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
	IL6016711	A. BUILDING: ______ B. WING ______	C 03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA VILLAGE CARE CENTER	**4101 WEST ILES AVENUE SPRINGFIELD, IL 62711**

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S9999	Final Observations	S9999		

Statement of Licensure Violations:

300.610a)
300.1010h)
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 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident.

Section 300.1210 General Requirements for Nursing and Personal Care

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following

Attachment A
Statement of Licensure Violations

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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 interviews and record review, the facility failed to identify pain location changes and a substantial increase in pain with a decline in functioning post fall in a timely manner for 1 of 4 residents (R4) reviewed for necessary care and timely treatment in the sample of 4. This failure resulted in a 48 hour delay in treatment for a right femoral neck fracture for R4.

Findings include:

1. The Admission Record identifies R4 as an 88 year old female admitted to the facility on 9/23/12 with diagnoses of Dementia with Behavioral Disturbances, Osteoporosis and general pain among others.

R4's Minimum Data Set (MDS) dated 12/24/14 identifies R4 to have cognitive impairment and requires the supervision/assist of one staff for transfer and minimal assist of one for ambulation.

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The balance section of the MDS indicates that R4 is not steady without the assistance of staff for ambulation. R4's current care plan includes a fall prevention plan due to history of falls.

The Facility's Incident Details Report, dated 1/21/15, documents R4 was found on the floor at 3:19pm. The report documents R4 was sent to the emergency room due to complaints of pain to right lower extremity and being unable to perform full ROM (range of motion) to right lower extremity. Hospital Report dated 1/21/15 documents "1. No acute osseous abnormalities, 2. Unchanged chronic compression deformity of the L3 vertebrae, 3. Marked Osteopenia, and 4. Marked degenerative disc disease and lumbar spondylosis most pronounced at L4-5. "

The Facility's Progress notes do not document when R4 was returned to the facility. Facility Progress Note, dated 1/23/15, at 12:57 AM, written by E14, Registered Nurse (RN), documents "Resident confused to place and time, attempting to get out of bed. Resident screaming, hitting and kicking at staff..."

On 1/23/15 at 7:38 AM, E6, Licensed Practical Nurse (LPN) documents in the Progress Notes R4's pain onset is gradual and "continuous." On 1/23/15 at 8:42 AM , E6 documents that the nurse Practitioner (Z3) was notified of residents recent discharge orders that include medication changes. E6 also documents "Resident insists on ambulating, complains of pain to right side pelvic area with needed pain medication given and since medication given, resident is ambulating at all times."

On 1/24/15 at 9:15 AM and 12:57 PM, E6 again documents in the Progress Notes R4's pain is

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continuous with the location of the pain "lumbar."

The Incident Report documents on 1/24/15 at 10:53 AM, R4 was again found on the floor in her room. Details of the Incident written by E6 documents "Care companions came to writer stating resident was on the floor. Writer went into resident's room and observed resident laying on the floor approximately 3 feet from the bed off the roll mat on her left side. Care Companions states they were in the room with roommate and did not hear resident getting out of bed. The Details document "Resident continues with ROM WNL (within normal limits) except right lower extremity. No visible injuries noted." The Incident Report documents Z1, R4's physician, and family were notified.

Progress Notes written by E6 at 2:26 PM on 1/24/15 documents "Resident continues to complain of pain to right lower extremity, right pelvic area and lower back. Staff assisted resident up and writer applied (brace). Resident continues to bear minimal weight to right lower extremity." The note documents Resident ate approximately 2-3 bites of breakfast and stated she couldn't eat anymore because of pain.

The Progress notes documents location of pain changed following the fall of 1/24/15 from lumbar to leg pain. On 1/24/15 at 4:31 PM , 9:33 PM, and 9:43 PM , E11, RN documents leg pain, pain continuous.

On 1/25/15 at 9:30 AM, E6 documents in the Progress Notes "Pain is of recent onset related to traumatic pain, pain location - back, hip, pain in continuous, pain level varies." E6 documents pain is affecting following areas "Decreased food consumption, limits mobility, stops engagement in

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recreational activities, change in mood and behavior." Nonverbal signs of pain are documented as "restlessness, agitation, anxiety, grimacing, loss of appetite, moaning, guarding or protecting body parts."

On 1/25/15 at 3:52pm, in the Progress Notes, E12, LPN, documents R4's pain location as hip and leg. At 8:17 PM and 9:40 PM , E12 documented pain location as hip. There is no evidence that either E6 or E12 identified the pain location as changing from lumbar to leg and hip following R4's fall on 1/24/15.

On 1/25/15 at 10:41 PM , E12 documents in the Progress Notes "Pain medication given as ordered PRN (as needed) for complaints of severe pain in right hip and pelvis. Resident seems delirious, talking and mumbling things that do not make sense. Ate minimal amount of supper. Care assistant from home agency at bedside. Writer notes that even during intervals of sleep, lying in bed, resident moans and mumbles, she appears to have tremor type jerking movements and is not resting comfortable."

On 1/26/15 at 12:16 PM, E10, LPN, documents R4 denied pain but documents at 3:59 AM, R4 complains of pain in hip/pelvic area. At 4:04 AM , E10 documents "Does not c/o (complain of) pain in the lumbar area. Does c/o of right hip pain. Not bearing weight well, transfers difficult. Requires watching closely while aware, very restless @ (at) these times pulling @ clothing et (and) bedding et repeating same phrases over et over." The note documents that R4 "Has no internal or external rotation of right leg et no shortening. PROM (Passive range of motion) per writer with no increased c/o pain in back or hip et no abnormalities noted."

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On 1/26/15 at 1:07 PM , E9, RN, documents in the Progress Note "message left with (Z1's) nurse regarding resident cognitive decline since she returned from the hospital on Thursday evening. Also notified nurse about resident's physical decline and increase in right hip, lower back and right groin pain since her fall on Saturday morning (bilateral pedal pulses strong, no redness/warmth noted on affected extremity) resident was walking when she returned from the hospital, but since her fall on Saturday she has been unable to get out of wheelchair/bed without an extensive assist of one staff member due to pain."

At 5:31 PM on 1/26/15, E13, RN, documents in the Progress Note "Received return call from (Z1's) nurse and order received to obtain x-ray of right hip d/t (due to) pain with movement." At 5:50 PM , E13 documented "Moves upper extremities and left lower extremity without c/o pain. Continues to c/o pain right groin and hip however refused pain med (medication) when offered by writer at 1630. Remains up in chair in DR (dining room) at present." At 6:40 PM , E13 documented R4's pain as sharp/throbbing with pain medication given for c/o right hip and groin pain with movement of right leg." The mobile x-ray was documented as done at 8:50 PM with results showing a fracture.

R4 's Hospital Records documents she was transferred to the hospital on 1/26/2015 and was diagnoses with a Right displaced femoral neck fracture. She underwent surgery for repair on 1/27/15, three days after the fall on 1/24/15.

On 3/13/15 at 2:00 PM , E6 stated R4 was going through a lot of things at the time of the fall on 1/24/15 and that she didn't think the pain location

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differed. E6 stated she thought she faxed notification to Z1 that R4 had fallen on 1/24/15 when asked why it wasn't documented in the progress notes.

On 3/13/15 at 3:10 PM, E9 stated that when she got report from E10, LPN on 1/26/15, she can remember thinking it's a new pain location after the fall on 1/24/15 and why wouldn't someone had picked up on that. She described R4 at that time as "different, having lots and lots of pain, lots and lots of confusion." adding that she realized some of it could be pain medication or other medications changes she had, but "her pain location had changed" and Z1 needed to be notified. E9 stated she called Z1 then and an order was received for a mobile x-ray.

On 3/14/15 at 10:40 am, E2, Director of Nurses (DON) stated she talked with E6 after R4 was transferred to the hospital and was told by E6 that R4 was bearing some weight and that Z1 was called due to increase in pain. The progress notes do not support this nor do they document notification to Z1 on the fall.

On 3/17/15 at 9:55 AM , Z1 stated that she has provided the facility nurses her cell phone number and have told them to call her anytime they need to. Z1 stated she did not recall getting notification on the fall but would have only documentation in the office if they did. Z1 stated if the facility faxed at a time when she wasn't in the office, she would not have seen it until the next office day. Z1 stated she is not in the office on Saturday or Sundays. When asked if R4 having a fall with a change in pain location is something she would have wanted them to call about stated "Yes, definitely I would have wanted to know. I always x-ray after falls if complaints of pain are made to

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rule out any fractures."

The facility policy entitled "Notification of a Significant Change in Condition" dated 4/1/08 documents that "The resident, residents legal representative and/or designated family member and the resident's physician will be notified promptly when the resident experiences a significant change in condition.

The facility's policy entitled "Nurse Notification of Physician" dated 4/1/08, documents "It is the responsibility of licensed nurses employed in this community to notify the resident's physician when the residents clinical condition may require or requires physician intervention. The policy documents nurses are to record the following in the resident's clinical record, all attempts to notified the physician or designated alternate; method of attempted contact, times and individuals contacted, assessment findings, additional information provided, physician's response, physician's orders, and resident's status and response to treatment ordered."

(A)

IMPOSED PLAN OF CORRECTION

NAME OF FACILITY: CONCORDIA VILLAGE CARE CENTER
DATE AND TYPE OF SURVEY: COMPLAINT#1541284/IL75602
March 17, 2015

300.610a)
300.1010h)
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.

300.1010 Section 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for Nursing and Personal Care

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.

Attachment B
Imposed Plan of Correction

300.4240 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).

This will be accomplished by:

I. The facility will immediately inform the resident; consult with the resident's physician; and if known, notify the resident legal representative and family member when there is an accident involving the resident which has the potential for requiring physician intervention; a significant change in the resident condition (physical, mental, or psychosocial status – i.e., deterioration in health, mental, or psychosocial in either life threatening conditions or clinical complications); a need to alter treatment (i.e., need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility.

II. All nursing staff will be inserviced on the facility's policy for physician and legal representative notification of change of condition. Additionally, inservicing will be conducted regarding notification of the Director of Nursing (DON) and/or the Nurse Leader on call after hours and on weekends regarding falls and resident change of condition to ensure thorough assessment and notification have been done to resident physician and legal representative.

III. The Director of Nursing (DON) and/or Clinical Nurse Leaders, and Household Coordinators will audit documentation in the medical record for compliance for compliance weekly for six (6) weeks and then quarterly in the Quality Assurance meetings. Audits with negative outcomes will result in further education for staff involved and/or possible disciplinary action.

IV. Documentation of in-service training will be maintained by the facility.

V. The Administrator, Director of Nurses, and Quality Assurance Committee will monitor Items I through V to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Seven (7) days from receipt of this Imposed Plan of Correction.

Attachment B
Imposed Plan of Correction