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
	IL6007843	A. BUILDING: _____ B. WING _____	C 04/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PALOS HEIGHTS	13259 SOUTH CENTRAL AVENUE PALOS HEIGHTS, IL 60463

(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 Complaint# 1691598/IL84282 Statement of licensure violations	S 000		
S9999	Final Observations 300.1210b) 300.1210d)6) 300.3240a) 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 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 These requirements were not met as evidenced	S9999	Attachment A Statement of Licensure Violations	

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by:
Based on observation, interview and record review, the facility failed to implement safety measures for a resident at risk for falls, to reduce the risk of injury for one of two residents (R6) reviewed for a serious injury in a sample of six residents (R6). This failure resulted in R6 being hospitalized and treated for an acute intracranial bleed.

Findings Include:

According to a face sheet R6 was admitted to the facility on 2/01/2016 with admitting diagnosis of a history of falling and other diagnoses of dementia and nottraumatic subarachnoid hemorrhage.

According to the electronic physicial therapy evaluation- with a certication start date of 2/02/2016: R6 had a prior hospitalization from 1/20 to 2/01/2016. R6 presented to the hospital with subdural acute hematoma status post fall on 1/20/2016. An emergency right sided craniotomy and evacuation of subdural hematoma, stripping of membrane was conducted 1/25/2016. R6's caraniotomy for subdural hematoma done on 1/25/2016 was also document of the hospital's transition of care report printed on 1/29/2016.

An occurrence Report dated Tuesday 2/2/2016 at 4:40am documented the following information: Type of occurrence Fall, Location -Hallway/Corridor, Activity Sitting Witnesses) None. Cognition prior to occurence oriented x 1 and after occurence oriented x 1. Injuries None Noted.
Immediate Actions Taken Neuro checks intiated, alarm applied, monitor resident closely, use gait belt for transfers/ambulation redirect, placed in wheelchair, family called to assist with behavior,

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ROM within normal limits for resident, Non-slip socks or shoes and Physician called.
Notes: Nurse's note of what happened written by E7 (nurse) on 2/02/2016 07:47- CNA (certified nurse aide) E6, notified writer patient fell, visually observed patient on the floor on the back, assist to chair, assessed patient , notified MD (medical doctor) and POA (power of attorney) Z4,neuro checks intitiated, resident had no complaints of pain or discomfort, will continue to monitor, endorsing to 7-3 nurse.

A follow-up Report entered on 2/04/2016 10:09 documented; 2/02/2016 4:40am E6 (CNA) notified E7 (nurse) R6 fell out of his wheelchair. R6 in therapy today with family. Family notified significant change in R6. He was droooling unable to follow directions as well as before and could not swallow medicine/ pudding. Family requested to send to hospital.

Clinical note entry dated 2/02/16at 3:19pm documented, Resident in therapy today with family (Z4) Family noticed significant change in resident. R6 was drooling at the mouth, unable to follow simple direction and could not swallow medicine or pudding. Family requested to send to hospital.

The hospital emergency Room Records dated 2/2/2016 contained a
CT head scan without IV contrast revealed changes in the postoperative area of R6's brain that was in line with an acute subdural hemorrhage. R6 was transferred to another hospital which could provide treatment for a cranial bleed.

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3/30/2016 at 12pm, E8 (Registered Nurse/RN) was interviewed. E8 reported she admitted R6 to the facility 2/1/2016. R6 was admitted for physical therapy after suffering a fall at home. The fall caused R6 to have Craniotomy for a subdural bleed in the brain. At admission, R6 could answer simple 'yes and no' questions. R6 was not agitated. E8 did the initial assessment of R6. E8 said that upon admission to the because of R6's history of falls, R6 was placed in a low bed, mats of the floor and a bed sensor. E8 was asked if any safety measures were taken for R6's recent head injury. E8 said all bed rails were down, floor mats were in place on both sides of the bed and the night stand was removed. R6 was not admitted to the facility with a helmet, nor was there an order for a helmet from the hospital. E8 said R6 had become agitated by the end of her shift. "R6 was sitting up in bed. R6 was told that it was time to go to sleep and he would lay back down for a short time then would again sit up in bed." R6's behavior had escalated by the end of the 3 to 11pm shift. E8 said she verbally endorsed over to the 11 to 7am shift that R6 needed increased monitoring due to agitation.

3/30/2016 at 11am, E6 (CNA)was interviewed. E6 reported she was the direct care staff for R6 on the 11 to 7am shift, 2/1/2016. E6 said that after R6's family left. R6 started yelling out for his daughter and trying to get out of bed. After the 3rd or 4th time R6's bed sensor went off. E6 told E7 (nurse) about his behavior. E7 told E6 to get R6 out of bed and place him by the nurse's station. E7 gave E6 no special precautions to take for R6's head injury. E6 got R6 dressed and transferred him to a wheelchair with a chair alarm. R6 was place at the nurse's station with at least 5 other residents who were up in wheelchairs for similar reasons. E7 said residents

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having behavior problems at night are dressed and set up at the nurse's station in a wheelchair. Nothing was added as a safety precaution for R6's head injury. E6 went to chart but was in visual control of R6. E6 said R6 was at first quiet but then started to rocked side to side and back and forth in the wheelchair. R6 fell forward out of the wheelchair on his knees. The wheelchair fell on top of him. E6 said R6's head did not hit the floor.
After R6 was assessed for injuries while he was lying on the floor, E6 was told to put to R6 back to bed and monitor R6 1:1 until the shift was over. "I didn't help with any other residents until shift ended. After the fall, R6 was quiet the rest of the shift."

4/4/2016 at 9:42am, Z2 (Attending Physician for R6) was interviewed. Z2 said he was R6's Attending Physician in the facility. Z2 was unfamiliar with R6's previous hospitalization for his original subdural hematoma and Craniotomy. Z2 confirmed that R6 suffered a subdural hematoma 2/2/2016 but said, "Staff in the emergency room 2/2/2016 had no reference to say if it was the same bleed as the first or a new bleed in the brain." Z2 was asked if R6's head being jerked back and forth cause a bleed in the brain. Z2 said, "Any sudden trauma to the head causing the brain to move in the skull could cause a bleed."

4/4/2016 at 3pm, the surveyor observed the location where R6's fall occured while accompanied by E13 (vice president of clinical development). E13 pointed out where the CNAs chart in the hallway and where residents are positioned around the nurse's station. R6 was a minimum of 6 feet away from E6 with at least 5 other residents.

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(A)

Imposed Plan of Correction
Name of Facility: Providence Palos Heights
Date and type of survey- 4/4/16 Complaint#1691598/IL8482

Licensure Violations
300.1210b)
300.1210d)6)
300.3240a)

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 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*

This will be accomplished by:

I. A Committee consisting of, at a minimum, the Medical Director, Administrator, and Director of Nursing (DON) will review and revise the policies and procedures regarding accident hazards/ nursing services/adequate nursing supervision. This review will ensure that the facility's policies and procedures address, at a minimum, the following:
   a. Recognition of situations that could lead to resident injury and/or death.
   b. Appropriate reporting procedures for staff.
   c. Appropriate and thorough investigations and follow-ups of accident hazards, inadequate assistance devices and supervision.
   d. The facility's responsibilities to prevent further potential abuse and or neglect while the investigation is in progress.
   e. The facility taking appropriate corrective action when an alleged violation is verified.

II. The facility will conduct MANDATORY in-services for all staff within 30 days that addresses, at a minimum, the following:
   A. Resident supervision, fall precautions and follow-up assessment and monitoring of residents who are experiencing a change in condition and/or need to be reassessed for safety or level of supervision.
   B. Assessment of resident risk for falls, supervision, monitoring, follow-up of incidents and identifying resident changes or indicators that may require reassessment or other interventions to prevent injury or death.
   C. Any new or revised policies and procedures, including actions needed to follow them that are developed as a result of this Plan of Correction.
   D. All staff will be informed of their specific responsibilities and accountability for the care provided to residents.
   E. Documentation of in-service training, assessments and related follow-up actions will be maintained by the facility.

III. The following actions will be taken to prevent re-occurrence.
   A. The above In-service education will be reviewed with all staff on a regular basis.
   B. Supervisory staff will ensure that the State Regulations regarding environmental hazards (reporting and follow-up) are followed.
   C. Supervisory staff will ensure that staffs are informed of the level of care required for each resident to whom they are assigned

IV. A Committee consisting of, at a minimum, the Medical Director, Administrator, and Director of Nursing (DON) will review and revise the policies and procedures regarding abuse and neglect. This review will ensure that the facility's policies and procedures address, at a minimum, the following:
A. Monitor Items I through III to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Ten (10) days from receipt of the Imposed Plan of Correction.