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
	IL6011373	A. BUILDING: ______ B. WING ______	C 06/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE OF STERLING	612 WEST ST MARY'S STREET STERLING, IL 61081

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S9999	Final Observations	S9999		

Statement of Licensure Violation:
1 of 1 Violation:

300.610a)
300.1210b)
300.1210d)3)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

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological

Attachment A
Statement of Licensure Violations

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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.

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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

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These Requirements are not met as evidenced by:

Based on interview and record review the facility failed to immediately notify R2's physician for a resident (R2) with a history of brain bleeds and blood thinning medication use when he (R2) fell and hit his head on the floor.

This failure resulted in R2 requiring emergency treatment. R2 sustained bilateral subdural hematomas (brain bleeds) and was hospitalized. R2 expired five days later as a result of his injuries.

This applies to 1 of 3 residents (R2) reviewed for physician notification in the sample of 10.

The findings include:

The hospital discharge summary dated May 20, 2019 showed R2 was transferred from the facility to a local hospital on May 11, 2019 following a fall and subsequently expired on May 16, 2019.

Facility's incident report dated May 11, 2019 states on May 11, 2019 at 7:00 AM, R2 was observed lying on the floor next to bed by Certified Nursing Assistant (CNA). R2 was laying on right side of body with no visible head injury noted, including assessment of head. R2 denied pain, vital signs, neurological checks, and mental status remained within normal limits until approximately 11:00 AM when wife, who was visiting, informed nurse of change in condition. Nurse assessed and observed acute change in neurological status. 911 immediately notified,

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physician notified, and Power of Attorney (POA) at bedside. Transferred to hospital for evaluation. Computed tomography (CT) of head results indicate acute Subdural Hematoma. Resident admitted to hospital.

R2's electronic face sheet dated June 5, 2019 showed R2 had diagnoses of dementia, repeated falls, acute myocardial infarction (heart attack), hydrocephalus (fluid in the brain) and difficulty in walking. R2's history and physical from May 11, 2019 showed diagnoses of brain shunt placement and frontal subdural intracranial bleeds (brain bleeds). R2's physician's order sheet showed R2 was taking two blood thinning medications.

R2's care plan dated December 22, 2017 stated "I (R2) am at risk for falls due to poor safety awareness, confusion, forgetfulness, dementia, weakness, difficulty in walking, anti-hypertensive medications, narcotics and history of falls. R2's care plan goal dated May 7, 2018 stated "(R2) will continue to utilize a pressure alarm."

R2's care plan dated March 6, 2018 states "(R2) prefers the use of bilateral ½ padded side rails on my bed for turning and repositioning, helping me transfer to and from bed safely, provides stabilization while sitting on the side of my bed, and it promotes safety while I receive activities of daily living (ADL) care from staff."

On June 5, 2019 at 1:20 PM, V7 stated R2 normally had two side rails up when in bed but when V7 found R2 his side rail was down. V7 stated R2 was not able to lower the side rails on his own. V7 stated (R2's) pressure alarm was on his bed but was not sounding when she found R2 on the floor. V7 Certified Nursing Assistant (CNA) stated on May 11, 2019 at approximately

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7:00 AM she walked past (R2's) room and noticed him on the floor on his right side with his head on the floor between the recliner and bed. V7 stated "I'm pretty sure he hit his head." V7 called for V17 Licensed Practical Nurse (LPN) to assess (R2).

On June 5, 2019 at 12:18 PM, V15 LPN stated she assisted V17 with initial assessment of (R2). Upon entering the room, (R2) was laying on his right side with his head behind the recliner. Staff then assisted (R2) to the side of his bed and then into his chair.

On June 6, 2019 at 9:19 AM, V18 Physician covering for primary physician stated (R2) was a candidate for surgical intervention. V18 stated the four hour delay in emergency treatment affected the outcome in this case. "Timing is paramount with a subdural hematoma." V18 stated "(R2's) fall directly contributed to his death as he bled from trauma to the head. The use of Plavix, Aspirin and (R2's) history of subdural bleeds made him a very high risk patient and this was a very unfortunate case."

On June 6, 2019 at 8:58 AM, V2 Director of Nursing stated Plavix and Aspirin are anti-platelets, not anti-coagulants so residents on these medications are not automatically sent for evaluation following an unwitnessed fall. If a resident had a fall, developed bruising and was on blood thinning medications the physician should be notified.
On June 7, 2019 at 10:42 AM, V7 stated (R2's) baseline functional status was one to two assist transfer and could use a walker for short distances. At approximately 10:45am (R2) was pale, wouldn't pick up his feet, his eyes were half open, he was not talking, his mouth was half

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open and he was "spacing out." V7 stated at this time (R2) required assistance of two staff members to transfer him into bed.

On June 6, 2019 at 10:05 AM, V16 Nurse Practitioner who was covering on-call for R2's primary physician stated she received a call from V17 Licensed Practical Nurse at 11:13 AM (Four hours after R2 fell) on May 11, 2019 and returned her call at 11:15 AM. V17 reported R2 was having seizure-like activity and had sustained a fall earlier in the morning. V16 gave orders to send R2 to the emergency room immediately for evaluation. V16 stated if she had been called four hours earlier when the fall occurred, she would have immediately sent him to the emergency room. V16 confirmed on her pager and computer system that she did not receive any calls from the facility on May 11, 2019 until 11:13 AM. V16 also confirmed she was the only person on call for the facility from the evening of May 10, 2019 thru the morning of May 13, 2019. (V16 was not notified of the 7:00AM fall incident until 11:15 AM).

On June 7, 2019 at 10:50 AM, V2 stated if a resident is experiencing an acute situation (seizure-like activity) the nurses know to notify 911 before attempting to call the physician. All of the nurses are aware they can do that. In (R2's) situation, 911 should have been called before the physician because R2 was at his baseline health condition right before the wife notified the nurse that the acute change occurred.

On June 7, 2019 at 11:32 AM, V17 stated her initial call to report R2's fall to a physician was at 9:00 AM and did not receive a call back. V17 called V16 at 10:45 AM to report R2's change in condition. V17 stated there was nothing unusual with his behavior or vital signs so she did not feel

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it was urgent to immediately notify on call physician. V17 stated there was a delay in notification because she was doing medication pass.

On June 11, 2019 at 1:22 PM, V20 Communications Specialist stated "Initial call from the facility to the switchboard was received at 11:10 AM. Local hospital attendant picked up the phone call at 11:11 AM. V16 was paged at 11:13 AM."

Record review of telephone log from local hospital showed the only phone call received from facility to local hospital switchboard occurred on May 11, 2019 at 11:10 AM.

The facility's Post Fall Assessment policy dated September 1, 2018 states "5. The physician and responsible party will be notified of the fall and findings from the assessment."

The facility's Change in Condition policy dated November 1, 2018 states "5. The Resident/Physician/Family/Responsible party will be notified when there has been: a. an accident or incident involving the resident...6. In the event of an emergency situation, 911 will be called immediately and the Physician/Family/Responsible party will be notified as soon as possible ..."

The facility's Abuse and Prevention policy revised on July 25, 2018 states "Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress."

On June 6, 2019 at 1:30 PM, V1 stated the facility

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S9999	Continued From page 7 has no policies regarding emergency care, physician notification or unwitnessed fall for a resident on blood thinning medication. (A)	S9999		