STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008841	A. BUILDING: _____ B. WING _____	C 03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRITY HC OF CHESTER	770 STATE STREET CHESTER, IL 62233

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S9999	Final Observations Statement of Licensure Violation 300.610a) 300.1210b) 300.1210d)3)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 shall be followed in operating the facility. 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. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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. (Section 2-107 of the Act) These requirements are not met as evidenced by: Based on record review and interview, the Facility failed to assess for causative factors contributing to falls and take corrective actions based on those factors for 1 of 3 (R2) residents with a history of falls in the sample of 9. This failure resulted in R2 sustaining a fracture of his right hip. Findings include: The Facility's Incident/Accident Reports document the following regarding R2: "7/23/15, 5:45 PM, (R2) was found lying on floor. Asked him if he hit his head as touching his left forehead. There is a 3.5 by 3.5 hematoma on his left forehead." The causative factor is documented as "Resident was attempting self transfer for toileting and lost balance." The corrective action for this fall is "Seat belt alarm applied."	S9999		

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S9999	Continued From page 2	S9999		

"8/8/15, 1:50 PM, Resident was standing in room, began to stumble, landed on both knees, no injury." The documented contributing factor is "Upon investigation, I learned that the resident was laying in bed with a shirt and a diaper on. The resident prefers to have pants on as well when in bed. The resident was attempting to get out of bed, unassisted, to get his pants. The resident is not steady and is unable to transfer self. The resident stumbled and fell to the floor." The documented "Plan of Action to Prevent Reoccurrence" is "We added to the care plan to leave pants on the resident while laying in bed. Staff was educated on this new process."

"9/10/15, 12:00 PM, Resident was on toilet when a Certified Nurse's Aide (CNA) came out and the next CNA went in to cover the leaving CNA. (R2) was on the floor. He stated that he landed on his knees." The documented causative factor is "Resident transferred with staff assistance from wheelchair to toilet, this staff member then exchanged positions with another CNA. During this period, the resident attempted self transfer back to wheelchair and fell." The documented corrective action is "Staff education provided related to Fall Management policy and Fall Prevention Program."

"10/8/15, 10:00 PM, resident observed sitting on blue mat beside bed on buttocks, back against bed, legs extended out. (R2) had moderate amount of urine on floor/mat. When questioned, resident stated he slid off the side of the bed using his left arm to catch himself. Complaining of left shoulder pain." The documented causative factor is "Resident was found sitting on mat next to bed after alarm sounded. Resident stated he slid off side of bed when attempting to transfer and ambulate to the bathroom." The

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S9999	Continued From page 3	S9999		

documented "Plan of Action to Prevent Reoccurrence" is "Prior to night shift change staff will assist resident to the toilet."

"10/14/15, 11:05 AM, resident attempting to get out of wheelchair without assistance and fell to the floor." The documented causative factor for this fall is "Upon standing, the resident fell to the floor. Resident claimed to be ready for lunch, Resident is a feeder and requires staff supervision and assistance to the dining room." The documented corrective action for this fall is "Staff will assist resident to the wheelchair at the time that lunch is ready to be served in the dining room."

"10/15/15, 3:30 PM, resident self transferred from the bed into the wheelchair, which was on the safety mat on the floor. Resident attempted to push the chair backwards and fell." The documented causative factor is "Resident attempted self transfer from the bed into the wheelchair. The wheelchair was on the safety mat next to the bed. Once in the chair the resident attempted to push it backwards causing the wheelchair to tilt and resident to fall." The documented corrective action is "The wheelchair will be placed next to the wall in the resident's room. We will continue with the floor safety mat next to the bed."

"10/25/15, 1:15 PM, (R2) attempting to put self on the toilet. Alarm sounded three times. Resident was found on floor in bathroom. States he bumped head. No injury noted." The documented corrective action for this fall is "A door alarm will be placed on (R2's) bathroom door."

"12/16/15, 6:30 AM, (R2's) chair was on blue pad on floor and it flipped backwards and hit the back

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S9999	Continued From page 4	S9999		

of his head. Back of head small abrasion cleansed." The documented causative factor is "resident on blue pad and flipped wheelchair backwards." The documented corrective action is "Remove pad to closet area when resident not in bed."

"1/12/16, 6:30 PM, CNA noted personal alarm sounding, entered room and resident was lying on the floor. Increased agitation, attempting to get off of the floor independently. Complaining of pain. No rotation of right or left leg. Sent to emergency room." There is no documented contributing factors. The documented corrective action is "(R2) to have low bed and continue with mats to side of bed and alarm - bed remains against the wall." R2's "History" from the emergency room, dated 1/13/16, documents "right hip intertronchanteric fracture. Transfer-another hospital." The "Patient Discharge Summary", from the second hospital, documents that R2's hip fracture was surgically repaired.

1/19/16, 6:15 PM, (R2) resting in bed, moaning in pain. Shook head "yes" when asked if right leg hurt. Attempted oxycodone and (R2) spit it out. 8:30 PM, (R2) continues to moan and is restless. 9:00 PM, resident with labored respirations. Oxygen saturation level at 68%. Oxygen applied at 4 liters per minute. Oxygen saturation level up to 80%. 9:40 PM, transferred to hospital. Oxygen saturation level at 90%. 1/20/16, 7:30 AM, Hospital called to advise that R2 has passed away.

R2's "Certificate of Death", dated 1/20/16, documents R2's cause of death as Pneumonia, Right Hip Fracture and Parkinson's Disease.

None of the Incident/Accident investigations listed

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above document that the Facility assessed for environmental factors, R2's toileting schedule, how medication may have contributed to the falls or potential orthostatic hypotension. E3, Corporate Registered Nurse (RN) and previous Director of Nursing (DON), confirmed on 3/2/16 at 11:55 AM that the Facility failed to assess for potential causative factors and take corrective action based on those factors when reviewing R2's falls. E3 also confirmed that R2 should not have been left alone on the toilet by the CNA's, while they switched locations, on 9/10/15.

R2 was originally admitted to the Facility on 3/3/15 with diagnoses, in part, of Parkinson's Disease, Malignant Neoplasm of the Bladder and Dementia.

R2's Minimum Data Set (MDS), dated 6/10/15, documents that R2 had short and long term memory problems; was frequently incontinent of urine and occasionally incontinent of bowel; was not on a toileting program; and required the limited physical assistance of one person for transfers, ambulation and activities of daily living.

R2's MDS, dated 7/16/15, documents that R2 had short and long term memory problems; was frequently incontinent of urine and occasionally incontinent of bowel; was not on a toileting program; and required the Extensive physical assistance of one person for transfers, ambulation, toilet use and activities of daily living.

R2's MDS, dated 10/16/15, documents that R2 still required the extensive physical assistance of one person for transfers, toilet use, ambulating in his room, and activities of daily living. The MDS documents that R2 was not on a toileting program. The MDS also documents that R2 was

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S9999	Continued From page 6	S9999		

not steady while moving from a seated to standing position, walking, turning around, moving on and off the toilet and surface-to-surface transfers.

R2's plan of care, with a start date of 3/4/15, documents a "Focus" that "(R2) is at high risk for falls related to unaware of safety needs." Documented interventions for this "Focus" include "7/8/15, one-on-one as needed when restless due to urinary urgency. 7/23/15, seat belt alarm in wheelchair. 8/8/15, pants on when he is laid down. 10/25/15, door alarm to bathroom door. 12/28/15, staff to toilet prior to evening meal and then prior to laying down. 1 hour after laying him down, offer toilet assist again in the evening." R2's plan of care also documents a "Focus" of "Functional Bladder Incontinence (history of tumor)."

On 3/2/16 at 12:25 PM, E1, Administrator, stated that R2 was not on a toileting program at any time while he lived in the Facility as "We couldn't find a pattern due to his urgency", despite R2's plan of care documenting to "toilet prior to evening meal and then prior to laying down. One hour after laying him down, offer toilet assist again in the evening."

R2's "Physician's Orders" document an order for Seroquel, dated 7/6/15, 25 milligrams (mg) by mouth at bedtime. This order was discontinued (D/C) on 7/27/15. The Drug.com website documents the following side effects for Seroquel: confusion, orthostatic hypotension and unusual drowsiness.

R2 has a documented "Physician's Order", dated 7/27/15, for Sinemet 25-100 mg by mouth five times daily. R2's "Physician's Orders" document

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S9999	Continued From page 7 that he continued receiving the same dosage of Sinemet until he expired on 1/20/16. The Web MD website documents side effect for Sinemet as dizziness and lightheadedness when rising from a sitting or lying position. There are no baseline orthostatic hypptension readings documented in R2's clinical record. E3, Corporate Registerd Nurse (RN) and previous Director of Nursing (DON), confirmed on 3/2/16 at 11:55 AM that the Facility did not conduct baseline orthostatic hypotension readings for R2 nor did they assess for postural hypotension after any of R2's falls. The Facility "Fall Management" policy documents "It is the policy of the facility to have a Fall Prevention Program to assure the safety of all resident in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary." The Facility failed to assess for the risk of falls and implement appropriate interventions for R2. (A)	S9999		

IMPOSED PLAN OF CORRECTION

NAME OF FACILITY: INTEGRITY HEALTH CARE OF CHESTER
DATE AND TYPE OF SURVEY: MARCH 8, 2016 - COMPLAINT #1641063/IL83661

300.610a)
300.1210b)
300.1210d)3)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 shall be followed in operating the facility.

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.

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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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.* (Section 2-107 of the Act)

Attachment B
Imposed Plan of Correction

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 in serviced on the facility's policy for physician and legal representative notification of change of condition. Additionally, in servicing will be conducted regarding notification of the Director of Nursing (DON) and/or designee 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.

III. All nursing staff will be in serviced on the facility's policy to assess for causative factors contributing to falls and take corrective actions based on said factors for those residents with a history of falls. The in servicing must also include the systemic changes to reasonably assure deficiency does not recur by review of protocol for safety interventions, monitoring, care planning and assessment.

IV. The Director of Nursing (DON) and/or Clinical Nurse Leaders, 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.

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

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

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