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
	IL6012355	A. BUILDING: ______ B. WING ______	C 02/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRALIA MANOR	1910 EAST MCCORD RTE 161 EAST CENTRALIA, IL 62801

(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	S9999		

Statement of Licensure Violations:

300.610a)
300.1210b)
300.1210d)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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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

Attachment A

Statement of Licensure Violations

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S9999	Continued From page 1	S9999		

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. Restorative measures shall include, at a minimum, the following procedures:

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.

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 Regulations were not met as evidenced by:

Based on interview and record review the facility failed to use a gait belt when transferring a resident, which required the assistance of two staff persons and a gait belt for 1 resident (R3)

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S9999	Continued From page 2	S9999		

Continued From page 2

reviewed for falls. This failure resulted in R3 falling and sustaining a right hip fracture.

The findings include:

R3's February 2015 Physician's orders stated that R3 had a diagnoses of Congestive Heart Failure; Diabetes Mellitus Type II; Hypertension; Atrial Fibrillation; Peripheral Vascular Disease and Angina; Dementia; Anxiety; Depression and Pain. R3's Minimum Data Set dated 01-12-2015 states in Section G; Line B that R3 is Extensive assist of two for transfers and R3's undated Fall Risk Evaluation stated that R3 was High Risk for falls. The facility's policy dated 12/2002 on "Gait Belt" use stated under "Policy"; It is the policy of the facility that all direct care staff shall use a gait belt when transferring or ambulation residents. The Gait Belt policy states under "Procedures"; Line 2: No resident will be transferred or ambulated without the use of a gait belt, unless to do so is contraindicated and this would be indentified on residents plan of care.

R3's Resident Progress Note, dated 01-12-2015 at 10:48, stated that CNA staff reported a controlled sit down with resident in 400 shower room. Upon entering shower room, R3 was observed sitting on buttocks with Right leg bent beneath her and left leg extended straight in front of resident. CNA staff stated, "We were transferring her from wheel chair to shower chair and her right leg started to bend behind her so we helped her sit on the floor." R3 extended her right leg in front of her and range of motion was within normal limits. R3 was assisted to the shower chair with 3 staff. R3 had a purple bruise on the right lateral breast and right arm with no swelling to the site. Z2 (Patient's Primary Physician) was

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S9999	Continued From page 3 notified as well as Z1 (Family Member). On 01-12-2015 at 12:27 PM, R3's Nurses Notes stated that CNAs brought R3 back to nurses station from lunch and she was lethargic and was in her wheel chair with her head down, skin yellow, cool and clammy. R3's respirations were even and unlabored, and her lungs clear. R3 had 3+ pitting edema to both of her lower extremities and no warmth to the site. R3 was complaining of severe pain in both lower extremities and her blood pressure was 106/ 62, pulse weak and thready and E5 (RN) was unable to palpate pulse radially. Z2 was notified, and at 2:18 PM, Z2 returned call and gave orders to send R3 to the hospital. On 02-23-2015 at 9:45 AM, Z1 (Patient's Family Member) stated that he was told that R3 had to get a shower, and while she was being transferred from her wheel chair to the shower chair, R3 had what the staff called a "controlled fall", and there were no problems related to the fall. Z1 stated that he thought the nurse did her best, but didn't identify a broken bone. Z1 also stated that R3 did have a bruise on her right breast and right ribs and realized that R3 was on a blood thinner and bruising can happen with that. Z1 did not mention R3 having fractured ribs. Z1 also stated that Z4 (Family Member) was there to be with R3 around 12:30 PM on 01-12-2015, and Z4 told Z1 that R3 was put back in bed and wasn't responding but was turning her head back and forth. Z1 stated that was when the facility called Z2 (Physician) to have R3 taken to the hospital. Z1 stated that it took a long time to get R3 sent out because they were waiting on Z2 to call and give orders. Z1 stated that R3's Death Certificate stated that R3 died from Cardiopulmonary Arrest, Congestive Heart Failure and Chronic Kidney secondary to Disease	S9999		

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S9999	Continued From page 4 and that R3 had a Fractured hip and Peripheral Vascular Disease. On 02-23-2015 at 11:20 AM, E7 (Certified Nursing Assistant) stated that she came in after R3's fall and was told that R3's legs buckled under her and they lowered R3 to the floor. E7 stated that E6 (Certified Nursing Assistant) and a Nursing Assistant student from the High School was also involved in the transfer, but doesn't know her name. E7 also stated that R3 was transferred to the shower chair after E5 (Registered Nurse) did an assessment of R3 and that R3 wasn't complaining of pain during the transfer and was not complaining of pain while being showered or when R3 was transferred back into her wheel chair. E7 stated that R3 had a bruise on her right breast and her right rib area, but no briusing on her right hip. E7 stated that R3's legs were swollen and draining, but R3 had that condition prior to the fall. On 02-23-2015 at 11:30 AM, E6 stated that she and a student (couldn't recall her name) from the high school Certified Nursing Assistant (CNA) program that was helping her with R3 because R3 was covered in bowel movement (BM) and needed a shower. E6 stated that she did not use a gait belt to transfer R3 from the wheel chair to the shower chair because R3 was completely covered with BM and didn't want to get the BM on the gait belt. E6 stated that when she and the CNA student stood R3 to transfer her to the shower chair, E6 stated that R3's right leg went behind her left leg and her knees were bending and E6 stated that she and the CNA student lowered E6 to the floor and while R3 was on the floor, her right leg was underneath her. E6 stated that she had her arm under R3's right arm when R3 was lowered to the floor, and that R3 was not complaining of pain but was complaining about being on the floor and wanted to be gotten up and put in the shower chair. E6 also said that R3 did not have a bruise	S9999		

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S9999	Continued From page 5 on her breast on right side before the transfer, and E6 also stated that R3 didn't have a bruise after the fall. On 02-23-2015 at 11:45 AM, E5 (RN) stated that the CNAs came and got her and they said that R3 had a "controlled fall". (lowered R3 to the floor). E5 stated that when she got into the shower room, R3 had her left leg extended out in front of her and the right leg was bent underneath her. E5 stated that when R3 extended the right leg out in front of her, R3 didn't complain of pain and there was no noticeable shortening or rotation of the right leg. E5 stated that she asked R3 two or three times if she was in pain and R3 kept saying "no". E5 stated that she also assessed R3 to see if she had feeling in the right leg and when performing range of motion to R3's right hip, she was not complaining of pain. E5 stated that R3 always had 2-3+ pitting edema in both lower extremities and she couldn't determine if there was an injury to the right leg or hip. E5 stated that around lunch time on 01-12-2015, the CNAs brought R3 up to the nurses station and she was lethargic, pale, and her pulse was weak and her blood pressure was low. E5 stated that they put R3 into bed and she called Z2 and didn't get an answer. E5 stated that she tried to call Z2 (Patient's Physician) again with no answer, and then around 1:00 PM she called the Z3 (Medical Director). E5 stated that Z4 was with R3 around 12:30 PM and Z4 stated that she believed R3 was not in a lot of distress and to wait and see what Z2 would say. E5 stated that Z2 (Patient's Primary Physician) finally called and gave the order to have R3 sent to the local hospital around 2:18 PM. On 02-23-2015 at 2:45 PM, Z2 stated via telephone that R3 had a lot of medical problems including Congesstive Heart Failure, Atrial Fibrillation, Deep Vein Thrombosis, Bruising, Stroke and Dementia and that R3 was a DNR (Do Not Resuscitate). Z2 stated that R3's	S9999		

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cause of death was Cardiopulmonary arrest and Congestive Heart Failure and did not believe that the hip fracture was the cause of death, but was a contributing factor. Z2 stated that he knew the family and they wanted to keep her comfortable. On 02-23-2015 at 3:30 PM, E1 (Administrator) stated that E6 was counselled on the proper use of gait belts and that the CNAs would be retrained on use of gait belts as well as monitored by the Director of Nursing, Assistant Director of Nursing and Nursing staff.

R3's Certification of Death Record dated January 15th, 2015 stated that the immediate "Cause of Death" Part I; line a.) Cardiopulmonary Arrest
line b.) Congestive Heart Failure
line c.) Chronic Kidney Disease
Part 2 (Significant conditions contributing to death but not resulting in the underlying cause given in Part I); Fracture hip and PAD (Peripheral Artery Disease)

(A)

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

Attachment B
Imposed Plan of Correction

Centralia Manor
Complaint 1550888/IL75119
Survey Date: February 23, 2015

Imposed Plan of Correction

300.610a)
300.1210b)
300.1220d)6)
300.3240a)

Section 300.610 Resident Care Policies

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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. Restorative measures shall include, at a minimum, the following procedures:

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.

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)

Compliance with the above Regulations will be accomplished by:

A. Resident assessments are to be reviewed to ensure that those residents who are at risk for falls have appropriate interventions and gait belts are used as per care plan.

B. Audits are to be conducted by the Shift Coordinator to determine that gait belts are being used appropriately and record.

C. Nursing staff is to be educated, as needed, on gait belt and the appropriate way to use, and any extra training as needed.

D. Results of audits and training are to be document and reviewed by the facility Quality Assurance Committee Monthly and for review and recommendations.

Completion date: 10 Days from Receipt of Notice

Attachment B
Imposed Plan of Correction

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: CENTRALIA MANOR COMPLAINT #: 0075119
LIC. ID #: 0047225
DATE COMPLAINT RECEIVED: 02/20/15 09:30:00

IDPH Code	Allegation Summary	Determination
104	NEGLECT	2
105	IMPROPER NURSING CARE	1 F323
131	RESIDENT INJURY	1 F323

X The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.