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
	IL6002679	A. BUILDING: _____ B. WING _____	03/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN VILLAGE CARE CENTER	400 SOUTH STATION ROAD GLEN CARBON, IL 62034

(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
S 000	Initial Comments Annual Licensure and Certification Survey Licensure Violations	S 000		
S9999	Final Observations 300.1210b)4)5) 300.1210d)6) 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: 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an	S9999	Attachment A Statement of Licensure Violations	

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effort to help them retain or maintain their highest practicable level of functioning.
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.

These requirements were not met as evidenced by:

Based on observation, record review and interview the facility failed to implement safety measures and or progressive fall interventions for 3 of 5 residents (R36, R9, and R29) reviewed for fall in the sample of 36. This failure resulted in R36 falling and being sent to the hospital for head trauma and a wound to the left side of her forehead requiring steri strips.

Findings Include:

R36's Electronic Health Record (EHR) Diagnoses dated 8/8/17 through 10/10/18 documents (in part) R36 has Alzheimer's disease and Abnormal Posture.

R36's Care Plan dated 03/18/19 documents R36 is unable to communicate and follow basic instructions. R36's Care Plan also documents "I am a potential risk for falls related to my decline from Dementia." R36's Care Plan documents R36 had a fall on 09/03/18 due to (R36) sitting down in the hallway, and R36 was unable to tell staff why

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she sat down in the hallway. R36's intervention for this fall was to slow down when walking, and hold her head up. R36's Care Plan documented on 10/16/18 R36 had a fall while being assisted back to her room after supper. R36 hit her head, and was sent to a hospital. R36's intervention for this fall is to walk with (R36) holding on to her gait belt as she uses a wheeled walker, and do not let go of R36.

R36's Care Plan dated 03/18/19 documents as of 3/19/19 R36 is no longer able to walk due to her dementia progression.

R36's Minimum Data Set (MDS) dated 07/20/18 documents R36 was a 2/2 for walking, which represents limited assistance of one staff. R36's MDS dated 07/20/18 also documents R36 balance for walking was a 1, which represents not steady but able to stabilize without staff assistance.

R36's MDS dated 01/18/19 documents R36 is an 8/8 for walking, which represents the activity did not occur. R36's balance for walking is an eight, which represents the activity did not occur.

R36's Event Report/Safety Events form dated 09/03/18 documents an unnamed Certified Nursing Assistant (CNA) observed R36 to sit on the floor. R36 was unable to say why she sat on the floor. R36's Intervention is remind R36 to slow down, when walking.

R36's Event Report/Safety Events form dated 10/16/18 documents V15 CNA was ambulating R36 back to her room to get ready for bed. V15 let go of the resident. R36 lost her balance and fell forward hitting the left side of her forehead on the floor. A large bump showed up on R36's head

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right away. R36 had two open slits to the center of the swollen area with moderate bleeding. Steri strips and ice were applied to her forehead. R36 was sent to the hospital for a CAT (computerized axial tomography) scan of her head.

R36's EHR Progress Noted dated 10/17/18 documents CAT scan results are extensive degenerative changes and a small focal hemorrhage in left occipital lobe.

R36's EHR Progress Note dated 10/22/18 R36 returned from the local hospital with an Intraparenchy hematoma of the brain due to trauma, and steri strips to the left forehead.

On 03/21/19 at 11:45 AM V19 CNA and V20 CNA entered the residents room, and told the resident time to get up for lunch. V20 stated" (R36) was weak so she needed two people to get her up." V19 placed a gait belt around her waist and V19 and V20 sat R36 on the side of the bed, and then lifted her up into her wheelchair. R36 did not pivot, but R36 was very rigid during her transfer.

On 03/22/19 at 8:40 AM V2 Director of Nursing stated "I expect they stay with the Elder, if they are care planned for assistance."

On 03/22/19 at 9:13 AM V18 Nurse Practitioner stated "If she needs assistance I would expect the CNA to stay with the patient."

On 03/22/19 at 12:42 PM V15 stated "We were walking with her (R36) walker to bed, and I stopped at the linen to get her a pad for her bed and a gown. She (R36) fell."

2. On 03/19/19 09:52 AM, R9 was observed

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sitting up in a high back wheelchair in dining area. R9 was observed wearing a helmet, dressed with shoes on and tapping right foot lightly on floor in a nervous motion. At 10:08 AM, R9 was observed taken by wheelchair to the activity of roll the ball. At 10:44 AM, R9 was given a puzzle type flexible toy for self activity. At 11:03 AM, R9 was observed ambulating with V16, CNA down the hall to the bathroom with a semi-steady gait. R9 was toileted and assisted back to the wheelchair in the hall and taken to dining room for lunch.

The POS, dated 03/01/19, documented R9 had the following diagnoses, in part as, cerebral ischemia, palliative care, Alzheimer's Disease, Insomnia, Dementia with behavioral disturbances, anxiety and aphasia. It documented on 06/20/18, may use soft helmet for protection when up.
The MDS, dated 03/15/19, documented R9 had a BIMS score of zero and required extensive assistance of at least one staff for ambulation, transfers, toileting and bathing. It documented R9 was on no restorative programs or any type of therapy.

The Event Reports for R9 were reviewed. It documented R9 had fallen at least 50 times from 05/31/18 to 02/17/19. The injuries sustained with these falls ranged from bruising, skin tears and lacerations. On 08/17/18 at 1:17 PM, R9 fell to the floor while attempting to sit in a chair. The intervention was to help her sit down in chair. On 08/17/18 at 2:40 PM, R9 fell to the floor sustaining a laceration to the left elbow. The intervention was to place a stop sign on the door. On 10/23/18 at 7:47 PM, R9 fell sustaining a skin tear to the left elbow. The intervention was to redirect away from furniture and to move furniture to allow more space. On 01/01/19 at 11:41 AM, R9 fell in the hallway sustaining a laceration to

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her face. The intervention was to continue to monitor safety utilizing approaches. On 01/14/19 at 12:30 PM, R9 fell in hallway and re-opened skin tear on nose from prior fall. The intervention was to pad the helmet and use hip protectors. On 01/25/19 at 1:15 PM, R9 fell in the hallway sustaining a cut to the inside of her lip. The intervention was to continue the approaches to keep safe. On 02/17/19 at 9:00 AM, R9 fell in the hallway. There was no intervention listed. The interventions listed for these falls were repetitive and not effective to keep R9 safe from falling.

The care plan, dated 12/04/18, documented R9 had a history of falling, unsteady gait and balance issues. It also documented R9 was confused, disoriented, wanders and paces. It documented R9 was unaware of her problems or safety risks. On 03/19/19, the care plan documented under falls "I am no longer able to ambulate around the unit. I now have a high back wheelchair with anti tippers on the back to prevent me from tipping my chair backwards. I need assist of one for locomotion."

On 03/21/19 at 8:55 AM, V16 stated it's hard to watch all of these residents when sometimes there's only two CNA's on the unit. She stated R9 falls a lot when we're helping other residents. At 9:00 AM, V17, CNA stated R9 was always moving and staff can't watch her all the time.

3. R29's MDS dated, 1/12/19, documents R29's Cognitive Skills for daily Decision Making score of 3 indicating R29 is severely impaired for daily decision making. R29's MDS further documents that R29 is not steady in moving from seated to standing position, moving on and off toilet and surface-to-surface transfer. R29's MDS further documents R29 uses a wheelchair for locomotion

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S9999	Continued From page 6 on the unit. R29's MDS dated, 10/12/18, documents R29's BIMs Score of 3 indicating R29 has severely impaired cognition. R29's MDS further documents R29 requires limited assistance with the support of 1 staff for transfers, requires limited assistance for locomotion on unit with support of once staff, and R29 uses a wheelchair for locomotion on the unit, and is not steady moving from seated to standing position and surface to surface transfer. R29's Event Reports (Falls) reviewed for the year, (March 2018-March 2019) documents R29 has had 51 falls. R29's Event Report, dated 2/5/19, at 9:30 AM documents in part, Called to residents room @ this time. Resident was resisting care during transfer with CNA. Resident fell and hit head on metal bed frame. Small laceration noted to (R) eyebrow with moderate amount of bleeding noted. Slight swelling noted. Pupils unequal. Call placed to 911 and resident sent to the emergency room alert and responsive. Resident returned at 1:48 PM with 3 sutures to (R) eyebrow. R29's Care Plan, dated 1/12/19, documents Falls: (R29) has a history of repeated falls. Poor safety awareness, unsteady on feed, impulsive. Dementia diagnosis. (R29) will try to get up from wheel chair at anytime, (R29) does not lock my brakes. (R29) has been belligerent and difficult to redirect at times, (R29) does not like anyone telling me what to do. (R29) tries to get up and walk, but sometimes legs buckle. (R29) does not understand that I need to have help when walking. Continued falls expected due to late stage dementia progression, psychosis, increasingly poor safety awareness. Use sit to	S9999		

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S9999	Continued From page 7 stand device as needed for transfers. R29's intervention for the fall 2/5/19 at 9:30 AM documents in part, (R29) became agitated very quickly during care and transfer. (R29) fell, struck his head on bedframe. Laceration above right eye. Root cause; agitation, resistiveness. Intervention: continue all interventions to keep (R29) safe as possible. 2 staff when giving direct care. On 3/21/19 at 10:40 AM, V12 Certified Nurse Assistant (CNA), transferred R29 from his wheel chair into bed using the sit to stand machine with a gait belt around R29s waist. R29 able to hold onto hand grasps and tolerated the transfer without difficulty. On 3/21/19 at 11:00 AM, V12 stated "I usually always transfer R29 by myself because there are only two-or three CNA's on the unit and it is hard to keep up on the other residents and keep them all safe." R29's Event Report, (Fall) dated 1/3/19 at 5:30 AM documents in part, (R29) sitting in floor in front of wheel chair next to counter, hand on counter and other hand in wheel chair. No injury noted. R29's Care plan, dated 1/12/19, documents, 1/3/19 0530 tried to stand up from his wheel chair and sat on floor. Root: poor safety, impulsive. Intervention: Continue to use previous interventions and keep him as safe as possible. R29's Event Reports on 12/25/18 document 3 falls. 1) 9:30 AM, " noted sitting on floor beside bed, mattress half off bed, incontinent of urine on bed and floor. No injury 2) 2:45 PM Resident in	S9999		

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wheel chair in activity area and stood up, fell to floor, breaking wheelchair armrests off wheelchair and cut right 4th finger. First aid provided. 3) 4:00 PM Resident observed by another nurse sitting in wheel chair and kneeled down on one knee then sat in the floor no injury.

R29's Care Plan, dated 1/12/19, documents in part, 12/25/19 Fall at 9:30, 2:45 PM and 4:00 PM, Interventions: Continue to use current interventions, keep as safe as possible.

R29's Event Report (Fall), dated 12/26/19, at 3:47 PM documents in part: At 2:30 PM observed by visitors sliding to floor from wheel chair in hall one. No injury.

R29's Care Plan, dated 1/12/19. documents, 12/26/19 2:30 PM, Stood up from wheel chair and slid to floor in hallway. Root; impulsivity, poor safety. Intervention: Continue to use current interventions; keep as safe as possible.

On 3/21/19 at 2:45 PM, V2 Director of Nurses (DON) when asked if progressive interventions were implemented with the falls on 1/3/19,12/25/19 and 12/26/19, V2 stated "We have tried as many things as we possibly can with R29, on those situations the fall committee reviewed and agreed to continue the current interventions". V2 stated "Yes, staff should have used two staff members while providing the transfer on R29 on 3/21/19 as documented in the care plan".

The Facility's policy on Falls titled Fall Procedure undated documents in part: 2. Defining Details of Falls. a. After an observed or probable fall, the staff will clarify the details of the fall, such as when the fall occurred and what the individual

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S9999	Continued From page 9 was trying to do at the time the fall occurred. b. For each individual, staff will distinguish falls in the following categories: 2. Falling while attempting to stand up from a sitting or lying down position and 3. Falling while already standing and trying to ambulate. 3. Identifying Causes of Fall or Fall risk: c. The staff will continue to collect and evaluate information until they either identify the cause of the falling or determine that the cause cannot be found. 5. Identifying Complications of a fall: a. Staff, with the attending physicians input, will define the complications of a fall such as bruising, fracture, or increased fear of walking. b. Additionally, the staff and physician will identify significant potential complications of falling for each resident at risk for falling; (e.g. fracture in someone with osteoporosis or bleeding in someone receiving anticoagulation. Documentation: When a resident falls, the following information should be recorded in the resident's record: 3. Interventions, first aid, or treatment administered. 6. Appropriate intervention taken to prevent future falls. Strategies for reducing the risk of falls: * Footwear properly fitted * Non-skid slippers. Staff education: All staff and volunteers receive orientation in fall prevention efforts and strategies. (B)	S9999		