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
	IL6007702	A. BUILDING: ______ B. WING ______	C 01/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH COUNTY CARE CENTER	312 WEST BELMONT SPARTA, IL 62286

(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 Facility Reported Incident of 1/4/2020/IL119495	S 000		
S9999	Final Observations Statement of Licensure Violation: 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. 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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 02/12/20

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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.

These requirements were not met as evidenced by :

Based on interview and record review, the facility failed to provide required supervision during toileting for 1 (R3) of 3 residents reviewed for falls in the sample of 3. This failure resulted in R3 falling from the toilet and sustaining an acute fracture to the left trochanter.

Findings Include:

R3's face sheet documents R3 was admitted to the facility on 10/24/19. R3's history and physical from a local discharging hospital dated 10/23/19 documents that R3 presented to the Emergency Room from home after experiencing a fall. This document further states R3 has a history of

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dementia and is more confused per family. R3's family have been thinking about long term placement due to altered mental status and unsafe living condition (living alone). During hospital stay, R3 was found to have sustained a compression deformity of L1 from fall at home. R3 was discharged to a Long Term Care Facility on 10/24/19.

R3's face sheet documents, among other diagnoses, diagnoses of: History of Falling, Abnormal gait and mobility, Fracture of trochanter, Compression fracture of first lumbar vertebrae.

R3's Morse Fall Scale was completed 10/24/19 and documents a score of 90. A score of 45 or more indicates a resident is fall risk.

R3's initial Care Plan has a focus area with a date initiated on 11/19/19 of ADL self-care performance deficit related to weakness and unsteady gait. The intervention for toileting was as follows: resident can assist with pivot transfers with toileting needs with assist of staff. The intervention under this same focus area for transfer status is the resident is able to pivot transfer with staff assist only. A focus area of high risk for falls related to dementia, weakness, unsteady and history of falls at home with initiation date of 11/19/19 has the following intervention: Follow facility fall protocol.

R3's admission MDS (Minimum Data Set) dated 10/31/19 documents R3 is cognitively impaired with a Brief Interview for Mental Status score of 7. R3's functional status for toilet use, which includes the defined area of how the resident uses the toilet room, and transfers on/off toilet is scored as "3 (Extensive assistance), 2 (One

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person physical assist)." The same MDS documents in all sections of G0300 which identifies R3's "Balance during transitions and walking" including "moving on and off toilet," as a "2 (Not Steady, only able to stabilize with staff assistance."

An untitled document with a subject line of: Free of Accident and Hazards/Supervision/Devices dated 1/14/19 was provided by V1 and verified on 1/28/19 at 1:19 PM, that this was the facility's 'fall protocol' referred to in R3's care plan. The document lists that it is the policy of the facility to ensure it identifies and provides needed care and services that are resident centered, in accordance with the resident's preferences, goals for care, and professional standards of practice that will meet each resident's physical, mental and psychological needs. Listed under the 'Procedure" was that the facility must ensure that: 1. The resident environment remains as free of accident hazards as possible. 2. Each resident receives adequate supervision and assistance devices to prevent accidents.

An injury incident report submitted on 1/6/20 to the state regulatory agency documents on 1/4/2020, R3 was found by staff in the male resident's bathroom, laying on his left side, on the floor. R3 had a skin tear to his right hand and could not bear weight on the left leg due to pain. R3 was sent to the local hospital for evaluation and treatment. This report also documented R3 had x-rays that showing an acute fracture through the base of the greater trochanter with mild displacement and soft tissue swelling. A final investigation report dated 1/8/20 concluded that R3 was assisted to the toilet, the CNA (Certified Nurse Assistant) determined to be V8, stepped out of the bathroom area where R3 was, and

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went to the linen closet right across the hall. R3 fell from the toilet, resulting in a skin tear on the right hand and pain in left lower extremity. R3 was transported to the local ED (emergency department) for evaluation and treatment via ambulance.

R3's "Progress Notes" dated 1/4/20 documents as reported in the serious injury report submitted to the state regulation agency that R3 sustained a fall on 1/4/20 at 9:25AM from the toilet. The note made by V6, LPN (Licensed Practical Nurse) at 10:43 AM, documents left lower extremity pain non weight bearing. On call doctor notified. New orders to send resident to local community hospital for evaluation and treatment. V6 documents the local ambulance service was notified of need to transfer and R3 left the facility at 10:30AM on a stretcher.

R3's Emergency Department note dated 1/4/20 documents R3 presented to the emergency department to be evaluated for the following condition: Closed displaced transverse fracture of the greater trochanter of the left femur. Discharge instructions were: only bed to chair at the nursing home. Follow up with primary care physician on 1/8/20 and may use Tylenol 650mg by mouth every 8 hours as needed for pain.

An incident report dated 1/4/20 regarding R3's fall documents under "nursing description" that R3 was noted lying on the bathroom floor. "Resident Description" documents that the resident stated, "these damn shoes tripped me up." Description of Action Taken documents that resident was assessed, and vital signs taken. On this same report the predisposing physiological items checked off were gait imbalance, impaired memory, confused, and weakness/fainted.

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On 1/28/19 at 1:15PM, V6 (Licensed Practical Nurse) stated that she was the nurse on duty when R3's fall occurred. V6 was in the "nurses' room"' charting when V8 (CNA) came and said, "I need you in the bathroom." V6 found R3 lying beside the toilet on his left side, somewhat up against the wall. When V6 and V8 asked R3 what happened,all he could state was 'he fell.' V6 and V8 were unsure if R3 tried to transfer himself or lost his balance. V6 stated that V8 (Certified Nurse Assistant) left him alone to run across the hall to the linen closet. V6 confirmed that R3 needed staff assistance at all times when he was up ambulating or in the shower/restroom for safety awareness and added that R3 was a high fall risk and was confused.

On 1/28/20 at 10:04 AM, R3 stated that he did not remember the fall on 1/4/20. He stated he was really busy at the moment, looking for his lost towel,and thanked the surveyor for her concern. R3 was observed self-propelling himself in his wheelchair around the facility sitting room.

On 1/28/20 at 11:55 AM, V1 (Administrator) stated that it would be her expectation that residents who are a high fall risk not be left unattended in the restroom for safety.

On 1/29/20 at 9:12 AM, V7 (Certified Nurse Assistant) stated that as long as R3 has lived here, in the facility, he has been considered a high fall risk. V7 would never leave R3 alone in the shower or bathroom due to his confusion and safety awareness. The only times he is left unattended is when he is in his chair, recliner or bed and has a chair alarm on. This has been the case since R3 has lived here.

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S9999	Continued From page 6 On 1/29/20 at 1:45PM, V9 (Licensed Practical Nurse) stated that she is the nurse that typically works days shift on the lower floor. V9 stated that R3 is a high fall risk due to his confusion and previous fall history and should have supervision when he is not in his chair or bed with an alarm on. V4 (Director of Nursing/DON) stated on 1/29/19 at 1:58 PM, R3 probably should have had someone with him in the bathroom. While V8 was only gone a couple seconds, that was when R3 had the fall and sustained the injury. (B)	S9999		