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
	IL6002836	A. BUILDING: _____ B. WING _____	C 01/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMS, THE	1212 MADELYN AVENUE MACOMB, IL 61455

(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 IRI of 12/28/15/IL82547 Statement of Licensure Violations	S 000		
S9999	Final Observations 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) 300.3240a) 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 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. (Section 3-202.2a of the Act) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. (A, B) (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on record review and interview, the facility failed to initiate assistive safety device recommendations and provide supervision during activities of daily living for one of three residents (R1) in a sample of three reviewed for falls. R1 fell and fractured a hip. Findings include:	S9999		

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A POS (Physician Order Sheet) dated 12/22/15 shows R1 was admitted on 12/22/15 with diagnoses of Acute Thrombosis of Deep Vein Left Lower Extremity, Generalized Muscle Weakness, and Shortness of Breath. R1's physician orders state, "Up ad lib (as desired) with assist every shift for ambulation."

A Nursing Admission Screen/History dated 12/22/15 documents R1 was admitted for rehabilitation for a DVT (Deep Vein Thrombosis). The assessment states R1 was alert, had an unsteady gait and short term memory problems. The assessment also states R1's left leg was very swollen from the groin to the foot due to the DVT and R1 requires assistance of staff for transfers, walking, and toileting. R1's Morse Fall Scale assessment dated 12/22/15 shows R1's score was 85, indicating R1 was at high risk for falls. The assessment documents R1 had a history of falls, was weak, and over estimated or forgot R1's limits.

R1's Progress Notes, written by E5 (RN - Registered Nurse), dated 12/28/15 at 8:05 a.m. state E5 (RN) was called to R1's room and found R1 lying on the bathroom floor. E5 documents R1 was complaining of left hip pain and R1 could not move R1's left leg. E5 reported R1 rated R1's hip pain level at a ten (zero to ten scale with ten being the worse pain). E5 also documented R1 was actively bleeding from a one inch laceration on the occipital lobe (back of head) and a pin point area on the left parietal lobe (side of the head). E5 (RN's) Progress note states R1 was transferred to a local hospital by ambulance and was admitted with a fractured left hip. A TRIPS (Tracking Record for Improving Patient Safety) From for Falls dated 12/28/15 and completed by

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E5 (RN) documents the cause of the incident was loss of strength/weakness during transfer off the toilet. E5 (RN) also documented predisposing factors to R1's fall were impaired memory, confusion, and gait imbalance.

On 1/07/16 at 9:35 a.m., E4 (CNA) stated, "I went to get (R1) for breakfast. I toileted (R1) before taking (R1). (R1) walked hand in hand (with E4) to the bathroom. (R1) walked. (R1) was a really good walker. If they (residents) are an assist it would be on their care plan. We look at them (care plans). It would tell us. I can't recall (R1's) instructions. I know (R1) was a one assist and for long distances (R1) was in the wheelchair. I helped (R1) with clothing and then went to make the bed. I came around to make sure (R1) was doing alright. (R1) was standing up pulling up (R1's) pants. Before I could get there (R1) took a couple steps and lost (R1's) balance and fell. There was no wheelchair or roller walker in the bathroom or the doorway. I think (R1) said (R1) lost (R1's) balance. (R1's) left leg was really swollen and that hadn't changed since (R1's) admission. I walked out to give (R1) privacy but the door was open so I could see (R1). When I was making the bed I kept turning around all the time (to see R1)." E4 (CNA) indicated R1 did not have a gait belt on or use a roller walker during (R1's) transfer or toileting. E4 (CNA) stated, "A one assist is just one person unless it states a gait belt in needed."

A Transfer Belt Policy dated 12/2013 states, "(Gait) belts are to be used on all residents requiring assistance with transfers. Disciplinary actions will occur if this policy is not followed."

On 1/07/16 at 2:05 p.m., E5 (RN) stated, "At the beginning of the shift (E4 CNA) alerted me and I

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went in and (R1) was lying on the floor. (R1) was awake and lying on (R1's) back on the floor in the bathroom. (R1) was alert and responding. (R1) had complaints of pain in the left hip. (R1) also hit (R1's) head on the wall or corner of the door. (R1) had a laceration on the back of the head. We applied pressure and ice. (R1) remained alert and talking the entire time. (E5 (RN) also reported, "I've transferred (R1) before and (R1) was always very easy to transfer. (R1) was a one person assist with a gait belt. It was (R1's) balance. You had to help (R1) maintain balance."

A Physical Therapy Plan of Care, signed by E6 (Physical Therapist) dated 12/23/15 states R1's level of functioning on 12/23/15 was as follows: Ambulates up to 40 feet with CGA (Contact Guard Assistance); Demonstrates standing balance - minimal assist to maintain; static can maintain, but easily thrown off balance; Functional transfer requiring contact guard assist (contact with patient due to unsteadiness. Patient Daily Treatment Notes from 12/23/15, 12/24/15, and 12/26/15 document R1's progression using a roller walker, supervision, and cues for hand placement for safety awareness when sitting/standing from wheelchair or toilet. An Occupational Therapy Plan of Care dated 12/23/15 indicates R1 required moderate assistance with toileting.

On 1/08/16 at 10:40 a.m., E6 (Physical Therapist) stated, "(R1) was a pretty high level but was only oriented to self. The main thing is (R1's) cognition. (R1) needed mostly verbal cues and to make sure (R1) was steady on (R1's) feet with the gait belt. They usually put one (a gait belt) on everybody. They look it up in the computer what they are supposed to do." Regarding R1's fall on 12/28/15, E6 stated, "I would have chosen to stay

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in the bathroom with (R1) in my professional opinion. Especially with not having a walker in front of (R1)." E6 indicated anytime a resident requires assistance a gait belt should be used.

A Fall Prevention Program Policy dated 04/2014 states staff are responsible for reading, knowing, and following the resident's plan of care. R1's Interim Care Plan dated 12/22/15 states R1 requires assistance with transferring, ambulating, personal hygiene, and toileting. R1's Interim Care Plan does not include the use of a roller walker, contact guard assistance, or supervision and cues for safety documented in the Physical Therapy Plan of Care.

On 1/08/16 at 11:30 a.m., regarding CNAs having access to resident care plans, E2 (DON - Director of Nursing) stated, "We make a copy and hang it up the the clean utility room for all the new residents. Physical Therapy generally tells (E7 - Restorative Nurse) and then (E7) issues a memo or a note." E2 (DON) stated, "Assist is hands on with a gait belt unless and there are very few we deem don't need a gait belt."

On 1/08/16 at 11:50 a.m., regarding communicating Physical Therapy recommendations to direct care staff, E7 (Restorative Nurse) stated, "Usually Physical Therapy tells me or if I'm not here they write a note and leave it on the desk. When I do the MDS (Minimum Data Set assessment) I ask (Physical Therapy) about their (the residents') balance and information for the MDS but (R1) wasn't here long enough for a MDS. Usually Physical Therapy, Occupational Therapy, and Speech Therapy print out their care plans and I get a copy. I look them over. One gets sent to the physician and I put a copy in the chart. I type

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S9999	Continued From page 6 an up date and put it on the floor. I notify the nurse and give a copy to the nurse and hang a copy (for the CNAs to review) in the clean utility room. I was off (not working) from 12/24/15 until 12/28/15. When I came in Monday the ambulance was pulled in the drive for (R1). I have no back up. There are three Restorative Aides but they don't do anything with the care plan revisions. On 1/07/16 at 12:38 p.m., regarding R1's 12/28/15 fall, Z2 (R1's Attending Physician) stated, "Did (R1) have (R1's) walker? I would expect (R1) to use (R1's) walker. (R1) always uses it here when (R1) comes for visits at the clinic. I admitted here there for a very bad DVT (Deep Vein Thrombosis) of (R1's) left leg. It was completely swollen from (R1's left) hip down. I'm sure it affected (R1's) balance too. (R1) should have had (R1's) walker and someone should have been there to remind (R1) not to get up. But even if they told (R1) not to get up with (R1's) short term memory problems (R1) might not remember their instructions and get up anyway." (B)	S9999		