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
	IL6006001	A. BUILDING: ______ B. WING ______	06/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	24588 CHURCH STREET CHENOA, IL 61726

(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
S9999	Final Observations	S9999		

STATEMENT OF LICENSURE VIOLATIONS:

300.610a)
300.1210a)
300.1210b)5)
300.1210d)6)
300.1220b)2)
300.1220b)3)
300.3240a)
300.7020b)2)

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
a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which

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S9999	Continued From page 1	S9999		

allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.
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:
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:
2) Overseeing the comprehensive assessment of

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S9999	Continued From page 2 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 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. Section 300.7020 Assessment and Care Planning b) The care plan shall be developed by an interdisciplinary team within 21 days after the resident's admission to the unit or center. The interdisciplinary team shall include, at least, the attending physician, a nurse with responsibility for the resident, other appropriate staff in disciplines as determined by the resident's needs, the resident, the resident's representative, and the certified nursing assistant (CNA) who is primarily responsible for this resident's direct care, or an alternate, if needed, to provide input and gain insight into the care plan. Others may participate at the discretion of the resident.	S9999		

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S9999	Continued From page 3 2) As new behaviors manifest, the behaviors shall be evaluated and addressed in the care plan. These requirements are not met as evidenced by: Based on observation, interview and record review the facility failed to implement new post fall interventions, failed to ensure current fall interventions were implemented and failed to maintain the documented safety interventions for three of twelve residents (R6, R22, and R26) reviewed for falls in the sample of 21. This failure resulted in a fractured wrist for R6 and a laceration requiring surgical intervention for R22. Findings include: 1. According to the facility resident roster, R6 resides on Unit 1, Dementia Care. The current Physician's Order Sheet (POS) documents R6 as having a diagnosis of Alzheimer's Disease. The Minimum Data Sets (MDS) dated 11/16/14 and 5/13/15 document R6 as having a severe cognitive impairment and requiring extensive assist with Activities of Daily Living (ADL's) for ambulation, hygiene and dressing. The Care Plan documents R6 being at high risk for falls. On 10/24/2015 at 10:50AM, an incident report documents R6 fell in the Rehab room with no apparent injuries, no careplan update was made after this incident. Incident reports document R6 fell at 8:15AM and at 8:15PM on 10/29/14. No Care Plan update was made after either fall on 10/29/14. An incident report documents that R6 fell on 11/7/2015 in the TV lounge and sustained a fractured wrist. No new Care Plan intervention was completed after this fall.	S9999		

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S9999	Continued From page 4 On 6/5/2015 at 10:00AM, E4, Care Plan Coordinator stated, " I don't know when the Care Plans were last updated or why they weren't updated previously.....I know they are not right. The previous Care Plan Coordinator for Unit 1 and 4 left and I am in charge of them all now." The Facility fall policy dated 2/17/2015 documents, in part, "Careplan revisions- interventions to reduce future occurrence and any physician ordered treatments....Review and update Fall Risk Assessment or tool and care plan intervention if necessary (ensure interventions on care plan are dated when added/deleted)." 2.) R22's Physicians Progress Notes dated 1/14/2015 and 5/13/2015 documents a history of multiple falls and a diagnosis of Parkinson's Disease. The Minimum Data Set dated 4/19/2015 documents R22 requires extensive assistance of one staff for transfers and limited assistance of one staff for ambulation and toilet use. The Fall Risk Assessment dated 4/19/15 documents R22 is at high risk for falls. The Care Plan dated 1/25/2015 for falls for R22 documents the following: "Safety: I have a red indicator to alert staff I am high risk for falls. My gait is unsteady and I require staff assist with transfers and mobility. I have a personal safety alarm for use when I am in bed or chair to alert staff I am getting up unsupervised. Please encourage me to call for assistance when wanting to get up. Please make sure my call light is within reach at all times when I am in my room." The interventions do not have a date when	S9999		

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S9999	Continued From page 5 initiated on the care plan. On 6/4/2015 at 10:10 AM, E4 (Care Plan Coordinator) stated "There are no dates on any of the care plans for initiation of a fall interventions. There are interventions that have been put in place that are not on the care plan for falls. Staff add safety alarms and don't notify the care plan coordinator, therefore they are not on the care plan. The bed and chair alarms and pads do not require a physicians order. We are reviewing all interventions on an individual basis and up dating them on the care plan." The Incident Report dated 6/3/2015 at 1:45AM, documents "Aides heard a loud thump and upon entering (R22's) room (R22) was found on the floor at the end of (R22's) bed, with a laceration to (R22's) right upper arm, and two on (R22's) back. (R22) stated (R22) was trying to use the bathroom, but didn't use (R22's) call light." The Interdisciplinary Notes dated 6/3/2015 at 9:15 AM documents "(R22) was found on the floor at the foot of his bed with two lacerations to his right arm, and two skin tears to his back at 1:45AM. (R22) was alert and oriented, had full range of motion, vital signs were normal except for a elevated blood pressure, no other complaint of pain except for (R22's) right arm. (R22) stated (R22) was trying to go to the bathroom. Call light was within reach on (R22's) bed, and tabs alarm was in place. The Physician was called at 2:28AM, 911 at 2:26AM and Power of Attorney at 2:31AM. (R22) left the facility via ambulance to the local hospital. The emergency room called to update the facility at 7:00AM and stated that (R22) was going to need surgery to debride and repair the upper right arm laceration."	S9999		

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R22's Emergency Room report dated 6/3/2015 documents a large degloving laceration to the right upper arm. The Assessment Plan documents a complex laceration to through right posterior arm recommending urgent debridement and repair in the emergency room.

R22's Operative Report dated 6/3/2015 documents a "large laceration to the posterior right arm which measures approximately 15 centimeters" and was U shaped. The laceration "extended through skin and subcutaneous fascia. The fascia was intact. The epidermis was quite torn, thin, and not salvageable."

On 6/5/2015 at 10:00AM, E20 (Certified Nursing Assistant) stated " I was in the hall outside (R22's) door when I hear a thump. The personal safety alarm did not sound. The alarm was still attached to (R22's) shirt but had not pulled apart the string on the alarm was longer that usual. (R22) was at the end of the bed sitting with (R22's) right arm near the garbage can and radiator unit. (R22) did not have the call light on. I could possibly have gotten to (R22) before the fall if the alarm sounded when (R 22) sat up before trying to stand."

On 6/4/2015 at 10:45AM, R22 was lying in bed with the personal safety alarm attached to R22's shirt and a sensor pad underneath (R22) in the bed. The string on the personal safety alarm was connected at the end on the bed and hanging down on the floor while attached to R22's shirt in the upper part of the bed. R22 was able to sit on the side of the bed with out activating the alarm.

On 6/4/2015 at 10:46AM, R22 stated "I stood up and fell the other night when I was trying to go to the bathroom. I think I turned on my call light but I

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S9999	Continued From page 7 am not sure. I hit my arm on the garbage can or something over there (pointing at the radiator)." 3.) R26's POS documents R26 to have a diagnosis of Alzheimer's Disease. According to the resident roster R26 resides on Unit 1 for dementia care. R26's current Care Plan documents R26 as needing assistance with transfers related to poor balance, an unsteady gait and at risk for falls. The current Care Plan intervention for falls is a "motion alarm" on the chair and in bed to alert staff when R26 is attempting to get up. The 1/29/2015 Incident report documents R26 had a fall resulting in a large hematoma on the back of R26's head. The report documents, "Advised daughter that we will be placing a chair pad alarm on resident so...it will be harder to remove..." On 2/2/2015 the fall investigation notes document, "Will change alarms from (personal alarm) which (R26) takes off and carries with her) to a pad alarm." On 6/5/2015 at 1:00PM, R26 was sitting in a recliner with a personal alarm attached to R26 rather than the pad alarm. On 6/5/15 at 1:00PM, E23 CNA, stated, "(R26) only has a (Personal alarm) that (R26) takes off and carries around with her". The Care Plan for R26 documents falls on 3/29/15, 5/21/15 and 5/25/15. (B)	S9999		