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
	IL6005300	A. BUILDING: _____ B. WING _____	C 12/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS MEMORIAL CHRISTIAN VLG	3400 WEST WASHINGTON SPRINGFIELD, IL 62702

(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
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610A 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 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	S9999		

Attachment A- Statement of Licensure Violations

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S9999	Continued From page 1 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to identify hazards and risks and provide supervision to prevent avoidable accidents for one of four residents (R4)with a history of falls in a total sample of six. This failure resulted in R4 sustaining a right temporal acute subdural hematoma, small intraparenchymal hemorrhage to the right front lobe and large right scalp hematoma. Findings include: R4's Physicians Order Sheet (POS) dated 11/1/2014 to 11/30/2014, documented R4's diagnoses to include, Osteoporosis, Muscle Weakness, Personal History of Fall and Subdural Hemorrhage. R4's Minimum Data Set (MDS) dated 8/25/2014, documented R4's Brief Interview for Mental	S9999		

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Status (BIMS) as 11 (Score 8-12: moderately impaired cognition). R4's MDS documented R4's needs extensive assistance with one person physical assist for transfers. The MDS documents R4 needs extensive assistance of two person physical assist for toileting.

R4's Care Plan, date initiated 5/15/13, Revision date 6/3/13, documented, follow facility fall protocol/falling star program.

The facility's Falling Star Protocol, not dated, documented, "The falling star protocol is a center based portion of the Fall Management Program. Purpose: To identify residents who are at risk for falling. To ensure residents benefit from participation. To distinguish residents with a visual identifier 'Falling Star' To include staff and families in fall prevention strategies. Protocol: A resident qualifies for the Falling Star Program if: They have fallen within 30 days prior to admission. Experience a change in condition or decline in Activities of Daily Living. Fallen in the facility. The resident is identified by a star on their name plate outside their door and on their wheelchair/walker."

The facility's Incident Log for September documented R4 had fallen on 9/9/14 and 9/11/14. The Incident Log documented R4 did not fall in October. In November R4 fell on 11/15/14 which resulted in a hematoma to R4's forehead. On 11/16/14 R4 fell which resulted in a hematoma to R4's forehead and subdural hematoma.

Nurse's Notes dated 11/16/14 at 2:45 PM, documented, "Writer heard slapping noise in the hallway and went down to residents room. Observed resident lying on the floor on right side with right arm under body and visible blood under

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her face. Co-nurse was present and immediately placed pillow under head. Co-nurse began first aide and cleansed area and applied cool compress to slow bleeding. Hematoma visible at left upper corner of forehead (3.5 centimeters (cm) x 4 cm), raised by 2 cm with laceration in center of hematoma. New orders were received from Personal Care Physician (PCP) to send (R4) to the Emergency Room for evaluation."

The Hospitalization Summary dated 11/19/14, documented, included, R4 was admitted to the hospital on 11/16/14 and discharge back to the facility on 11/19/14. Cat scan of head documented "1. Small right temporal acute subdural hematoma. 2. There is a tiny, 5 millimeter intraparenchymal hemorrhage in the right frontal lobe without significant associated edema/mass effect. 3. Large right scalp hematoma. 4. Volume loss and chronic ischemic microangiopathy."

On 11/25/14 at 10:50 AM, R4 was observed sitting in her wheelchair in the middle of 200 hallway. R4 was asking "Where am I?" R4 had a large amount of purple bruising on the top of her nose, on both right and left cheeks and under her chin. Yellowish brown bruising noted to her forehead. R4 was asked what had happened to her and replied "I fell down."

On 11/25/14 at 10:50 AM and 3:07 PM, No falling star was observed on R4's door or R4's wheelchair.

On 11/25/14 at 3:07 PM, E8, Licensed Practical Nurse (LPN) was asked what does it mean when a star is on one side of the door. E8 said the side of the door where the star is, means that resident is on the falling star program. E8 was asked why

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there was no star on R4's door or wheelchair. E8 said "There should be a star on R4's door and wheelchair, it must have fallen off."

On 11/25/14 at 8:57 AM, Z1, R4's daughter/ Power of Attorney, was asked about R4's fall on 11/16/14. Z1 said, R4 was assisted to the bathroom and on the toilet riser. The staff then gave R4 the call light and left her in the bathroom alone. Z1 said the staff found R4 beside her bed on the floor with her head facing toward the foot of the bed and her pants were half way down. Z1 said she did not know how R4 managed to get from the bathroom to the bed with her pants half way down. Z1 said R4 cannot manage sitting on the toilet by herself. Z1 stated R4 needs someone to stay with her because she will just get up when she is finished and not wait for help.

On 11/26/14 at 11:21 AM, E8 was asked if on 11/16/14 prior to R4's fall if R4 had been in the bathroom and walking back to her bed without assistance. E8 said she could have been. E8 was asked if any staff would take R4 to the bathroom and give her the call light and tell her to call for help when she was finished. E8 said, "No one was to leave her alone on the toilet because (R4) was on the falling star program and could not be left alone in the bathroom." E8 said R4 was noncompliant about turning on her call light and asking for help.

Nurse's notes dated 9/6/14 at 1:40 PM, documented, "Resident non compliant with transfer and putting herself to bed. Nurse's Noted dated 9/6/14 at 9:29 AM, documents "Resident is non compliant with asking and waiting for help with going to the restroom or getting into bed." R4's Nurse's Note, on 10/26/14 at 11:02 AM, documents "Resident attempting to self transfer

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from her bed to the bathroom. Resident reminded that she needed assistance with ambulation and transfers." R4's Nurse's Note on 10/27/14 at 1:01 PM, documents "Resident noted to be self ambulating in her room without her walker. Resident states that she was going to the bathroom. Staff assisted resident to the bathroom. Afterwards resident was placed by the nurses station for observation."

On 11/16/14 at 9:14 AM, Nurse's Notes documented "Resident non-compliant with waiting for help. Resident will turn her call light on but not wait for someone to help her. Resident has been explained that she really needs to wait for help so she doesn't fall again and get hurt."

The facility's Fall Incident/Occurrence witness statement dated 11/16/14 at 2:45 PM, written by E9, Certified Nurse's Assistant (CNA) , documented, R4 was found in her restroom at 2:43 PM. E9 statement documented E9 left R4 in the restroom to see why the resident across the hall was hollering and heard the nurse running down the hall to R4's room.

The Fall Incident/Occurrence, witness statement dated 11/16/14 at 2:45 PM, written by, E10, Registered Nurse (RN) documented "Walking by residents room as I was coming into work today and saw staff running to (R4's) room. (R4) was lying on her right side on the floor beside her bed. Her pants were half way up. Resident fell yesterday as well. Direct pressure applied to bleeding hematoma on right forehead. Bleeding stopped. Ice then applied to hematoma. Appears the resident also broke nose as septum deviated, swollen and bleeding. (E9) said she put R4 in her bathroom, call bell given. Resident instructed to stay there and use call bell when finished. had

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S9999	Continued From page 6 shoes and socks on, pants halfway up." (A)	S9999		

Lewis Memorial Christian Village
3400 West Washington
Springfield, IL 62711
217-787-9600

PLAN OF CORRECTION

F323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

1. The corrective action for the alleged deficient practice has been achieved by the following:
   A. Restorative staff performed Falling Star Program audit ensuring all residents at risk have falling stars placed on name plates and assistive devices.
   B. R4's falling star removed during hospitalization and replaced on 11/25/2014

2. Residents have the potential to be affected by the alleged deficient practice. However, due to the re-education of staff and community awareness (see attachment F323 2-A) the alleged deficient practice will not recur.

3. Upon review of the facility's policy and procedures, no changes need to be implemented for the alleged deficient practice does not recur.
   A. R4's care plan updated with new interventions as required. (See attachment F323 3-A) Care plan meeting notes with R4's POA also addresses noncompliance (see attachment F323 3-A2)
   B. R4's MDS evaluated for look back period 8/19/2014-8/25/2014. During that period, only 1 documented toilet transfer out of 23 reflected assist of 2 (see attachment F323 3-B)
   C. Physical Therapy outcomes work sheet for the period of 7/9/2014-8/5/2014 evaluated resident as being contact guard assist. (See attachment F323 3-C)
   D. R4's history of falls reflect self transferring and self toileting except fall on 11/16/2014 in which resident was assisted to bathroom. New interventions added 11/17/14 which included supervision in the bathroom. (see attachment 3-A)
4. The following Quality Assurance programs have been implemented for continued compliance:
   A. Falling star protocol packs were placed on each hall containing stars for name plates and assistive devices. Staff was re- educated to replace stars if they fall off equipment or to initiate protocol on qualifying residents.(See attachment F323 4-A)
   B. Restorative staff to perform weekly Falling Star Program Audits (see attachment F323 4-B)
   C. Newly hired nursing staff are educated on Falling Star Program policy

5. Completion date for corrective action: 12/12/2014

6. _____ accepted
   Cynthia Schaaf, Administrator

attachment B- Imposed plan of correction

This plan of correction is being submitted pursuant to the applicable federal and state regulations. Nothing contained herein shall be construed as an admission that the Facility violated any federal or state regulation or failed to follow any applicable standard of care.