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
	IL6008973	A. BUILDING: _____ B. WING _____	07/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESENCE ST JOSEPH CENTER	659 EAST JEFFERSON STREET FREEPORT, IL 61032

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S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 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 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/10/15

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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 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.
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 are not met as evidenced by:

Based on interview and record review the facility failed to evaluate resident falls for root cause, and failed to implement additional individualized fall prevention measures based on the root cause for two of two residents (R1, R2) reviewed for falls in a sample of ten. These failures resulted in R1 sustaining a fall with fracture.

Findings include:

1. R1's Fall Risk Assessment, dated 7/6/15,

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documents that R1 has a score of seven which puts R1 at high risk for falls.

R1's Incident Report, dated 1/8/15, documents that R1 attempted to transfer self from R1's wheelchair to R1's bed and fell. The Incident report also documents that the new intervention put into place following this fall was a fall mat next to R1's bed.

R1's Incident Reports, dated 3/30/15, 4/6/15, and 4/8/15, document that R1 fell while attempting to transfer self from R1's bed to R1's wheelchair. R1's Care Plan, dated 7/20/15, documents that the interventions for each of these falls was "bounce mat next to R1's bed continues to work."

R1's Incident Report, dated 6/13/15, documents that R1 was found on the floor beside R1's bed, and R1 had no injuries.

R1's Nursing notes, dated 6/14/15 at 11:53 a.m., documents that R1 was administered as needed pain medication for visual signs of pain, and R1 started reporting pain and discomfort to R1's hip area to all staff.

R1's Care plan, dated 7/20/15, documents that the new intervention for R1's 6/13/15 fall was to increase R1's pain medication, and was added to the care plan 6/14/15.

R1's Nursing notes, dated 6/15/15 at 4:31 p.m., documents that R1 was was complaining of pain with any movements to R1's right hip, and R1 was sent to the Emergency room for evaluation.

R1's Pelvis X-ray, dated 6/15/15, documents no fractures to R1's Pelvis.

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R1's Incident report, dated 6/16/15, documents that R1 was found on R1's knees next to R1's bed.

R1's Nursing notes, dated 6/16/15 to 6/21/15, document that R1 continues to complain of pain to right leg and hip.

R1's Nursing notes, dated 6/22/15 at 12:57 p.m., documents that Z1 (R1's Nurse Practitioner) had scheduled a Computed Tomography of the R1's pelvis.

R1's Computed Tomography (CT) results, dated 6/22/15, documents that R1 had a fracture across the inferior aspect of the right ischial tuberosity, the inferior lip of the right acetabulum.

On 7/21/15 at 12:50 p.m., E8 (Restorative Nurse) stated, "My goal is to try and put in a new intervention with each fall. If they're in a low bed and have a bounce mat we don't have to have a new intervention it's preventing injury. We try to evaluate the interventions to see if they are working. When (R1) fell on 6/13/15 the new intervention was to increase (R1's) pain medication."

On 7/21/15 at 1:20 p.m., E2 (Director of Nursing) stated, "(R1) fell on 6/13/15 (R1) was trying to get himself into bed. We always add something to interventions after falls...There was no relation with pain and the fall that occurred on 6/13/15...The new interventions for the 6/13/15 fall were added after the pelvis fractures were found on 6/22/15...On 6/16/15, (R1) fell trying to get into bed from (R1's) wheelchair."

On 7/21/15 at 1:45 p.m., E8 stated, "Pain was not the cause of (R1's) fall on 6/13/15, but I initiated

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the pain medication intervention for (R1) because (R1) personally complained to me about increased pain on 6/14/15. I hoped it would prevent future falls if (R1) wasn't in pain."

2. A Resident Incident Report dated 2/17/15 documents R2 fell on that date sustaining a fracture to the right femur. The report also documents the intervention of a floor mat and keeping R2's bed in the low position were initiated. R2's Resident Incident Reports dated 4/17/15 and 4/30/15 document R2 had fallen out of bed onto the floor mat on both of those dates. The reports do not include a root cause for R2's falls. Both reports document as interventions, "Low bed with bounce mat continues to work to prevent injury."

R2's care plan dated 2/17/15 documents the intervention of, "low bed with floor mat," as the fall prevention measure that was added after R2's fall. R2's care plan interventions dated 4/17/15 and 4/30/15 states, "...low bed with bounce mat continues to work to prevent injury."

On 7/21/15 at 11:50 a.m. E8 (Restorative Nurse) stated E8 adds fall prevention interventions to residents' care plans. E8 verified E8 investigated R2's falls which occurred 4/17/15 and 4/30/15. E8 verified no additional fall prevention interventions were added to R2's care plan stating, "Our goal is to prevent injuries not to prevent falls."

A fall prevention program policy dated 6/18/13 states, "If the patient/resident falls...Document all factors contributing to the fall, interventions currently in place and implementation of any additional safety measures..."

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(B)