Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6007678	B. WING		C 01/07/2015	5	
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
SYCAM	SYCAMORE HEALTHCARE CENTER 720 SYCAMORE QUINCY, IL 62301						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPL	LETE	
S9999	Final Observations		S9999				
	Statement of Licens	sure Violations	de lini de didenno un monero a seguipi				
	300.1210b) 300.1210c) 300.1210d)6) 300.3240a)						
	Nursing and Person b) The facility shall p and services to attar practicable physical well-being of the res each resident's com plan. Adequate and care and personal c resident to meet the care needs of the re	eneral Requirements for al Care provide the necessary care in or maintain the highest mental, and psychological ident, in accordance with prehensive resident care properly supervised nursing are shall be provided to each total nursing and personal sident. Restorative measures inimum, the following					
THE POPULATION AND ADDRESS OF THE PO		giving staff shall review and bout his or her residents' care plan					
	care shall include, a and shall be practice seven-day-a-week b 6) All necessary preassure that the resid as free of accident hoursing personnel shat each resident reand assistance to present the section 300.3240 At a) An owner, license	asis: cautions shall be taken to lents' environment remains azards as possible. All hall evaluate residents to see receives adequate supervision event accidents. buse and Neglect e, administrator, employee or					
	agent of a facility sha ment of Public Health	all not abuse or neglect a					
BORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	TITLE	(X6) DATE		

01/16/15

STATE FORM

KVSC11

If continuation sheet 1 of 3

Attachment A Statement of Licensure Violations

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007678			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING	i:	COMPLETED	
		B. WING	B. WING		C 01/07/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
SYCAMO	ORE HEALTHCARE CI	ENTER 720 SYCA QUINCY,				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 1	S9999			
	resident		у организация объема от технология объема от технология объема от технология объема от технология объема от те			
	These requirements by: Based on record revialled to ensure all right the required assistive residents (R1) reviet three. This failure right transferred from the chair, without the usifalling and sustaining findings include: A Fall Risk Assessmedocuments R1 has to Osteoporosis, Osteomuscle Weakness, a R1 as being "High R" A Plan of Care, date "had an actual fall du (sit to stand) lift duriries and now will be a (m) Date initiated: 9/10/2 of Care documents for transfer, toilet use for transfer, toilet use	wheelchair to the shower se of a mechanical lift, R1 g a femur fracture. nent, dated 11/17/14, she current diagnoses of parthritis, History of Falls, and Hemiplegia and scored				
1	document the nurse room. (R1) was sittir with (complaint) of pa	1 12/05/14 at 7:30 p.m., was "called into shower ng in front of shower chair ain to left legreceived R. (Emergency Room)."				
((R1) from (wheelchai	rm, dated 12/06/14, /14 staff were "transferring ir) to shower chair with two Shower chair rolled. (R1)				

Illinois Department of Public Health

Illinois Department of Public Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		С	
		IL6007678	B. WING		1)7/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
SYCAMO	ORE HEALTHCARE CI	ENTER 720 SYCA QUINCY,				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 2	S9999			
	lowered to floor. (C E.R. for evaluation. (fracture)."	complaint) of leg pain. Sent to Admitted with left femur				
	documents "The pa fracture of the left fe	re Summary, dated 12/10/14, tient (R1) was admitted with a emur after patient sustained a time. (R1) underwent surgical."				
	Nursing) stated that mechanical lift to tra transferred from a w with a mechanical lift required the use of a	p.m., E2 (Director of a resident who requires a ansfer, would need to be wheelchair to a shower chair ft. E2 concluded that R1 has a mechanical lift for all she fell during a transfer over one year ago.				
	(B)					
PORTAL DESIGNATION AND ADMINISTRATION ADMINISTRATION AND ADMINISTRATION ADMINISTRATION AND ADMINISTRATION AND ADMINISTRATION AND ADMINISTRATION AND ADMINISTRATION AN						

			i			
		EDITO PANAL				

Illinois Department of Public Health

KVSC11

PRINTED: 02/03/2015 FORM APPROVED

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
						C	
IL6007678		B. WING		ž .	07/2015		
NAME OF I	PROVIDER OR SUPPLIER			, STATE, ZIP CODE			
SYCAMO	SYCAMORE HEALTHCARE CENTER 720 SYCAMORE QUINCY, IL 62301						
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	T	DDOWNEDIO DI AVIOTO DE CO			
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
S9999	Final Observations		S9999				
,	Statement of Licens	sure Violations	***************************************				
	300.1210b) 300.1210c) 300.1210d)6) 300.3240a)		-				
	Nursing and Person b) The facility shall and services to atta practicable physical well-being of the reseach resident's complan. Adequate and care and personal cresident to meet the care needs of the reshall include, at a machine procedures: c) Each direct care-to be knowledgeable a respective resident of the care shall include, at a machine procedure of the care shall include, at a machine procedure of the care shall include, at a machine procedure of the care shall include, at a machine procedure of the care shall include, at and shall be practiced and shall be practiced seven-day-a-week be of the care of accident has free of accident has the residuant of the care of accident has a service of accident has a	provide the necessary care in or maintain the highest l, mental, and psychological sident, in accordance with a prehensive resident care properly supervised nursing care shall be provided to each e total nursing and personal esident. Restorative measures inimum, the following giving staff shall review and about his or her residents' care plan ection (a), general nursing the a minimum, the following ed on a 24-hour,					
	and assistance to pr Section 300.3240 Ab a) An owner, license	O Company					

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE 01/16/15

If continuation sheet 1 of 3

PRINTED: 02/03/2015 FORM APPROVED

С

01/07/2015

Illinois Department of Public Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING:

IL6007678

NAME OF PROVIDER OR SUPPLIER

B. WING_

NAME OF PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY	Y, STATE, ZIP CODE			
SYCAMO	ORE HEALTHCARE CENTER	720 SYCA QUINCY,					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM	/ FIII I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
S9999	Continued From page 1		S9999				
	resident						
	These requirements were not met as exby: Based on record review and interview, to failed to ensure all residents were trans the required assistive devices, for one of residents (R1) reviewed for falls, in a sathree. This failure resulted in R1 being transferred from the wheelchair to the such air, without the use of a mechanical I falling and sustaining a femur fracture.	the facility ferred with of three ample of hower					
7)	Findings include:	THE PLANTAGE PROPERTY.					
m region has some and the latest and	A Fall Risk Assessment, dated 11/17/14 documents R1 has the current diagnose Osteoporosis, Osteoarthritis, History of Muscle Weakness, and Hemiplegia and R1 as being "High Risk" for falls.	es of Falls					
	A Plan of Care, dated 12/11/14, docume "had an actual fall due to her releasing h (sit to stand) lift during transfer. (R1) rea and now will be a (mechanical lift) for tra Date initiated: 9/10/2013." Additionally, to Care documents R1 as "total assist of for transfer, toilet use and bathing. (Meditf for all transfersDate initiated: 9/09/2	nands off evaluated insfers. the Plan f two staff					
r	Nursing notes, dated 12/05/14 at 7:30 p. document the nurse was "called into sho room. (R1) was sitting in front of shower with (complaint) of pain to left legreceiverders to send to E.R. (Emergency Roon	wer chair	::				
() a	A Incident Report Form, dated 12/06/14, documents on 12/05/14 staff were "trans R1) from (wheelchair) to shower chair wassist and gait belt. Shower chair rolled.	ith two					

Illinois Department of Public Health STATE FORM

PRINTED: 02/03/2015 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C B. WING IL6007678 01/07/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 720 SYCAMORE SYCAMORE HEALTHCARE CENTER **QUINCY, IL 62301** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 2 S9999 lowered to floor. (Complaint) of leg pain. Sent to E.R. for evaluation. Admitted with left femur (fracture)." A Hospital Discharge Summary, dated 12/10/14, documents "The patient (R1) was admitted with a fracture of the left femur after patient sustained a fall at the nursing home. (R1) underwent surgical repair...on 12/06/14." On 1/07/15 at 12:34 p.m., E2 (Director of Nursing) stated that a resident who requires a mechanical lift to transfer, would need to be transferred from a wheelchair to a shower chair with a mechanical lift. E2 concluded that R1 has required the use of a mechanical lift for all transfers ever since she fell during a transfer using a sit to stand, over one year ago. (B)

Illinois Department of Public Health