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
	IL6003289	A. BUILDING: _____ B. WING _____	C 03/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKFORT HEALTHCARE & REHAB CENTEI	2500 EAST ST. LOUIS STREET WEST FRANKFORT, IL 62896

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S 000	Initial Comments Complaint #1651002/IL83590 Complaint #1651309/IL83943	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 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 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	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/04/16

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S9999	Continued From page 1 shall include, at a minimum, the following procedures: 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. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to ensure for a safe environment to prevent resident injury for 4 residents (R1, R3, R4, R14) of 6 residents reviewed for environmental safety and accidents and injuries in the total sample of 14. These failures resulted in R4 with a fractured right metatarsal, R4 with facial bruising covering her entire face, laceration on her face and skin tears on her body which resulted in increased pain, and resident voicing issues with self esteem and not wanting to be seen by other resident because of the condition of her physical appearance and R14 with an actual injury to neck and subsequent visit to emergency room after voicing suicidal ideation and actual suicidal actions.	S9999		

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Finding Include:

1.) On 2/24/16 at 2:40 PM, R4's right hand on the fourth and fifth digit and on the outer aspect of the right hand was noted to be bluish gray with discoloration. R4's fifth digit (pinky) was at an abnormal angle. When questioned, R4 stated that she had walked out of her bathroom this morning and caught her foot on the soda can cases sitting in the floor by the bathroom doorway. R4 stated she had stumbled forward and had attempted to catch herself but had fallen on her knees in front of her recliner and attempted to catch herself with her right hand and it had bend backwards. When she had done that (tried to catch herself), R4 stated it was just a little sore. R4 stated she had not told any staff at this time. R4 stated that she never had enough room for her stuff and she and her roommate were always trying to find more space or trying to figure out where to put things. R4 had her TV/cable box, two cases of soda, books, magazines on the floor by her dresser in the walkway between her bathroom and her recliner. R4 stated she and her roommate had gotten the soda over the weekend and had been there since because it was the only place she could find to put it.

R4's Care Plan with admit date of 6/11/12 and identified problem start date for falls of 1/18/16 shows identified intervention of: observe resident environment and personal routine; ensure resident's safety and goal is R4 will remain free from falls for 90 days with target goal of 4/21/16.

R4's Accident/Incident Report dated 2/24/16 at 2:40 PM shows was made aware resident had tripped over soda box onto floor. R4 stated that she hurt pinky finger but is fine. R4's roommate witnessed fall. Neither reported to staff. Slight

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ecchymosis noted to right pinky finger. Range of motion within normal limits. Residents denies pain at this time. Completed by E2 DON (Director of Nursing).

R4's Post Fall Investigation dated 2/24/16 done by E2 shows swelling/redness/bruising to right fifth digit hand, assessment of environment is cluttered area.

R4's document to IDPH (Illinois Department of Public Health) with message of Initial and follow up to follow dated 2/25/16 shows: Date of incident is 2/24/16 and per resident she ambulated without walker from bathroom to chair. R4 stated, "I tripped on soda box went to my knees and right hand landed on chair." Resident stated she was fine. No complaints of pain. On 2/25/16 R4 complained of pain in right hand and doctor was notified and x-ray ordered. Results are acute fracture of fifth digit

2.) On 2/24/16 at 1:30 AM, R3 stated she had been attempting to go to the bathroom and had fallen and that was why she was all bruised and cut up. R3's face was covered in blue, purple, black, gray, red discolored bruising to entire face. R3 also had a laceration under her chin with steri-strip covered with a Band-Aid. R3 also had a skin tear on her outer right elbow with a transparent dressing with light yellow drainage. R3 also had a scratch on the right side of her nose that was uncovered, steri-strips on the let hand with a skin tear.

R3's TAR (Treatment Administration Record) for 2/2016 on the back shows no breakdown noted, resident fall earlier this shift: 1.) left skin tear right outer forearm 3.5 x 1.5 cm(centimeters) covered with clear transparent dressing after cleansed

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with w/c (washcloth). 2.) 1 cm scratch to outer left nares. 3.) Skin tear to top of right hand 1.5 cm x 1 cm - cleansed with w/c covered/closed with band aid. 4.) Skin Tear left index finger cleansed and closed with steri-strips 1.5 cm length. 5.) Laceration under chin 2 cm x 1 cm - cleansed, closed and covered with steri strips and Band-Aid for pressure. 6.) laceration to throat (superficial) - closed after cleansing and covered with clear transparent dressing.

R3's Accident/Incident Report dated 2/20/16 at 4:10 PM done by E10 LPN (Licensed Practical Nurse) shows resident report coming to bathroom in wheelchair unassisted, got up from wheelchair grabbed commode riser and it moved, resident reports falling forward and face/chin hit commode riser, then hit floor.

On 3/3/16 at 1:45 PM at 1:45 PM, E10 stated she had been the nurse that had taken care of R3 when she had fallen and taken care of her immediately afterward. E10 stated the commode riser was not bolted to anything and it was moved out and away from the commode so E10 could get to R3 to assess her. E10 stated from what she understood the old commode risers had been replaced with new bolted ones because of the incident with R3 and it being a safety issue. E10 stated after R3's injury she had looked "horrible" and had bruising over entire face plus some cuts on her face, neck and body. E10 stated R3 had an increase in pain medications recently.

On 2/24/16 and 2/25/16 R3 stated she did not want to come out of her room because her face looked so bad with all the bruising and she didn't want anyone to see her like that. R3 also stated that she had been taking pain medication ever since the fall on 2/20/16 because the pain was so

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bad in her face and all over from the fall.

On 2/25/16 at 2:45 PM, Z7 (Physical Therapy Assistant) stated R3 prior to fall on 2/20/16 had been coming out on occasion during therapy. Z7 stated that since R2's fall on 2/20/16 she had not been able to get her to come out of her room. Z7 stated R3 made statements that she looked awful. Z7 stated R3 had also been complaining of increase in her pain since her fall on 2/20/16.

On 2/25/16 at 5:30 PM during daily status meeting with E1 administrator, stated the previous commode risers (that R3 had been using during her fall on 2/20/16) had been removed from the building and she was working with maintenance and had ordered new commode risers for the whole building that were bolted to the toilet so they would not move and would be stationary.

R3's Care Plan with admit date of 1/14/16 shows R3 is at high risk for falls and the goal is R3 will remain free from falls. R3 had a hand written update on 2/20/16 that stated one on one with resident to use call light and wait for assistance with transfers and tilting however, this is already addresses as an intervention on 1/22/16. No new interventions were in place after most recent fall.

On 3/2/16 R3's Care Plan behind nurses station in binder had no update after fall on 2/20/16.

On 3/3/16 at 3:00 PM, E3 RN/CPC stated residents assessments should be accurate and complete and residents care plans should reflect these comprehensive, complete and accurate assessment. E3 stated this should usually happen within 24 hours of the problem being identified. E3 stated she was not the one that

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updated R2's plan of care on 2/20/16 that the Director of Nursing had done that. E3 stated there are two place Care plans are kept and that is in the residents chart and in a binder behind the nursing station.

R3's assessment with reference date of 2/11/16 shows her mental status to be a 15 out of 15 which makes her able to make appropriate decisions and voice wants and needs.

3.) On 3/10/16 at 11:30 AM, R14 stated he had to go to the emergency room last night because he was so upset and tried to cut his neck with a pocket knife. R14 stated he didn't want to be here anymore and did not feel that anyone cared for him and at the time he just felt like he wanted it all to end. R14 stated he had the knife since he was admitted to the facility last May. R14 stated it was not the first time he had told staff he had wanted to die.

R14's Nursing note date 3/9/16 at 7:20 PM shows "CNA reported R14 refusing to go to bed; writer suggested resident be transferred to recliner if agreed. CNA walked down hall to R14's room and yelled, 'he is cutting his neck with a knife;' writer noted resident with pocket knife in right hand and laceration to left side of neck with minimal bleeding. CNA reports R14 trying to cut with knife. Writer told CNA to call 911. R14 refused to drop knife. R14 states, 'I want to kill myself, I want to die.' Police arrived and forced knife out of resident's right hand. EMS (Emergency Medical Services) arrived and transported resident to hospital."

R14's document titled "Patient Care Summary" dated 3/9/16 shows "asked patient why he would want to take a knife to his neck. Patient states, 'It

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was the heat of the moment. I just got caught up; it was silly to do. I was just so irritated.' Also shows, 'I told them I might do something to myself and today I cut myself with a pocket knife.'"

On 3/30/16 at 10:10 AM Z13 (Medical Staff) stated R14 had come into the ED (Emergency Department) last night because he had tried to cut himself with a knife. Z13 stated he was not happy at the care center and he had told them (facility) he was not happy and he was going to try to do something to himself/hurt himself . Z13 stated R14 was evaluated by the ED doctor and the doctor stated R14 was very alert and oriented and this was not something that warranted a psychiatric evaluation. Z13 stated R14 was discharged back to the facility after he was evaluated. Z13 stated the areas R14 had cut on his chest were superficial and had been cleansed and no dressing was required.

On 3/10/16 at 5:00 PM, E7 RN stated she had been the nurse on duty when R14 had went to the ED 3/9/16. E7 stated she did not know where R14 had gotten the knife but as far as she knew no residents in the facility should have a knife. E7 stated R14 had cut his shirt as well as his neck but it was superficia,l but she had other staff call 911 because R14 would not put the knife down and would not let any of the staff have the knife and she was concerned for not only R14's safety but the rest of the residents and staff safety. E7 stated the police had to take the knife from R14 because he would not give it to her or any staff. E7 stated all staff know not to approach R14 by himself because he makes accusations against staff that are not true and it is part of his plan of care. E7 stated R14 had an episode back in February where R14 had been given Ativan but

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she was not sure what it was for.

On 3/10/16 at 4:45 PM E16 Social Service stated R14 had a previous episode of voicing plans/ideation's of suicide and R14 had made them to her. E16 stated at the time E3 RN was at the facility and she made E3 aware of what R14 was saying about wanting to die/be dead. E16 stated she and R3 where the main staff to take care of the situation. E16 stated the first incident of R14 having suicidal thoughts had occurred at the beginning of February of this year. E16 stated at that time R14 was put on 15 minute checks, was moved into a different room and all possible items he could hurt himself with was removed such as shoe strings, belt, cords, curtains, etc. E16 stated she thought staff had checked R14's room for any possible issues or problems related to him being able to hurt himself. E16 stated she does not know where or how long R14 had his knife. E16 stated she didn't think any resident was suppose to have a knife in the building for safety reasons.

On 3/11/16 at 11:00 AM, E3 RN/CPC (Registered Nurse/Care Plan Coordinator) stated she was the nurse that had been here when R14 had his first episode of voicing that he might want to hurt himself. E3 stated she had made the doctor aware and she with the staff had checked R14's room for any safety issue/items. E3 stated R14 was placed in a different room when this happened and all items that could pose a risk had been removed, such as shoe laces, strings, belts, cords and R14 was placed on a every 15 minute check. E3 stated the doctor gave orders to give R14 Ativan 0.5 mg IM (Intramuscularly) now for acute agitation. E3 stated she does all the care plans for resident. E3 stated R14 had a recent quarterly Care Plan done (3/7/16). E3 stated

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R14's issues with possible self harm was not put on his plan of care. E3 stated all staff should know they are not to go into R14's room by himself because he makes allegations that are not completely true and accurate.

On 3/10/16 at 7:30 PM E24 CNA (Certified Nursing Assistant) stated she had been the one who had originally found R14 with the knife in his hand cutting at his neck. E24 stated she had attempted to put him to bed earlier and R14 had refused so she had left the room. E24 indicated that she had been in the room by herself when R14 refused to go to bed. E24 stated R14 previously had voiced an episode where he intended to harm himself, in early February 2016 and R14 had been put on 15 minute checks and put in another room. E24 stated that only lasted a few days and he was returned back to his original room. E24 stated she did not know who if anyone had checked R14's room for any items he could possibly hurt himself with. E24 stated she thought R14's room had been checked and did not know how R14 had gotten the knife he had hurt himself with on the evening of 3/9/16.

On 3/11/16 at 2:20 PM Z2 (Primary Care Physician) stated R14 had issues with depression and had previous episode where he had voiced/made threats he was going to hurt himself. Z2 stated at that time he had ordered a one time dose of Ativan. Z2 stated R14 and no residents should have access to a knife to be able to hurt themselves while in the facility. Z2 stated R14 never seems happy and is very hard to please and often gets irritated and will get worked up fast. Z2 stated it is important that staff continue to follow that plan of care and make sure they always go into take care of R14 according to his plan of care and be consistent. On 3/ 1/16 at

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2:20 PM, Z2 stated that even though he communicates a lot with staff through reciprocity, his expectation is that everything that happens and is going on with the resident as well as orders are documented in residents charts.

R14's nursing note dated 2/11/16 at 1:35 PM shows social service reported to writer resident is agitated; Z2 called and stated give IM Ativan 0.5 mg x 1 now for acute agitation. Call if doesn't get better.

R14's POS (Physician Order Sheet) shows 2/11/16 to give Ativan 0.5 mg IM x 1.

Review of R14's Care Plan with admit date of 5/26/15 shows no identified problems related to suicidal ideation/threats, goals or interventions. R14's Care Plan does state to use 2 people with all ADL's (activities of daily living) due to contradictory statements made per resident.

R14's most recent brief mental assessment done one 3/4/16 show it is a 15 out of 15 and is able to make needs and wants known.

4.) R1's Nursing notes dated 2/25/16 at 2:20 PM shows resident was witnessed to lose balance and sat down in the floor onto her buttock in the hallway outside of her room with no apparent injuries.

R1's care plan with admit date of 2/7/16 show identified problem of falls related to advanced age and weakness's and the goal is she will remain free from falls for 90 days.

On 3/1/16 R1's Care Plan was reviewed and R1's fall on 2/25/16 is not identified on the plan of care for re-assessment and no new interventions

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were put in place to prevent further falls

R1's Fall Risk Assessment has only one completed on 2/8/16 and R1 is scored at a moderate risk for falls on this, there is no re-assessment after fall on 2/25/16.

On 3/3/16 at 3:00 PM, E3 RN/CPC (Registered Nurse/Care Plan Coordinator) stated if a resident falls then a new fall risk assessment should be done and the care plan reviewed and update. E3 stated the day of the fall would be on there as well as a new intervention. E3 stated all of a residents individualized care is based of the residents own care plan.

On 2/24/16 at 10:00 AM, Z8 POA (Power of Attorney) stated R1 has been admitted to the facility after a hospital stay for TIA's (Transient Cerebral Ischemic Attack). Z8 stated R1 had fallen before due to these TIA's.

On 2/24/16 at 3:20 PM R1 stated she had fallen before because the TIA's had happened. R1 stated she had come to the facility after being in the hospital for a TIA and to help build up her strength because she was having some weakness.

R1's notes from the discharging hospital dated 2/6/16 shows R1 with weakness, Transient episode of left face and arm weakness, likely TIA, facial twitching, stroke-like symptoms.

On 2/25/16 at 2:45 PM, Z7 (Therapist) stated she had been treating R1 since her admission and R1 had problems with gait, balance and generalized weakness.

R1's Fall Risk Assessment for 2/8/16 in not

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003289	A. BUILDING: _____ B. WING _____	C 03/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKFORT HEALTHCARE & REHAB CENTEI	2500 EAST ST. LOUIS STREET WEST FRANKFORT, IL 62896

(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 12 scored accurately an/or staff is unable to provide corresponding information. Under Section B.) history of falls- has no falls in past 3 months. Z8 and R1 both stated R1 has fallen in last 3 months due to TIA's. Under section E.) Gait/Balance/Ambulation-balance problem while stand/walking are not scored; decreased muscular coordination/jerking movement is not scored. On 2/25/16 therapist states R1 had both of these indicated upon admission and throughout stay at facility. Under Section F.) Systolic Blood Pressure lying and standing drops is marked as no problem but when asked RN's E3, E6 and E8 none were able to provide information where this was completed. E3 signed off as having completed the form. On 3/3/16 at 3:00 PM, E3 stated floor nursing usually does the vital signs with admission. R1's Fall Risk Assessment dated 2/8/16 shows a score of 9, moderate risk for falls. This assessment indicates a total score above 10 represents high risk for falls. If staff had complete and accurate assessment and marked falls noted per family, and balance and muscular movement noted per therapist, this would have made R1's Risk Assessment Fall Score at least a 13, which puts her at a high risk category and identifies R1's actual identified risk factors for falls. R1's Fall Risk Assessment for 2/8/16 is not accurate or comprehensive and does not identify R1's actual identified risk factors. Review of R1's original Care Plan for fall Risk dated 2/16/16 does not have identifying information that R1's TIA's are possible in contributing to her risk of falls. R1's care plan does not identify R1's TIA as a risk or problems identified at all for R1.	S9999		

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S9999	Continued From page 13 On 3/3/16 at 3:00 PM, E3 RN/CPC indicated all resident care plans are based off resident assessments and if a care plan is to be comprehensive, complete, accurate and then the residents assessments must be comprehensive, complete and accurate. E3 stated she did not realize R1 was discharged from the hospital due to TIA's and stated the signs and symptoms R1's complains of having with her TIA's were not incorporated in her plan of care. R1's assessment with reference date of 2/14/15 shows test for mental status at a 15 out of 15, making her able to make appropriate and adequate decisions. (B)	S9999		