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 01/14/2020

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

(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 Facility Reported incident of 12/30/19/IL119086 investigation	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) 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 — TITLE — (X6) DATE
Electronically Signed — 01/24/20

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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)

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 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 requirement are not met as evidenced by the following:

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Based on observation, interview, and record review, the facility failed to implement post fall interventions and failed to update care plans with post fall interventions for two of three residents (R1, R2) reviewed for falls in the sample list of three.

Findings include:

1. R1's Face Sheet dated 1/13/20 documents R1 has a diagnosis of Alzheimer's Disease.

R1's Transfer Directive dated 9/4/19 documents R1 transfers by mechanical lift with assistance of one staff.

R1's Progress Note dated 9/15/19 at 10:45 PM by V11, RN documents V11 was outside of R1's doorway and heard V12 CNA (Certified Nursing Assistant) call out for V11. V11 found R1 sitting on the floor inside the bathroom with V12. V12 told V11 that V12 was assisting R1 and when V12 turned to grab something R1 stood up and sat on the floor. R1's Fall Investigation dated 9/15/19 documents the root cause of the fall was R1 stood up from the toilet without assistance and sat on the floor. This investigation documents an intervention to have nonskid socks on R1 at night time and keep R1 in eye sight when giving care since R1 can be impulsive.

R1's Progress Note dated 9/18/19 at 10:27 PM by V9, RN documents R1 was lying on the floor on R1's left side in the hallway. V10, CNA was attempting to move R1 out of the doorway of a resident room when R1 slid out of R1's wheelchair and V10 assisted R1 to the floor. R1's Fall Investigation dated 9/18/19 documents the root cause of the fall was R1 slid out of R1's

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S9999	Continued From page 3 wheelchair when the Certified Nursing Assistant (V8) was trying to move R1 into R1's room. This investigation documents interventions to educate staff on proper placement of R1 to make sure R1's bottom is in the wheelchair properly and a nonskid device was added to R1's wheelchair. R1's Progress Note dated 12/29/19 at 3:45PM by V4 RN (Registered Nurse) documents, staff (V5 Certified Nursing Assistant) was pushing R1 down the hall in R1's wheelchair and R1 put R1's feet down quickly and fell forward out of the wheelchair onto R1's front side hitting R1's head and face on the floor. This note documents R1 had a laceration to R1's forehead and an abrasion to R1's nose. R1's Fall Investigation dated 12/29/19 documents the root cause of the fall was R1 stopped the wheelchair while the chair was in motion and R1 fell onto R1's face on the carpet. This investigation documents an intervention for staff to place foot pedals down when pushing R1 in R1's wheelchair. R1's Progress Note dated 12/29/19 at 4:30 PM by V4, RN documents R1's systolic blood pressure continued to rise and R1 was sent to the local emergency room for evaluation. R1's CT (Computed Tomography) of the brain dated 12/29/19 documents "Impression: 2. Punctate hyperdensity within left anterior superior paramedian parietal lobe suspicious for a tiny acute parenchymal hemorrhage. A short-term follow-up head head CT is recommended as clincially indicated." R1's CT of the brain dated 12/30/19 documents "Impression: 1. Punctate hyperdensity projecting over the high left paramedian parietal lobe appears similar to yesterday's CT. This could represent a tiny focus of hemorrhage or a tiny calicification. Short-term	S9999		

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follow-up CT head may be performed, as clinically indicated."

R1's Care Plan revised on 12/30/19 documents R1 is at risk for falls related to gait/balance problems, unaware of safety needs, and psychotropic medication use. This Care Plan documents R1 had a fall on 3/29/19, but does not document R1's falls and post fall interventions for R1's falls on 9/15, 9/18, and 12/29/19.

On 1/13/20 at 9:17 AM, R1 was sitting in a wheelchair in R1's room. R1 had a reddened area on the bridge of R1's nose.

On 1/13/20 at 1:36PM, V7(CNA) transferred R1 from the wheelchair to R1's bed. R1's wheelchair did not contain a nonskid device.

On 1/14/20 at 8:56AM, R1 was lying in bed asleep. R1's wheelchair did not contain a nonskid device. At 12:07 PM V7, CNA stated R1 does not use a nonskid device in R1's wheelchair.

On 1/14/20 at 12:00 PM V2 Director of Nursing of Residential Care stated post fall interventions should be updated on each resident's plan of care. V2 confirmed R1's post fall interventions for R1's falls on 9/15, 9/18, and 12/30/19 were not on R1's Care Plan. V2 stated R1 should have a nonskid device in R1's wheelchair since that was a post fall intervention for R1's fall on 9/18.

2. R2's Face Sheet dated 1/14/20 documents R2's diagnoses including Spinal Stenosis, Chronic Obstructive Pulmonary Disease, and Macular Degeneration.

R2's Transfer Directive documents R2 transfers with assistance of one staff, gait belt, and four

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wheeled walker.

R2's Progress Note dated 5/27/19 at 11:48 PM by V13, RN documents R2 was found lying on the floor in R2's room. R2 stated R2 was switching chairs when R2 tripped and fell and hit R2's head on the floor. R2 complained of back pain and had a 1.5 cm (centimeters) by 1 cm skin tear to R2's left elbow. R2's Fall Investigation dated 5/27/19 documents the root cause of R2's fall as R2 was self transferring and an intervention to apply a nonskid device in R2's recliner to prevent falls.

R2's Progress Note dated 6/7/19 at 11:15 AM by V14 RN documents V15 CNA entered R2's room and R2 was standing between R2's bed and wheelchair holding onto the wheelchair. V15 attempted to reach R2, and R2 fell landing on R2's left side. R2 was fully clothed and not wearing footwear. This note documents V16 (R2's Daughter) was notified of R2's fall and requested R2's walker be kept near R2. R2's Fall investigation dated 6/7/19 documents the root cause of R2's fall as "improper footwear" and documents an intervention to re-educate R2 on the importance of proper footwear.

R2's Fall Investigation dated 8/26/19 documents R2 was found at 2:15 PM lying on the floor of R2's room with R2's head near the dresser. R2 complained of headache, bilateral hip pain and lower back pain and was transferred to the local emergency room for evaluation. This investigation documents the root cause of R2's fall as R2 was ambulating without assistance and documents an intervention to remind R2 to use the call light and frequently check on R2 when R2 is in R2's room alone.

R2's Progress Note dated 12/30/19 at 4:04 PM by

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V17 documents V17 was called to R2's room by V6, CNA. R2 had gotten up from the toilet to wash R2's hands and V6 transferred R2 to the seat of R2's walker and forgot to lock the wheels of the walker. R2 rolled off of the walker and onto the floor. R2 complained of right hip pain. R2's Fall Investigation dated 12/30/19 documents the root cause of the fall as R2's wheeled walker was not locked and while R2 was sitting and washing R2's hands the walker rolled out from underneath of R2. This investigation documents an intervention to remind staff to make sure the wheels are locked when leaving R2 unattended sitting on the walker seat, and to check R2 more frequently.

R2's Care Plan revised on 6/7/19 documents R2 is at risk for falls and R2 fell on 4/16, 5/27, and 6/7/19. This Care Plan documents an intervention dated 5/28/19 for R2 to have a nonskid device in the seat of R2's recliner to prevent sliding. R2's Care Plan does not document post fall interventions for R2's falls on 6/7, 8/26, and 12/30/19.

On 1/13/20 at 12:38 PM, R2 was sitting in R2's room in a recliner. At 1:49 PM R2's recliner did not have a nonskid device in place.

On 1/13/20 at 3:49 PM, V8 (CNA) entered R2's room and assisted R2 from the recliner to a standing position using a gait belt and wheeled walker. R2's recliner did not contain a nonskid device. V8 stated R2's recliner did not contain a nonskid device. V8 assisted R2 with ambulation and transferred R2 back into R2's recliner.

On 1/14/20 at 12:00 PM ,V2 (Director of Nursing of Residential Care) stated post fall interventions should be updated on each resident's plan of

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S9999	Continued From page 7 care. V2 confirmed R2's post fall interventions for R2's falls on 6/7, 8/26, and 12/30/19 were not on R2's Care Plan. V2 stated R2 transferred to the unit with the intervention to use a nonskid device in R2's recliner and V2 should have a nonskid device in R2's recliner per R2's Care Plan. The facility's Fall Risk Assessment and Protocol dated 9/8/16 documents residents who have been identified as being at risk for falls will have this noted in their care plan and include interventions to have the call light within reach, bed in low position, and nonskid footwear when ambulating. This protocol documents that additional interventions determined by the interdisciplinary team will be documented in the resident's care plan. The facility's Incident and Accident Reporting policy dated 7/18/2013 documents after an incident or accident occurs the nurse will start an investigation within 24 hours of the event. After the investigation is complete the Director of Nursing and other staff members will review for further action/interventions that need to occur. Interventions and actions will be documented on the investigative report, shared with the appropriate staff, and updated on the resident's Care Plan. (B)	S9999		