</p> <p>A</p>	S9999		
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