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 03/16/2021

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

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S 000	Initial Comments Complaint Investigation 2141496/IL131530	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.1220b)2)3) 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	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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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 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:
2)Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.
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

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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.

These requirements were not met evidenced by:

Based on observation, interview, and record review, the facility failed to provide adequate supervision, and implement progressive interventions to prevent falls for 1 of 4 residents (R2) reviewed for falls in the sample of 4. This failure resulted in R2 falling and requiring emergency medical care for a laceration to her nose, and fractured nasal bone.

Findings include:

R2's Electronic Medical Record (EMR) dated 3/11/21 documents R2's diagnosis includes, Dementia, Hypertension (HTN), Anxiety, Heart Failure, Cerebrovascular Accident (CVA), Fractured Nasal Bones.

R2's Minimum Data Set (MDS). Dated 2/9/2021, documents R2 has severely impaired cognition. R2 requires extensive assist of 2 for transfers. R2's MDS documents she has poor balance and is only able to stabilize with staff assistance when moving from seated to standing position, walking, turning around, moving on and off toilet, and during surface to surface transfers

R2's Care Plan Focus, initiated 8/2/20, documents R2 has risk for falls related to (r/t) Impaired Mobility, takes medications that could have adverse reactions that could interfere with

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her safety, heart failure, and history of self-transferring. The facility initiated the following interventions on the following dates to address R2's fall risk: 8/20/20, anti- rollbacks to be placed on (wheelchair (w/c) to prevent rolling; 10/28/20, Placement of non-skid in front of toilet and bed. Offer assist to toilet before bed; 11/8/20, Occupational Therapy (OT) to evaluate for recliner safety; 1/3/21 staff to make sure she is wearing appropriate footwear when ambulating or transferring; Stop light program initiated; 1/4/21 Place concave mattress on bed; and 1/5/21 Begin frequent rounds on all shifts." The Care Plan Intervention dated 1/5/21 did not document how often frequent rounds should be conducted on all shifts to monitor R2.

R2's Progress Note, dated 2/3/21 6:16 PM documented that a Certified Nurse's Aide (CNA) was passing by R2's room and saw R2 lying on the floor in front of the refrigerator. The Note documented R2 sustained a skin tear to her right 1st finger and right elbow.

R2's Care Plan Intervention, initiation date of 2/4/21, documented "Request schedule pain medications for adequate pain control along with PRN (as needed) for breakthrough pain."

R2's Progress Note, date 2/15/2021 at 1:40 PM documents "Resident very tearful & (and) fretful all of this shift. Resident attempting to transfer self out of recliner & onto toilet by self." The note documented that 1:1's provided for positive reinforcement and reassurance.

R2's Progress Notes dated 2/15/21 at 9:30 PM documents "Resident heard yelling, writer went to check on resident. Resident was laying on the floor next to dresser on the wall across from bed

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on her back with her head towards the door. Resident assessed while on the floor, and left leg was rotated inwards. Writer went and got another nurse to assess resident with the same conclusion. Resident covered up and pillow placed under head. (R2)'s medical doctor office called to update and get orders to send to Emergency Room (ER) for evaluation and x-ray's [sic]. (Power of Attorney/(POA) called and notified of fall. POA had concerns about sending resident to hospital because previous hospital visit. Hospice called and notified of fall and wanting resident sent to (ER) for x-ray's [sic] and evaluation. Ok given to send and be treated plus admitted if need be. Ambulance Service called to transport to (local hospital)."

R2's Progress Notes dated 2/16/21 at 6:15 AM document, "Resident returned to facility per Ambulance Service back to room, falls with neuro checks continued. Resident changed and made comfortable, call light in reach. Will continue to monitor safety and needs."

R2's Care Plan, revised on 2/17/21 documented "Continues to attempt self-transfers/ambulation without calling for assist." The Care Plan interventions to address this fall documented the facility would obtain a UA (urinalysis) and labs). The Care Plan did not address how staff were going to monitor R2 for attempting to self-transfer/ambulation.

R2's Progress Note, dated 2/19/21, documented "Begin frequent round on all shifts to monitor for safety. Every 3 hours for increased falls initial rounding sheet in room q (every) 3 (hours)." This intervention was not added to R2's Care Plan.

R2's Progress notes dated 2/22/2021 at 7:49 AM,

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documented "Writer alerted by staff at 3:55 AM that resident was bleeding on the floor in her room. Resident assessed had a large hematoma on her forehead and a bleeding laceration across her nose. Ambulance was called at 0400 (4:00 AM) to transport resident to Local Hospital to be evaluated and treated. POA and Hospice Nurse both notified."

R2's Progress notes dated, 2/22/2021 at 8:39 AM document, "Resident returned to facility per facility transport van. Resident noted to have bruising to nose, forehead hematoma & bruising to the right side of the hematoma, bilateral eyes above and below. Resident complains of (c/o) pain. Morphine given for c/o. pain."

R2's X-Ray Report from ER visit on 2/22/21 documents include, "The images demonstrate a new acute nasal bone fracture with overlying soft tissue swelling. New right frontal soft tissue swelling."

R2's Progress Note, dated 2/22/21 at 10:22 PM documented "Hospice company to order floor mats, new mattress and chair/bed alarm."

R2's Care Plan Interventions, initiated on 2/22/21, documented "Allow for essential caregiver visits with daughter." The Care Plan Interventions, initiated on 2/23/21 documented "Hospice was consulted re (regarding) alarm and floor mats."

R2's My Way Steady Steps Fall Management Program dated 2/23/21 documents, "Keep at nurse's station when not in bed or during cares provided by staff."

The Interdisciplinary Team (IDT) Note, dated 3/4/21, documented "IDT met to discuss fall

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interventions placed. Continued current interventions and follow up as needed."

R2's Progress notes dated 3/7/21 at 1:40 PM document, "Resident observed sitting on floor of bathroom. Floor was wet. Resident's pants noted to be soiled. Wheelchair was positioned behind resident in doorway. Hospice, and POA notified. No injuries noted."

R2's Post Incident Evaluation Form, dated 3/7/21, documented R2 was attempting to self-transfer to the toilet. The Incident Evaluation did not document why R2 was in her wheelchair alone in her room.

On 3/9/21 at 3:25 PM, R2 is in her wheelchair in her room. R2 had bruising and a hematoma to her forehead, both eyes were bruised, and her right and left cheeks were bruised. R2's bridge of nose had an opened dried laceration. A Red Traffic Light sign was on her wheelchair. There was no chair alarm on her wheelchair and there was no mat on the floor next to her bed.

On 3/9/21 at 3:25 PM, V3 Registered Nurse (RN) Nurse Manager states, "The alarm and floor mat need to come from Hospice and they have been notified."

On 3/11/21 at 10:00 AM, V1 Administrator and V2 Director of Nurses (DON) both stated they did not know why R2 did not have her alarm on or bedside mat on the floor.

On 3/11/21at 11:00 AM, R2 had no alarm on her bed and has no bedside mat on the floor. R2 was sleeping in her bed.

On 3/11/21 at 11:10 AM, V9 Licensed Practical

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S9999	Continued From page 7 Nurse (LPN) stated, "(R2) is supposed to have a chair alarm. I don't know why she doesn't. Still waiting on hospice to bring it in." On 3/11/21 at 2:38 PM, V13 Hospice Patient Care Manager stated, "When the Hospice Nurse requested the alarm for (R2), (V13) had called the facility to make sure the facility uses alarms because some facilities do not. She left a message with (V1) the Administrator and with (V3) the Nurse Manager because neither one answered the phone call. No one got back to her. She called (V3) on 2/22/21 and left a message. She called (V1) on 2/25/21 and left a message. To this day no one has called her back." On 3/11/21 at 2:42 PM, V14 Hospice Nurse stated, "I went to the facility to see (R2) when she got back from the ER on 2/22/21. I suggested an alarm and a mat for the floor. I contacted my boss (V13) (Patient Care Manager) I was told we needed to get approval from the facility for the chair/bed alarm because it is considered a restraint. My manager left a message with (V1) the Administrator and with (V3) the Nurse Manager and she has never heard anything back from them." The Facility's "Fall Prevention-Steady Steps" Policy, with revision date of 2/17/20 documents, Policy: It is the policy of this facility to provide each resident with an appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. Additionally, all resident falls in this community are analyzed and trended through the Quality Assurance/Performance Improvement (QAPI) process to determine if additional measures are required by the community to decrease falls including but not limited to Performance	S9999		

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S9999	Continued From page 8 Improvement Project." The Policy documents "Fall Prevention: Residents identified as at risk for falls, will have clinically appropriate interventions put into place to reduce the risk for falls and/or to prevent recurrence of falls. The Interdisciplinary Team will review and modify the fall risk prevention plan of care at a minimum of quarterly, after each fall, and as clinically indicated. Interventions for the fall prevention plan will be modified following the interdisciplinary review and changes will be made to the plan of care accordingly. Fall Risk Analysis Intervention Tool will be completed on Admission/Readmission and a change in condition that could potentially affect the resident's fall risk by the Interdisciplinary Team." The Policy documented the following under the section "Red Light Protocol": The Red Light Protocol is a community-based portion of the Fall Management-Steady Steps Program. The Purpose: To assist in identifying resident who are at the highest risk for falling. To ensure residents will benefit from participation. To distinguish residents with a visual identifier "Traffic Light". To include staff and families in fall prevention strategies. Protocol: A resident qualifies for the Red Light Program if they are identified to be at highest risk for falls. The resident is placed in the program at the discretion of the Interdisciplinary Team. A "Traffic Light is placed on the resident's room nameplate/door frame, bed, and various appliances-wheelchair, walker. etc. to indicate the resident is part of the Red Light Program." The Policy documents under the Section "POST FALL INTERVENTION" documents "Attempt to determine appropriate fall intervention(s) and implement as soon as possible after the fall. Utilize the Patient Centered Intervention Tool to assist in determining potential interventions with input from appropriate associates. The resident will be screened by the Rehab Department after	S9999		

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S9999	Continued From page 9 each fall. Care Plan will be reviewed and revised with additional/modified fall interventions as indicated." " B "	S9999		