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
	IL6013791	A. BUILDING: _____ B. WING _____	C 12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMPBELL COURT	426 E. DOUGLAS JACKSONVILLE, IL 62650

(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
Z 000	COMMENTS COMPLAINT INVESTIGATION #2049314/ IL00129018	Z 000		
Z9999	FINDINGS Statement of Licensure Violations: 350.620 a) 350.1210 350.1220 j) 350.1230 d)1) 350.1230 d)2) 350.3240 a) Section 350.620 Resident Care Policies a)The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.1220 Physician Services j) The facility shall notify the resident's physician of any accident, injury, or change in a resident's condition that threatens the health, safety or welfare of a resident. Section 350.1230 Nursing Services d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction	Z9999	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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Z9999	Continued From page 1 or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 2) Basic skills required to meet the health needs and problems of the residents. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. Based on record review and interview, the facility failed to exercise necessary operating direction when the facility failed to implement their policies on: 1) Physical Injury and Illness/Individual Medical Emergencies 2) Nursing Services and 3) Safe Individual Handling; and failed to provide timely and effective medical services. These failures resulted in 1 of 1 individuals (R1) sustaining a Left Femoral Neck Fracture requiring surgical intervention. The facility also failed to address the medical needs of 1 of 1 individual (R1) when nursing services failed to: assess individual following post operative discharge from hospital, educate staff on dressing change for a new surgical site, educate staff on signs and symptoms of post-operative complications, and educate staff on transfer technique related to fractured femur, resulting in (R1) being readmitted to the hospital with pneumonia. Findings include: ISP (Individual Service Plan) dated 7/23/20 identifies R1 as a 62 year old male with diagnoses including Bilateral Aphakia, Hearing Impairment and Hypertension who functions at the Profound Level of Intellectual Disability.	Z9999		

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Z9999	Continued From page 2 1. Policy 5.57 Revised 05/19 documents; "Subject: Physical Injury and Illness/Individual Medical Emergencies. Policy: Individuals served by the agency shall receive timely and effective medical service for physical injuries and illnesses and medical emergencies...Definitions: Neglect : Failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness... Procedure: In the event that an individual sustains an injury or illness, staff on duty shall conduct observation and take appropriate action consistent with the following: A. As soon as the injury or illness is determined to be a medical emergency, the DSP (Direct Support Person) is to call 911...C. Notify the RN (Registered Nurse for consultation and QIDP (Qualified Intellectual Disability Professional) or Administrator for direction." R1's Nursing Health History and Assessment date 7/13/20 documents; "Physical Limitations: Legally blind-bilateral aphakia glaucoma, Bilateral Hearing impairment and unsteady gait. General Observations...(R1) requires total assistance with transfers and remains in w/c (wheelchair) propelled by staff." In addition, R1's weight is documented as 89.4 pounds. R1's ISP documents; "Risk Assessment Summary: A risk assessment was completed on 7/23/20 for (R1) and found the following risks for him. (R1) is not able to report pain or discomfort. He has diabetes and most recently was evaluated for poor gait leading to frequent fall, a gait belt and wheelchair are now in order for use transporting. (R1) is not able to report abuse or potential for abuse." Progress Note written by E3/DSP (Direct Support Professional) dated 11/26/20 at 6:00 AM,	Z9999		

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Z9999	Continued From page 3 documents; "On 11/26/20 at 5:30 AM, I (E3) was putting (R1) on to the shower chair, I (E3) had walked away to grab soap and he (R1) fell onto his left side....there were no marks or anything that I (E3) saw at that time." The sections to identify persons notified is blank. R1's Nursing Note dated 11/26/20 documents; "Notified by E2/QIDP at 4:42 PM that (R1) had fallen in the shower during the morning and now could not move leg and was not tolerating pressure placed on it. Instructed (R1) to be taken to ER (emergency room) immediately. Call placed to ambulance. At 6 PM received a call that it was a broken femur. Admitted into (local hospital). Surgery scheduled for the next day." R1's MAR (Medication Administration Record) documents Acetaminophen (Tylenol) was administered at 1:00 PM on 11/26/20 for knee pain by E4/DSP. R1's Hospital Records document R1 was seen in the emergency department on 11/26/20 at 7:57 PM with a diagnosis of Left femoral neck fracture. On 11/27/20, the records document R1 had surgery (left hip pinning) to repair the fracture. On 12/7/20 at 8:30 AM, E1/Administrator verified E2/QIDP contacted him on 11/26/20 between 4:30 PM and 5:00 PM to report R1 had fallen during his shower early that morning. E1 stated he was told R1 had bruising on the left hip, would not bear weight and was showing signs of pain. E1 directed E2 to have the facility call ambulance to have R1 transported to local emergency department. E1 confirmed he was not notified of R1's fall prior to the above phone call. E1 was asked if staff should have reported R1's fall to the nurse. E1 responded, "Yes."	Z9999		

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Z9999	Continued From page 4 During interview with E3 on 12/7/20 at 10:15 AM, E3 stated on 11/26/20 (E3) woke (R1) up at 5:00 AM and put (R1) in wheelchair to take him to the toilet prior to giving R1 a shower. E3 stated; "I (E3) began rinsing (R1) off in the shower and had to go get soap. (R1) fell off the chair. I (E3) lifted him off the floor and got him (R1) up to wheelchair then to toilet. (R1) would not help stand so I (E3) left him on toilet for (E4/DSP). It was extra hard to lift him." E3 confirmed R1 was left alone in the bathroom and sitting on toilet until E4 arrived at approximately 7:30 AM. E3 stated she filled out a GP-15 (Incident Report) before leaving that day but did not report the incident to the Nurse, QIDP or Administrator stating; "did not think anything was wrong." E3 confirmed R1 is typically able to assist with standing and transfers with the use of a gait belt. On 12/7/20 at 11:20 AM, E4/DSP stated she arrived to work on 11/26/20 around 7:20 AM. E4 stated, "Upon my arrival, (E3) said (R1) had fallen in the shower that morning. (E3) said (R1) was dead weight and she needed my help transferring him off the toilet." E4 stated (R1's) left knee was banged up and she thought that was why R1 was not standing. E4 reported it took two staff to clean him up following a bowel movement with one assisting R1 to stand and the other cleaning R1. E4 stated R1 had a gash and a bruise on his left knee. E4 stated R1 was transferred from the toilet to a wheelchair and taken to the living room where she elevated his left leg. E4 stated she was aware E3 had not reported the incident to anyone. E4 also confirmed she did not report the fall to anyone. E3 stated she administered R1 Tylenol for knee pain at 1:00 PM and worked until 2:30 PM.	Z9999		

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Z9999	Continued From page 5 On 12/7/20 at 4:28 PM, E9/RNT (Registered Nurse Trainer) stated; "On 11/26/20 at 4:42 PM , I (E9) got a call from (E2/QIDP). (E2) stated (R1) had fallen in the shower and was unable to bear weight. After (E2) described (I) told her to call for an ambulance to transport to transport to ER." E9 confirmed the 4:42 PM call was her first knowledge R1's injury and also confirmed the DSP should have reported R1's fall to the nurse, the QIDP, and/or administrator immediately. On 12/14/20 at 9:48 AM, E5/DSP stated she worked the evening shift (3:30-11:30 PM) on 11/26/20 with E6/DSP. E5 stated R1 was in bed when she arrived. E5 stated R1 being in bed was unusual. E5 also stated E7/DSP told her R1 had fallen when E3/DSP was showering him (early morning) but no injury was reported to her. E5 stated it took herself (E5) and E6 to get R1 up and while get R1 dressed they noticed a scrape on R1's left knee. E5 stated R1 would not stand and E6 called the QIDP to report R1's change. On 12/14/20 at 10:19 AM, E10/RN (Registered Nurse) was asked if the facility contacted her when R1 fell. E10 responded; "I (E10) was not contacted until 11/28/20 and that was to provide training on a new medication." E10 was asked when the staff should have reported R1's fall. E10 responded; "As close to the time of incident as possible and by then end of the shift." E10 was asked if the staff should have moved R1 from the floor to the toilet after he fell. E10 responded; "No." E10 was also asked if staff should have left R1 sitting unattended on the toilet for approximately two hours. E10 responded; "No." On 12/14/20 at 10:33 AM, E6/DSP stated she worked the evening shift (3:30-10:30 PM) on	Z9999		

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Z9999	Continued From page 6 11/26/20 with E5/DSP. E6 stated upon her arrival on 11/26/20, E7/DSP reported that R1 had fallen during his shower that morning. E6 reported herself and E5 went to check on R1 and he was sleeping. E6 then stated about 4:00-4:15 PM, they (E5 and E6) went to change R1's adult diaper and it took two of them when it generally takes one. E6 stated she contacted E8/Home Manager who told her she would call E2/QIDP and was directed to call for an ambulance to transport R1 to the emergency room. On 12/14/20 at 2:05 PM, E7/DSP stated she worked the day shift with E4/DSP on 11/26/20 and came in around 7:30 AM. E7 stated E4 informed her that R1 had fallen on night shift during his shower. E7 reported R1 was seated on the couch when she arrived and both legs were elevated. E7 stated R1 is usually transferred with one person but on 11/26/20, it took two people. E7 reported R1 was not acting himself, refused to stand and refused to eat. E7 stated R1 was placed back in bed with the assistance of E4 and E4 gave R1 Tylenol for pain. E7 confirmed she was not aware if E3/DSP had reported the fall and also confirmed she placed no phone calls to the nurse or administration that day. On 12/14/20 the local ambulance provider stated a call came in to transport R1 to the local hospital at 1717 (5:17 PM) on 11/26/20. 2. Policy 7.02 Nursing Services Revised 03/19 documents; "The home shall provide nursing services to meet individuals' needs and to comply with licensing standards. All individuals shall receive proper treatment of minor accidents and/or illnesses through the RN (Registered Nurse) Trainer. PURPOSE: 1. To provide	Z9999		

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Z9999	Continued From page 7	Z9999		

quality health care 24 hours per day to individuals in need. 2. To maintain an optimal level of health to all individuals via RN Trainer intervention. 3. To serve as a primary resource of health care and provide education to direct care personnel and individuals. 4. To ensure supervision as an active process in which the RN Trainer monitors, directs, guides and evaluates the outcomes of the delegated task or activity. The RN Trainer maintains accountability for the tasks and responsibilities, as subcomponents of the total patient care, delegated to authorized direct care staff... PROCEDURE: ...4. The RN Trainer shall complete individual's health assessment...during routine scheduled and PRN (as needed) visits to homes...5. The following procedures shall be used to report minor illnesses or injuries to the RN Trainer. a. DSP(Direct Support Person) observes, or individual approaches DSP with a minor illness or injury. b. DSP relays the symptoms to RN Trainer and documents on a Progress Note (GP-15) when appropriate. C. RN will communicate professional judgement based on given information and the DSP shall implement and document the RN's responses. d. If symptoms worsen at any point, the RN Trainer will be notified for further instructions/follow up."

R1's Hospital discharge records dated 11/28/20 document R1 was discharged to the facility on 11/28/20 following surgical repair of left femoral head fracture. Discharge Instructions include a dressing change daily for three incision sites and an order for as needed pain medications. Hospital discharge records document the patient was provided a copy of the discharge instructions and verbalized understanding.

R1's Hospital Records dated 12/1/20 document R1 was re-admitted to the hospital on 11/29/20

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Z9999	Continued From page 8 with a diagnosis of Pneumonia. An electronic message dated 12/7/20 and sent by E9/RNT (Registered Nurse Trainer) documents, "There was no assessment upon his (R1's) first return home from hospital because I (E9) was not made aware that he had been discharged on 11/28/2020 from (Local hospital)-(the day after his surgery). I(E9) became aware he was home at (facility) on 11/29 when I (E9) received a call about the audible wheezing I (E9) could hear over the phone which sounded as if he (R1) was in respiratory distress, and said to call the ambulance. He (R1) was re-admitted at that time." On 12/7/20 at 4:28 PM, E9/RNT stated the facility had not informed her of R1's discharge from the hospital on 12/28/20. On 12/14/20 at 10:19 AM, E10/Regional Nurse Trainer was asked if she spoke to the local hospital prior to R1's discharge on 11/28/20. E10 responded; "No." E10 was asked if she assessed R1 upon his return from the hospital following surgery to repair the Left Femur Neck fracture. E10 responded; "No." E10 was asked is R1's hospital discharge packet had been reviewed. E10 responded; "No." E10 was asked if education had been provided to staff related to R1's surgical wound, complications that could be associated with post-surgery or transfer techniques. E10 responded; "(I) only educate on medication component." E10 was asked if a care plan was developed for R1. E10 responded; "I don't (do not) know." 3. Policy 7.25 Safe Individual Handling Revised 04/16 documents; "Each home is dedicated to providing quality care to individuals..Our Safe	Z9999		

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Z9999	Continued From page 9 Individual Handling Program is designed to meet the following goals: 4. Protect staff and individuals from injury...Procedure: 2. Transfers without using a mechanical lifting device are limited to: a. Assisting individuals who are ambulatory or stable with weight bearing transfer in and out of bed, wheelchairs, chairs, shower chair, tubs and stool or commodes...c. Other lifts and transfers where the back and knees remain vertical and the lift does not exceed 30 pounds in total. R1's Nursing Health History and Assessment date 7/13/20 documents; "Physical Limitations: Legally blind-bilateral aphakia glaucome, Bilateral Hearing impairment and unsteady gait. General Observations...(R1) requires total assistance with transfers and remains in w/c (wheelchair) propelled by staff." Additionally, R1's weight is documented as 89.4 pounds. During interview with E3 on 12/7/20 at 10:15 AM, E3 stated on 11/26/20 (E3) woke (R1) up at 5:00 AM and put (R1) in wheelchair to take him to the toilet prior to giving R1 a shower. E3 stated; "I (E3) began rinsing (R1) off in the shower and had to go get soap. (R1) fell off the chair. I (E3) lifted him off the floor and got him (R1) up to wheelchair then to toilet. (R1) would not help stand so I (E3) left him on toilet for (E4/DSP). It was extra hard to lift him." E3 confirmed R1 was left alone in the bathroom and sitting on toilet until E4 arrived at approximately 7:30 AM. E3 stated she filled out a GP-15 (Incident Report) before leaving that day but did not report the incident to the Nurse, QIDP or Administrator stating; "(I) did not think anything was wrong." E3 confirmed R1 is typically able to assist with standing and transfers with the use of a gait belt.	Z9999		

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Z9999	Continued From page 10 On 12/14/20 at 10:19 AM, E10/RN (Registered Nurse) was asked if the staff should have moved R1 from the floor to the toilet after he fell. E10 responded; "No." (A)	Z9999		