STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016570	A. BUILDING: _____ B. WING _____	C 06/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENFIELDS OF GENEVA	0N801 FRIENDSHIP WAY GENEVA, IL 60134

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S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)5) 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.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an 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. 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.	S9999		

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S9999	Continued From page 2 Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on observation, interview and record review, the facility failed to follow physical therapy instructions for transferring and assisting residents to use the bathroom, and also failed to follow their policy for transferring residents. This applies to two of three residents (R1, R2) reviewed for falls. This failure resulted in R1 sustaining a cervical fracture and being hospitalized. The findings include: 1.) R1 was admitted to the facility on 5/8/2015, discharged to a local hospital on 5/19/2015 after a fall incident at the facility, and expired on 5/25/2015 at the hospital. The facility's electronic medical record (EMR) showed diagnoses that included rehabilitation, aftercare for traumatic bone fracture, hypertension, urinary tract infection, anticoagulant use, difficulty walking and personal history of fall. R1's 5-day Minimum Data Set (MDS) completed 5/27/2015 showed R1's cognitive skills for daily decision making as "modified independence - some difficulty in new situations only" and R1 required extensive assistance with one person	S9999		

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physical assistance for bed mobility, transferring, walking in the room, locomotion on and off the unit, dressing and toilet use. R1's MDS also showed R1 was not steady, only able to stabilize with staff assistance for moving from seated to standing position, walking, turning around and moving on and off the toilet and surface-to-surface transfer.

The facility's comprehensive nursing admission assessment dated 5/8/2015 showed R1 had a disturbed gait/balance, limited range of motion and a "recent fall" where R1 "sustained pelvic fracture."

R1's Fall Risk Assessment dated 5/8/2015 showed a score of 11, indicating R1 was a "high fall risk with a score of 10 or above."

E6's (RN-Registered Nurse) clinical notes for R1 dated 5/19/2015 at 8:01 a.m. showed, 7:30 a.m., R1 "up with walker, to bathroom with Certified Nursing Assistant (CNA). CNA in bathroom lifting toilet seat and patient started to fall, unable to catch the fall. R1 landed on her buttocks and then her head against the wheelchair wheel. R1 didn't seem in any acute increased pain, however when asked she said her head hurt. E6 called 911 due to R1 being on blood thinner/Lovenox daily and her diagnosis of pelvic fracture."

The facility's interim care plan for R1 showed: "New Admission Plan of Care: 1. Fall Risk. Interventions: Alarms in place for 72 hours, call light in reach, walkways free of clutter." The Physical Therapy Care plan for R1 started on 5/8/2015 showed Problem: "R1 is unable to perform functional transfers without assistance. Interventions: Transfer using the transfer board/lift devices (unspecified). Problem: R1 is

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unable to maintain (sitting/standing) balance without assistance and support."

Hospital records for R1 showed R1 arrived at the local hospital on 5/19/2015 at 8:09 a.m. Results of the CT scan of R1's cervical spine dated 5/19/2015 showed: Findings: "Type III base of dens fracture. Anterior displacement of 3.5 mm" and on 5/20/2015 showed, " CT scan of C-spine showed C2 fracture. C2 fracture, in C-collar for at least 4-6 months."

Hospital records showed R1 was admitted to the intensive care unit on 5/19/2015 and expired on 5/25/2015. Z3's (MD-Neurosurgeon) documentation dated 5/25/2015 showed R1 had a "right frontal hypertensive intracranial bleed with extension into the ventricular system with acute hydrocephalus and acute ventricular hemorrhage and subarachnoid hemorrhage."

On 6/17/2015 at 2:15 p.m., E3 (CNA) said she transferred R1 to the bathroom with a walker. E3 said she brought a wheelchair in to transport R1 to the bathroom but R1 said she could walk with a walker. E3 said the CNAs can check the 24 hour shift report for resident transfer status, ask the nurse, or check the computer. E3 said she did not confirm R1's transfer status prior to transporting R1 to the bathroom. E3 said she did not place a gait belt on R1 during the transfer. E3 said she walked with R1 to the bathroom, and let go of R1 to adjust the toilet seat. "When I let go of her, she fell. She fell onto her buttocks and then fell backwards and hit her head on the wheel of the wheelchair."

On 6/18/2015 at 10:10 a.m., E3 said, "I should have had a gait belt on R1 while walking her to the bathroom. It is best to hold the gait belt all

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S9999	Continued From page 5 the time when transferring a resident if they are a one person assist." R1's Resident Care Instructions from the EMR, dated 5/8/2015, showed ADL/Transfers: 1 person assist. Mobility: Wheelchair. The 24 hours shift report dated 5/19/2015 lacked documentation to show the transfer status of R1. On 6/17/2015 at 2:40 p.m., Z2 (Physical Therapist) said, "Physical Therapy does the evaluation of the residents. We expect the nurse to put in our suggestions. Only if the resident is independent do I put in an order that states the resident is independent and does not need staff assistance with walking or transferring. On 5/18/2015, R1 was assessed by physical therapy as a contact guard assist, which meant a staff member should have at least one hand on the resident at all times when transferring or standing." On 6/17/2015 at 2:05 p.m., Z1 (MD) said "Facility staff should follow the recommendations of the Physical Therapist for standing and transferring." On 6/18/2015 at 8:25 a.m., Z3 (MD-Neurosurgeon) said R1's cervical fracture was called a "Type II dens fracture. This fracture was caused by the fall R1 sustained on 5/19/2015 when she hit her head." Z3 said "R1 experienced a rapid hemorrhage, arterial in nature, in her brain on 5/25/2015. Three physicians consulted on the rapid nature of R1's brain hemorrhage. I doubt the brain hemorrhage was caused by the fall, but the cervical fracture definitely was." On 6/18/2015 at 9:22 a.m., E1 (Administrator) said "Nothing was documented on the 24 hour	S9999		

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nursing report dated 5/19/2015 regarding transfer status for R1. We found the nurses are not consistently filling out the transfer status on the 24 hour nursing report,or the Resident Care Instructions on the computer, and were not updating the transfer status per physical therapy's guidelines."

(A)

2.) R2 was admitted to the facility on 2/14/2014. The facility's face sheet dated 6/11/2015 showed R2 had diagnoses including dementia with Lewy Bodies, hypertension, diabetes, insomnia, congestive heart failure, anxiety, depression and neck disorder. R2's quarterly MDS dated 5/1/2015 showed severe cognitive impairment and R2 required extensive assistance by one person for transferring, ambulation, dressing and toileting, and was totally dependent on staff for bathing.

R2 had fall risk assessments completed on 1/29/2015 with a score of 17 and 6/11/2015 with a score of 19, indicating R2 was high fall risk with a score of 10 or greater. On 6/18/2015 at 10:00 a.m., E7 (RN-MDS Coordinator) said fall risk assessments are required to be completed quarterly on residents and R2's quarterly fall risk assessment completed on 6/11/2015 "was late."

The facility's nursing documentation dated 6/5/2015 at 4:30 p.m. showed: "At 12:00 p.m. today R2 was lowered to the floor by CNA while transferring her from recliner to wheelchair. Per CNA R2's right knee gave way and R2's head ended up on CNA's chest. She added that she tried to keep resident in standing position but not able to, so she lowered her to the floor on her knees. A stat bilateral knee X-ray was ordered by

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the physician. The facility nursing documentation continued to show on 6/6/2015 at 7:33 a.m. R2's "right knee is bigger than the left knee, complains of pain when turning." At 3:57 p.m. on 6/6/2015 the facility's documentation showed R2's spouse requested to send R2 to the local hospital and at 7:15 p.m. the local hospital reported R2 was "admitted for fracture to right knee joint." On 6/11/2015 at 12:37 am., the nursing documentation showed R2 was readmitted to the facility at 4:05 p.m. on 6/10/2015 with diagnosis of fracture to right distal femur. R2 with knee brace intact and on at all times except during hygiene and skin checks. R2 is on bed rest with non-weight bearing to right leg."

On 6/17/2015 at 9:25 a.m. and again on 6/18/2015 at 1:25 p.m., R2 was observed sitting up in a chair in her room, sleeping.

The Resident Care Instructions for R2, dated 6/17/2015 showed, Comments: Bed rest, non-weight bearing to right leg. The 24 hour nursing report for 6/5/2015 lacked documentation to show the transfer status of R2.

On 6/17/2015 at 3:33 p.m., during a telephone interview, E5 (CNA) said "I stood R2 up from the recliner. I was supposed to use a gait belt, but I did not. R2 will sometimes scratch you when you try to use a gait belt, so we will hold her hand instead. Then she started to lean on me so I lowered her to her knees on the floor. I called two other CNAs to help me and we put her back to bed."

On 6/18/2015 at 8:50 a.m., E1 (Administrator) said E5 put R2 back to bed before calling the nurse to assess R2, and did not use a mechanical lift to transfer R2 from the ground

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back to her bed, per the facility's policy. E1 also said R2 has been known to refuse the use of a gait belt with ambulation, and if R2 was refusing the gait belt for transfer, then E5 should have told the nurse before attempting to transfer the resident without a gait belt. E1 also said the facility does not have R2's rejection of care or the refusal of the gait belt addressed in a care plan. During the same interview, E7 (RN) said there was no care plan in place to address R2's high fall risk. "The high fall risk score does not trigger a care plan. It only triggers after the resident falls."

The Facility's policy and procedure entitled "Safe Resident Handling" revised on May 2013, showed "Procedure: 1. Designation of method of transfer or handling: a. An initial screen is performed on all residents, by a Physical Therapist, to match the appropriate type of transfer. b. Therapy reports verbally to nurse level of assistance required - then is communicated via 24 hour report. 2. Gait belt usage is mandatory for all resident assists with exception of bed mobility and/or medical contraindications. 3. Transfer of resident off the floor: a. A resident observed on the floor will not be moved until assessed by a nurse. b. If it is found that the resident may be transferred from the floor, only a total mechanical lift will be used. NO other method of transfer may be utilized.

The facility's policy entitled "Safe Lifting and Movement of Residents" revised December 2013 showed: "Policy Interpretation and Implementation: 3. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan."

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(B)

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ILLINOIS DEPARTMENT OF PUBLIC HEALTH

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IMPOSED PLAN OF CORRECTION

Greenfields of Geneva
Survey Date: 6/18/2015 Complaint 1573192/IL77946

Attachment B
Imposed Plan of Correction

300.610a)
300.1210b)5)
300.1210d)6)
300.1220b)3)
30.3240a)

300.610a)

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.

300.1210b)5)

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.

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

300.1210d)6)

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.

300.1220 b)3)

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.

300.3240a)

Section 300.3240 Abuse and Neglect

a) *An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.* (A, B) (Section 2-107 of the Act)

This will be accomplished by:

Resident assessments are to be reviewed to ensure that those residents who are at risk for falls/injuries have appropriate interventions on their care plans. The facility must ensure that the resident environment remains free of accident hazards as is possible; and each resident receives adequate supervision and assistance to prevent accidents.

Staff are to be educated on the process to maintain resident safety, and on the facility's Fall Policy.

The facility is responsible for an audit to be done, at least monthly to verify that this procedure is completed as mandated per this imposed plan of correction.

The facility Administrator or designee will be held responsible to monitor logs and/or audit tools used to verify compliance with imposed plan of correction.

Completion Date: 10 days from receipt of this Notice.