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
	IL6001739	A. BUILDING: _____ B. WING _____	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN NURSING HOME	1507 7TH STREET LINCOLN, IL 62656

(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 Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/04/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001739	A. BUILDING: _____ B. WING _____	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN NURSING HOME	1507 7TH STREET LINCOLN, IL 62656

(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	Continued From page 1 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) 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. 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:	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001739	A. BUILDING: _____ B. WING _____	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN NURSING HOME	1507 7TH STREET LINCOLN, IL 62656

(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	Continued From page 2 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. Noncompliance resulted in two deficient practices. A. Based on interview, observation and record review, the facility failed to follow their gait belt and transfer policies during a resident transfer and failed to implement current care plan interventions to prevent further falls for two of six residents (R1 and R12) reviewed for falls in the sample of 20. As a result, R1 fell and sustained a left forehead laceration that required nine sutures to be placed at the local emergency room. These Regulations were not met as evidenced by: Findings include: The facility's Gait Belt policy dated 10/21/11 documents, "It is the policy...that gait belts are utilized on all residents requiring physical	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001739	A. BUILDING: _____ B. WING _____	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN NURSING HOME	1507 7TH STREET LINCOLN, IL 62656

(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	Continued From page 3	S9999		

assistance with transfer...The gait belt will be used for any resident that has been assessed to need...a stand by assist for safe transfer ability..."

The facility's Transfers- Commode to Wheelchair policy dated 8/1/05 documents, "The resident will be transferred from one surface to another with appropriate level of assistance from direct care staff. All assistance with transfers from caregiver should be focused at gait belt site. Any movement of resident from surface to surface requires a gait belt to be appropriately placed around the resident..."

1. R1's current electronic diagnoses document R1's diagnoses to include the following: "History of falling, muscle weakness, and abnormalities of gait and mobility."

R1's Minimum Data Set dated 12/30/15 documents R1's Brief Interview for Mental Status indicates R1 is cognitively intact.

R1's current electronic fall care plan documents current fall interventions as follows: "Date initiated: 10/10/13- Ensure that (R1) is wearing appropriate footwear with non-skid soles when ambulating or mobilizing in a wheelchair; Date initiated: 1/16/15- Tab alarm at all times, position tab alarm to middle upper back. Verify alarm in place and functioning with each care..." R1's current electronic ADL (activities of daily living) care plan documents a current intervention initiated on 9/12/13 as follows: "Transfers: Two person assist, on both sides during transfer to and from bed; sitting to standing and standing to sitting; wheelchair to commode and commode to wheelchair..."

R1's Post Fall Investigation form dated 12/30/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001739	A. BUILDING: _____ B. WING _____	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN NURSING HOME	1507 7TH STREET LINCOLN, IL 62656

(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	Continued From page 4	S9999		

states R1 fell while transferring from a wheelchair to the toilet with, "transfer assistance of one person." This same report documents a gait belt was not used at the time R1 was transferred and R1 was wearing, "plain socks only." R1's Investigation Conclusion dated 12/30/15 documents the following: "On 12/30/15 at 5:20 a.m., (E9, Certified Nursing Assistant) was transferring (R1) to the toilet from (R1's) wheelchair when (R1) lost (R1's) balance falling forward striking the left side of (R1's) head on the floor, causing a laceration approximately 3 centimeters long...(R1) received stitches (at local emergency room) to forehead laceration."

On 1/26/16 at 1:45 p.m., E6 and E11, Certified Nursing Assistants, assisted R1 to transfer from R1's wheelchair to R1's toilet. At this same time, R1 stated that R1 had recently fallen in the bathroom, sustaining a forehead laceration. R1 then pointed to a red linear area on R1's left forehead approximately 3 centimeters long, and explained that it was the area that recently had sutures placed. R1 also stated that a gait belt was not used when R1 was transferred by E9, Certified Nursing Assistant, on 12/30/15.

R1's local hospital emergency room report dated 12/30/15 documents the following: "fell at nursing home hit head and face with laceration to left forehead...length 3 centimeters...wound explored, irrigated and examined...debrided. Closure of skin...9 sutures...laceration repaired..."

On 1/26/16 at 1:08 p.m., E3, Assistant Director of Nursing, stated that R1 should have been a two-person transfer on 12/30/15, but (E9, Certified Nursing Assistant) attempted to transfer R1 without assistance from another staff member. E3 also stated that R1 was not wearing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001739	A. BUILDING: _____ B. WING _____	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN NURSING HOME	1507 7TH STREET LINCOLN, IL 62656

(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	Continued From page 5	S9999		

appropriate non-skid footwear at the time of R1's fall. E3 then stated that E3 expects gait belts to be used at all times when R1 is transferred and facility staff should follow the interventions in place on R1's care plan.

R1's Post Fall Investigation form dated 12/1/15 documents R1 fell out of a wheelchair and was barefoot at the time of the fall. This same report documents, "chair alarm not on (R1)" R1's Investigation conclusion documents the following: "On 12/1/15...(R1) observed on the floor on (R1's) back, next to the bed with (R1's) head under (R1's) wheelchair...(R1) had just been placed in wheelchair prior to incident...alarm was not in wheelchair...when asked if (R1) slid out of (R1's) wheelchair, (R1) stated 'yes'. (R1) was not wearing any shoes or socks..."

On 1/26/16 at 1:08 p.m., E3, Assistant Director of Nursing, stated that R1 was not wearing appropriate footwear and a fall alarm was not in place in R1's wheelchair at the time of R1's fall on 12/1/15. E3 also stated that facility staff should be following all interventions in place on R1's current care plan.

2. R12's current electronic diagnoses document R12's diagnoses to include the following: "Osteoarthritis, muscle weakness, and difficulty in walking.

R12's current electronic fall care plan documents a current fall intervention initiated on 11/4/14 as follows: "Slipper socks on when in bed."

R12's Post Fall Investigation form dated 2/16/15 documents R12 fell out of bed and was barefoot at the time of the fall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001739	A. BUILDING: _____ B. WING _____	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN NURSING HOME	1507 7TH STREET LINCOLN, IL 62656

(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	Continued From page 6 On 1/26/16 at 1:08 p.m., E3, Assistant Director of Nursing, verified that R12 was barefoot at the time of R12's fall on 2/16/15 and stated, "(R12) should have been wearing nonskid footwear." B. Based on observation, record review and interview, the facility failed to maintain water temperature in a safe operating range on the memory care unit. This failure has the potential to affect five residents (R36- R40) on the supplemental sample. Findings include: The facility's Water Temperature Inspection policy (dated 3/2/14) documents the following: "Hot water in resident areas will range from 95 to 110 degrees Fahrenheit and cold running water will be provided..." On 1/26/16 at 9:30 AM, the water temperature in R36's bathroom sink read 120 degrees Fahrenheit. On 1/26/16 at 9:35 AM, the water temperature in R37 and R38's bathroom sink read 121 degrees Fahrenheit. On 1/26/16 at 1:20 PM, the water temperature in R39 and R40's bathroom sink read 120 degrees Fahrenheit. On 1/26/16 at 1:30 PM, E8 (Life Safety Coordinator) confirmed the water temperature readings in R36, R37, R38, R39 and R40's bathroom sinks and stated that these water temperatures were too high. E8 also stated that E8 does not like water temperatures to rise above 110 degrees Fahrenheit.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001739	A. BUILDING: _____ B. WING _____	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN NURSING HOME	1507 7TH STREET LINCOLN, IL 62656

(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	Continued From page 7	S9999		

(B)