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
	IL6001804	A. BUILDING: ______ B. WING ______	C 11/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK-LINDSEY VILLAGE	101 WEST WINDSOR ROAD URBANA, IL 61801

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S 000	Initial Comments Complaint Investigation #2068490/IL128118	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1010h) 300.1210b) 300.1210d)3)6) Section 300.1010 Medical Care Policies h)The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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:

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:

3)Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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.

These requirements are not met as evidenced by the following:

Based on interview and record review the facility failed to complete post fall assessments and neurological assessments following an unwitnessed fall, and failed to notify the physician of a change in a resident's (R1) condition resulting in a delay in treatment for a subdural hematoma (a collection of blood between the layers of the brain.) This failure resulted in R1 being hospitalized and led to R1's subsequent death. R1 was one of three residents (occupying a licensed-only bed) reviewed for falls in the

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sample list of three.

Findings include:

R1's Admission Record dated 10/28/20 documents R1 admitted to the facility on 8/24/20 and has diagnoses of Mild Cognitive Impairment, Hypertension, Fracture of upper/lower end of right fibula, and Fracture of lower end of right tibia.

R1's Order Summary Report dated 10/29/20 documents an order for R1 to receive Aspirin (blood thinning medication) 81 mg (milligrams) by mouth daily starting on 8/11/20.

R1's Nursing Note dated 10/18/20 at 7:29 PM by V14 RN (Registered Nurse) documents R1 was found on the floor lying in front of R1's wheelchair at the foot of R1's bed. This note documents R1 denied hitting R1's head and R1 had no apparent injuries.

R1's Post Fall Assessments dated 10/18/20 at 5:25 PM, 10/19/20 at 5:44 PM, and 10/20/20 at 5:11 AM document a neurological assessment was "not applicable." There is no documentation in R1's medical record that neurological assessments were completed after R1's fall on 10/18/20 at 5:25 PM.

R1's blood pressure log dated 10/28/20 documents R1's blood pressures as follows: 10/18 at 5:40 PM 132/73, 10/19 at 1:47 PM 134/81, 10/20 at 5:00 AM 118/69, 10/20 at 2:54 PM 168/93, 10/21 at 3:55 PM 153/92, 10/22 at 2:13 PM 153/85, 10/23 at 2:25 PM 161/104, 10/24 at 2:59 PM 155/90, 10/25 at 2:00 PM 160/68. There is no documentation that R1's Physician V20 or V4 Nurse Practitioner were notified of R1's change in blood pressure first

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noted on 10/20/20 at 2:54 PM.

R1's Emergency Department Transfer Note dated 10/25/20 at 2:25 PM by V15 RN documents R1 was sent to the local Emergency Room by ambulance. This note documents "Reason for Transfer: For higher level of care, (R1) not eating last days, lethargic." This note documents "difficult to arouse, reported by NAs (Nursing Assistants) been last days from Wednesday (10/21/20.)" There is no documentation in R1's medical record that R1 had a change in appetite and level of alertness prior to 10/25/20, and there is no documentation that V20 or V4 were notified of R1's change in condition prior to 10/25/20.

R1's Hospital History and Physical Note dated 10/26/20 at 1:24 AM by V8 Intensive Care Unit Physician documents R1 was found to be unresponsive and was brought the Emergency Department. This note documents R1's CT (Computed Tomography) scan showed a 7 mm (millimeter) Subdural Hematoma and neurosurgery recommended no surgical intervention. This note documents that R1 had sustained a fall and was found on the floor on Wednesday (10/21/20) and R1's systolic blood pressure remained elevated of greater than 200.

R1's CT of the brain without contrast dated 10/25/20 at 3:17 PM read by V24 Physician documents the clinical indication for the scan as altered mental status and R1 being unresponsive for an unknown amount of time. R1's brain CT documents an impression of "1. Slightly hyperdense left inferior lateral frontal lobe convexity subdural hematoma with maximum thickness of 7 mm."

R1's Hospital Death Summary by V25 Physician

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S9999	Continued From page 4 documents R1 date of death as 10/27/20 at 11:59 PM. This summary documents R1's cause of death as subdural hematoma, and R1's final diagnosis during hospital stay as "subdural hematoma sustained from fall/trauma." On 10/28/20 at 11:52 AM V14 RN stated R1 was found on the floor in R1's room on 10/18/20 when staff brought R1's supper tray to the room. V14 stated V14 assessed R1, and stated since R1 told V14 that R1 did not hit R1's head V14 did not complete a neurological assessment for R1. V14 stated V14 also worked the 11:00 PM to 7:00 AM shift on 10/20 and V14 stated V14 did not complete a post fall assessment for R1. V14 stated post fall assessments are completed on first and second shifts since V14 does not like to wake the residents up during the night. V14 described R1 prior to R1's fall as being alert and oriented with periods of confusion at times. On 10/28/20 at 11:07 AM V16 RN stated V16 provided care for R1 on 10/19 and 10/21. V16 stated post fall neurological assessments were not completed for R1 since R1 had said R1 did not hit R1's head when R1 fell on 10/18/20. V16 stated on 10/22 R1 appeared "sleepy", but V16 thought it was because R1 had gotten up earlier than R1's normal that day. On 10/28/20 at 12:07 PM V15 RN stated V13 CNA (Certified Nursing Assistant) reported to V15 on 10/25/20 at an unidentified time that R1 had been lethargic and slow to respond for several days since 10/21/20. V15 stated V15 had not seen R1 for a couple weeks and R1 was more responsive on 10/25 than on 10/26. V15 stated V15 did not notify V4, V20, or V23 of R1 being lethargic and slow to respond on 10/25 since R1 was up in R1's wheelchair and R1 was eating.	S9999		

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V15 stated on 10/25/20 around 11:30 AM R1 was difficult to arouse. V15 stated V15 placed a cool wash cloth on R1's forehead and sat R1 up in bed. V15 stated R1 would wake, but then fall back to sleep. V15 stated V23 Nurse Practitioner was notified and R1 was sent to the Emergency Room.

On 10/28/20 at 12:23 PM V13 CNA stated on 10/22/20 R1 was "lethargic, super tired, and wouldn't talk to me (V13)," and V13 reported R1's changes to V16 RN on 10/22 around 8:00 AM. V13 stated V16 told V13 that R1 was tired because V13 had gotten R1 up earlier than normal. V13 stated R1 did not eat lunch and still wasn't talking much when V13 laid R1 down around 1:00 PM. V13 stated V16 came to R1's room and asked R1 if R1 "was ok," and R1 told V16 that R1 was "fine." V13 stated on 10/24 R1 still appeared lethargic and didn't eat much, and on 10/25 R1 still appeared to be tired. V13 stated V13 reported to V15 RN on 10/24/20 that R1 had been lethargic for a few days, and V15 told V13 that R1 "was just tired." V13 stated during the morning of 10/25/20 R1 was not responding at all and V15 sent R1 to the hospital around 3:00 PM.

On 10/28/20 at 1:25 PM V11 CNA stated V11 provided care for R1 on 10/23 and described R1 as "weak." V11 stated V11 obtained R1's vitals and reported them to the nurse.

On 10/28/20 at 12:40 PM V2 Director of Nursing stated when a resident has an unwitnessed fall an initial neurological assessment should be completed, even if the resident states they did not hit their head. V2 stated if the neurological assessment is normal then additional neurological assessments do not need to be completed. V2 stated post fall assessments and

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S9999	Continued From page 6 vital signs are to be completed every shift for 72 hours following a fall. V2 confirmed there was no documentation that neurological assessments were completed for R1 following R1's fall on 10/18, and post fall assessments completed on 10/18 3rd shift, 10/19 1st shift, 10/20 2nd shift, 10/20 3rd shift, 10/21 1st shift. V2 stated the physician is to be notified of any changes in a resident's condition. On 10/28/20 at 4:08 PM V2 stated V2 would expect the physician to be notified of changes in a resident's condition. V2 stated if a resident has an elevated blood pressure V2 would expect the nurses to recheck the blood pressure, and if it remains elevated notify the physician. V2 confirmed R1's blood pressure on 10/23/20 at 2:25 PM was 161/104 and there is no documentation in R1's medical record that R1's blood pressure was rechecked, or that V4 or V20 were notified. V2 confirmed there is no documentation that V4 or V20 were notified of R1's lethargy, decreased appetite, and elevated blood pressure until 10/25/20 when R1 was unresponsive. On 11/2/20 11/2/20 at 1:02 PM V2 stated the facility does not have a policy and procedure on post fall neurological assessments. V2 stated V2 submitted an electronic mail that documents the time frames and frequency that neurological assessments are to be completed post falls. On 10/28/20 at 3:52 PM V4 Nurse Practitioner stated since R1's fall on 10/18/20 was unwitnessed, post fall neurological assessments should have been completed. V4 stated V4 should have been notified of R1's elevated blood pressure of 161/104 on 10/23/20. V4 stated with R1's elevated blood pressure, increased sleepiness, and decreased appetite V4 stated the facility should have notified a provider before 10/25/20, and R1 could have been sent to the	S9999		

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S9999	Continued From page 7 Emergency Room prior to 10/25/20. V4 stated since R1's fall on 10/18 is relatively close to when R1 transferred to the hospital on 10/25, it is possible that R1's fall caused the subdural hematoma. On 11/2/20 at 10:30 AM V20 Physician stated V20 would have recommended the facility perform close neurological assessments along with routine monitoring for several hours following R1's fall on 10/18/20, and continue reassessments on a regular basis for 24 to 36 hours. V20 stated V20 was unaware of R1's elevated blood pressure, increased sleepiness and changes in appetite prior to 10/25. V20 stated V20 would have ordered for R1 to be sent to the Emergency Room, and earlier intervention and treatment could have changed R1's outcome of being unresponsive on 10/25/20. V20 stated by identifying R1's change in condition three days sooner, it would have made a big difference, and R1 would have survived. The electronic mail dated 11/2/20 at 11:20 AM from V2 documents post fall neurological assessments are completed every 15 minutes for the first two hours, then every 30 minutes for two hours, then every 60 minutes for four hours, then every 8 hours until 72 hours has lapsed or until the resident is asymptomatic. The facility's Fall Risk Assessment and Protocol dated 9/8/16 documents a nurse will assess a resident immediately following a fall and the resident will be assessed every shift for 72 hours, and the assessment documented in the medical record. The facility's Family and Physician Notification of Changes policy dated 3/3/15 documents "To	S9999		

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ensure that prompt communication alerts the family and physician to acute changes with the resident. An acute change of condition is a sudden, clinically important deviation from the resident's baseline in physical, cognitive, behavioral or functional status. 1. Meadowbrook Health Center (Clark Lindsey Village) shall immediately inform the resident/consult with the resident's physician; and if know, notify the resident's legal representative or an interested family member (unless they have asked to not be notified) when there is: a. An accident involving the resident which results in injury and has the potential for requiring physician interventions; b. A significant change in the resident's physical, mental, or psychosocial status (i.e., (for example) a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); c. A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or d. A decision to transfer or discharge the resident from the facility. 2. The nurse will record in the resident's medical record any changes in the resident's medical condition or status. They will also record notification of family member/POA (Power of Attorney) and the physician in the interdisciplinary notes."

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

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includes measurable objectives and timetables to 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)

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 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.

These requirements are not met as evidenced by the following:

Based on interview and record review the facility failed to develop a care plan to include fall risk and fall prevention interventions for one resident (R1) (occupying a licensed-only bed) of three residents reviewed for falls in the sample list of three.

Findings include:

R1's R1's Admission Record dated 10/28/20 documents R1 admitted to the facility on 8/24/20

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S9999	Continued From page 10 and has diagnoses of Mild Cognitive Impairment, Hypertension, Fracture of upper/lower end of right fibula, and Fracture of lower end of right tibia. R1's Order Summary Report dated 10/29/20 documents an order for R1 to receive Aspirin (blood thinning medication) 81 mg (milligrams) by mouth daily, Metoprolol Tartrate 25 mg every 12 hours for Hypertension, and Losartan Potassium 50 mg daily for Hypertension. R1's Fall Risk Assessment dated 10/18/20 at 5:25 PM documents a total score of 75, indicating R1 is at high risk for falling. R1's Incident Audit Report dated 8/6/20 at 4:32 PM documents R 1 was found kneeling at the side of R1's bed. This report documents the intervention for R1's fall was to obtain laboratory values, a urine sample, and R1 was sent to the Emergency Room. R1's Incident Audit Report dated 8/17/20 at 12:28 AM documents R1 was found lying on R1's right side on the floor. This report documents the post fall intervention was to check on R1 frequently and place R1's bed in low position. R1's Incident Audit Report dated 8/19/20 at 6:30 AM documents R1 was found sitting on the floor beside R1's bed. This report documents the post fall intervention was to use an overlay mattress with bolster or perimeter mattress. R1's Incident Audit Report dated 10/18/20 at 5:25 PM documents R1 was found on the floor in front of R1's wheelchair in R1's room. This report documents the post fall intervention was to ensure R1 has the remote for television at hand when watching television, conduct frequent rounding, encourage use of call light, and to "follow care plan interventions." R1's Care Plan revised on 8/31/20 does not	S9999		

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identify R1 as being high risk for falls and does not document post fall interventions following R1's falls on 8/6, 8/17, 8/19, and 10/18/20.

On 10/28/20 at 4:08 PM V2 Director of Nursing confirmed R1's care plan does not identify R1 as being at risk for falls or post fall interventions following R1's falls in August and October 2020. V2 stated when a resident transfers from the skilled unit to the greenhouse unit, their care plan does not carry over and they are considered the same as a "new admission." V2 stated R1 was residing on the skilled care unit in August at the time of R1's falls.

The facility's Baseline Care Plan policy dated 1/24/18 documents the facility will develop and implement a baseline care plan within 48 hours of a resident's admission. This policy documents the purpose of the care plan is to promote continuity of care, increase resident safety, and safeguard against adverse events. This policy documents the care plan will include resident health and safety concerns to prevent a decline or injury such as an elopement or fall, and identify the resident's needs for supervision and assistance with Activities of Daily Living.

Section 300.690 Incidents and Accidents
a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.

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S9999	Continued From page 12 b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. These requirements are not met as evidenced by the following: Based on interview and record review the facility failed to notify the Illinois Department of Public Health of a serious incident or accident causing physical harm or injury to R1. The facility also failed to submit a narrative summary of this reportable incident/accident to the Department. R1 is one of three residents reviewed for falls in the sample list of three. Findings include: R1's Admission Record dated 10/28/20 documents R1 admitted to the facility on 8/24/20	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001804	A. BUILDING: ______ B. WING ______	C 11/02/2020

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S9999	Continued From page 13 and has diagnoses of Mild Cognitive Impairment, Hypertension, Fracture of upper/lower end of right fibula, and Fracture of lower end of right tibia. R1's Order Summary Report dated 10/29/20 documents an order for R1 to receive Aspirin (blood thinning medication) 81 mg (milligrams) by mouth daily starting on 8/11/20. R1's Nursing Note dated 10/18/20 at 7:29 PM by V14 RN (Registered Nurse) documents R1 was found on the floor lying in front of R1's wheelchair at the foot of R1's bed. This note documents R1 denied hitting R1's head and R1 had no apparent injuries. R1's Emergency Department Transfer Note dated 10/25/20 at 2:25 PM by V15 RN documents R1 was sent to the local Emergency Room by ambulance. This note documents "Reason for Transfer: For higher level of care, (R1) not eating last days, lethargic." This note documents "difficult to arouse, reported by NAs (Nursing Assistants) been last days from Wednesday (10/21/20.)" R1's Hospital History and Physical Note dated 10/26/20 at 1:24 AM by V8 Intensive Care Unit Physician documents R1 was found to be unresponsive and was brought the Emergency Department. This note documents R1's CT (Computed Tomography) scan showed a 7 mm (millimeter) Subdural Hematoma and neurosurgery recommended no surgical intervention. This note documents that R1 had sustained a fall and was found on the floor on Wednesday (10/21/20) and R1's systolic blood pressure remained elevated of greater than 200. R1's CT of the brain without contrast dated	S9999		

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S9999	Continued From page 14	S9999		

10/25/20 at 3:17 PM read by V24 Physician documents the clinical indication for the scan as altered mental status and R1 being unresponsive for an unknown amount of time. R1's brain CT documents an impression of "1. Slightly hyperdense left inferior lateral frontal lobe convexity subdural hematoma with maximum thickness of 7 mm."

R1's Hospital Death Summary by V25 Physician documents R1 date of death as 10/27/20 at 11:59 PM. This summary documents R1's cause of death as subdural hematoma, and R1's final diagnosis during hospital stay as "subdural hematoma sustained from fall/trauma."

On 10/28/20 at 4:08 PM V2 Director of Nursing stated V5 Chief Executive Officer advised V2 that R1's subdural hematoma did not need to be reported to the Illinois Department of Public Health (IDPH) since R1's last fall was on 10/18, and the facility did not believe the subdural hematoma was caused by R1's fall, but that it was possible that R1 had a "stroke." On 10/29/20 at 9:51 AM V2 Director of Nursing stated V2 first became aware of R1's subdural hematoma on the morning of 10/27 after V2 reviewed R1's electronic hospital records. V2 confirmed the facility did not notify IDPH of R1's subdural hematoma and did not conduct an investigation to identify the cause of R1's subdural hematoma.

The facility's Incident and Accident Reporting policy dated 7/18/13 documents an accident "Refers to any unexpected or unintentional incident, which may result in injury or illness to a resident." This policy documents the following "Regulatory References: Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each

Illinois Department of Public Health

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S9999	Continued From page 15 incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The Director of Quality or his/her designee is responsible for notifying the Regional Office of IDPH by fax or phone within 24 hours after each reportable incident or accident. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within 7 days after the occurrence. A copy of all reports to the Regional Office shall be forwarded to the Administrator." AA	S9999		