

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6002679</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/14/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>EDEN VILLAGE CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>400 SOUTH STATION ROAD GLEN CARBON, IL 62034</b>
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(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
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S 000	<p>Initial Comments</p> <p>Complaint #1646771/IL90106</p> <p>Statement of Licensure violations</p>	S 000		
S9999	<p>Final Observations</p> <p>300.610a) 300.1210b) 300.1210d)6) 300.3240a)</p> <p>These requirements were not met as evidenced by: Based on interview and record review, the facility failed to assess, identify causative factors contributing to falls; implement, monitor and modify current interventions to prevent falls for 2 of 4 residents (R1, R3) reviewed for falls and injuries in the sample of 8. This resulted in R1 and R3 being sent to the hospital for evaluation and treatment of injuries secondary to falls. R1 sustained a head laceration with 7 staples and R3 sustained multiple contusions including a large left periorbital swelling and bruising, contusions to the left shoulder and right knee and a laceration to the right middle finger with 5 sutures.</p> <p>Findings include:</p> <p>1. R3's Physician Order Sheet (POS), dated 11/2016, documents multiple diagnoses significant for Alzheimer's Disease, Spondylosis, Spinal Stenosis and Dementia.</p> <p>R3's Minimum Data Set (MDS), dated 8/17/16 and 11/16/16, documents R3 is severely cognitively impaired and requires extensive</p>	S9999	<p><b>Attachment A</b> <b>Statement of Licensure Violations</b></p>	

Illinois Department of Public Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

12/30/16

Illinois Department of Public Health

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S9999	<p>Continued From page 1</p> <p>assistance of one staff person for transfers, ambulation and dressing and is totally dependent on staff for toileting. The MDS, dated 8/17/16, documents R3 requires extensive assist of one staff person for walking between locations in his/her room and walking in corridor on unit. The MDS, dated 11/16/16, documents R3 requires limited assist of one staff person for walking in room and in corridor on unit. Both MDS document R3 was not steady and only able to stabilize with staff assistance when moving from the seated to standing position, turning around, moving on and off toilet and surface-to-surface transfers.</p> <p>R3's Fall Risk Evaluation, dated 11/16/16, documents R3 has a total score of 17 (score of 10 or higher represents a high risk for falls).</p> <p>R3's Safety Event Report, dated 4/29/16, documents at 9:13 PM, R3 was apparently walking to bathroom with staff and slipped on wet floor and sat down on the floor.</p> <p>R3's Care Plan entry, dated 4/29/16, documents, "Staff reminded to always put shoes on R3 prior to walking her or keep gripper socks on her at night. Surgical shoe on left foot due to fracture of small toe."</p> <p>R3's Safety Event Report, dated 5/27/16, documents at 2:56 PM, R3 fell in common area after she tried to stand up unassisted from recliner.</p> <p>R3's Care Plan entry, dated 5/27/16, documents, "Frequent visual checks and assist with transfers as usual."</p> <p>R3's Safety Event Report, dated 10/16/16, documents at 2:05 PM, R3 was walking with staff, tripped over her own feet and fell and hit right side of her head.</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>R3's Care Plan entry, dated 10/16/16, documents, "Frequent checks. Staff to continue current plan of care. Staff reminded to get assist from another staff member to help with walking."</p> <p>On 12/12/16 at 1:05 PM, E3, Assistant Director of Nursing (ADON), stated that at the time of the fall R3 only needed standby assist so E15, Certified Nursing Aide (CNA), did not use a gait belt when she ambulated E3.</p> <p>R3's Safety Event Report, dated 11/20/16 documents at 2:30 AM, R3 was found on the floor at the end of the bed next to wall and a red area noted to left cheek. Care Plan Note for 11/20/16 documents, "Frequent visual checks."</p> <p>R3's Safety Event Report, dated 11/20/16, documents at 3:40 AM, R3 was found in her room lying on the floor next to her bed. R3 had a large amount of facial swelling and bruising to her right knee and a skin tear to the back of her right 3rd finger. Left eye swollen. R3 was sent to the ER. R3's Story Of My Fall Form, dated 11/20/16 at 3:40 AM, documents, "(Question) When was the last time the staff assisted you in any way? (Answer) 2:30 AM Resident fell at 2:30 AM. (Question) What did they do for you? (Answer) Bed Check - hourly checks." This form was signed by E16, CNA.</p> <p>R3's Nurse's Notes, dated 10/20/16 at 3:40 AM, document, "Went to (room #) to check on Elder lying on the floor next to bed on left side @ 3:40. Noted elder lying between bed and night stand. elder has significant large amount of facial swelling: left eye bruised swollen shut. 3rd right finger bleeding skin tear noted to back of 3rd finger on right hand. Cleansed finger, applied</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>TAO (Triple antibiotic ointment) and band aid to it. Noted bruising right knee measures 4 x 3 centimeters reddish bruising to right knee. ROM (range of motion) to right knee. Ice applied to left eye and face. Initial neurochecks @ 0345. Neurochecks WNL (within normal limits). No changes is responsive with normal usual responses from elder. Unable to check left eye due to swelling. Called MD (Medical Doctor)." The Nurse's Notes document R3 was transferred to ER, family, Department, and ADON (Assistant Director of Nursing) notified of fall and injury.</p> <p>On 12/14/16 at 2:48 PM, E4, Licensed Practical Nurse (LPN) stated R3 was on hourly bed checks after the first fall the night of 11/20/16.</p> <p>On 12/14/16 at 2:55 PM, E17, CNA, stated R3 was on hourly bed checks after her earlier fall at 2:30 AM that night.</p> <p>On 12/14/16 at 9:20 AM, E2, Director of Nursing (DON), stated R3 did not fall often and on the night she fell twice she actually had UTI (Urinary Tract Infection).</p> <p>2. R1's POS, dated 12/2016, documents multiple diagnoses significant for Hemiplegia, Hemiparesis and Alzheimer's Disease.</p> <p>R1's MDS, dated 8/19/16 and 11/18/16, document R1 is severely impaired cognitively and requires extensive assistance of one staff person for transfers and dressing and totally dependent on staff for toilet use. Both MDS document R1 was not steady and only able to stabilize with staff assistance when moving from the seated to standing position, turning around, moving on and off toilet and surface-to-surface transfers.</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>R1's Fall Risk Evaluation, dated 11/17/16, documents R1 has a total score of 18 (score of 10 or higher represents a high risk for falls).</p> <p>R1's Safety Event Report, dated 3/9/16, documents at 9:45 PM, R1 slid out of his wheelchair reaching for something in the trash can. The Care Plan with entry date 3/9/16 documents, "Continue current plan of Care."</p> <p>R1's Safety Event Report, dated 6/20/16, documents at 7:30 PM, R1 fell while trying to transfer self onto toilet, hit head, sent to ER for evaluation of head laceration. R1's Story of my Fall Sheet, dated 6/20/16, documents the last time R1 was toileted was at 3:15 PM. R1's Nurses' Notes, dated 6/20/16 at 11:30 PM, documents, (Recorded as Late Entry on 6/21/16 at 00:47), "Elder got up out of wheel chair on Hall 100 and tried to take self to restroom. Elder fell and hit head on the floor. Elder sustained an 8 centimeter laceration to the left occipital area of the head." R1's Care Plan entry, dated 6/20/16, documents, "Ice for pain, monitor for infection, neurochecks per facility protocol." R1's Care Plan was not revised at this time with progressive interventions to prevent her from future falls.</p> <p>R1's Safety Event Report, dated 10/3/16, documents at 4:53 AM, R1 was found on the floor in doorway to Room 107 (R1 lives in another room on that hall), incontinent of bowel at the time. R1 was confused. BM (bowel movement) was found on his bed in his room also. R1's Care Plan entry, dated 10/3/16, documents, "Continue current plan of care." The Care Plan was not updated with any new/progressive</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>interventions to prevent future falls.</p> <p>R1's Safety Event Report, dated 10/11/16, documents at 10:00 PM, R1 was found in the shower room, slid from wheel chair onto floor. R1's Story Of My Fall Form, dated 10/11/16, documents,"(Question) What fall interventions were in place? (Answer) Chair Alarm. (Question) Were the fall interventions in place applied properly and functioning properly? (Answer) No. Chair alarm had a low battery on it." R1's Care Plan entry, dated 10/11/16, documents, "Frequent checks to monitor his location and safety." The Care Plan was not updated with any new/progressive interventions to prevent future falls.</p> <p>R1's Safety Event Report, dated 11/30/16, documents at 7:45 AM, R1 fell in his room after getting out of bed and attempting to walk. No shoes on, slipped on the floor. R1's Care Plan entry, dated 11/30/16, documents, "Frequent checks. Staff to get him up when he is awake. He is awake anywhere from 5 AM on. This varies day to day."</p> <p>On 12/12/16 at 1:55 PM, when asked, what "Frequent checks" mean? E3 stated it means 15 minute checks for 24 hours done after every fall.</p> <p>On 12/14/16 at 11:30 AM, E2 stated there is not enough information on the fall investigation form provided by staff. E2 stated when the forms are submitted, she would not go back and add any new information surrounding the fall because that would be altering the document.</p> <p>The Facility Policy on Assessing Falls and Their Causes, dated 2001, documents, "When a resident falls, the following information should be</p>	S9999		
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S9999	Continued From page 6  recorded in the resident's medical record:" and lists in part, "6. Appropriate interventions taken to prevent future falls." (B)	S9999		
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