

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005615	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/01/2017
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 6901 NORTH GALENA ROAD PEORIA, IL 61614
---	---

(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	<p>Initial Comments</p> <p>Statement of Licensure Violations</p>	S 000		
S9999	<p>Final Observations</p> <p>Statement of Licensure Violations</p> <p>300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p>	S9999	<p style="text-align: center;">Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE 02/10/17
---	-------	------------------------------

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005615	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/01/2017
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 6901 NORTH GALENA ROAD PEORIA, IL 61614
---	---

(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	<p>Continued From page 1</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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:</p> <p>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.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>3) Developing an up-to-date resident care plan for each resident based on the resident's</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005615	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 02/01/2017
NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 6901 NORTH GALENA ROAD PEORIA, IL 61614		
(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	<p>Continued From page 2</p> <p>comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on observation, record review, and interview the facility failed to document, assess, and investigate an incident and failed to implement new fall interventions and complete a fall assessment after each fall for three of three residents (R1-R3) reviewed for falls in a sample of three.</p> <p>This failure resulted in R1 sustaining a "Mildly displaced, acute right femoral neck fracture on 11/27/17.</p> <p>Findings include:</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005615	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/01/2017
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 6901 NORTH GALENA ROAD PEORIA, IL 61614
---	---

(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	<p>Continued From page 3</p> <p>The facility's Fall Prevention and Management Program policy dated 8/13/2012 documents: "Each resident will be assessed for the risk factors for falling at move in, quarterly, with a change in condition, upon return from a health care facility and after a fall...On the day of move in each resident will be assessed for risk for falls by a licensed nurse using the community approved fall risk assessment tool...the interdisciplinary team will develop a plan for services to improve or maintain the resident's standing or sitting balance and other interventions to reduce the resident's risk for falls. The plan will include specific information about the resident's routine."</p> <p>1. R1's electronic Nursing Admission Assessment documents R1 was admitted to the facility on 11/10/16. The same assessment documents for R1 "unable to orient...resident is very confused and alert only to self."</p> <p>R1's electronic medical record documents that R1 has had only one Fall Assessment completed on 11/10/16 which documented that R1 was at a high risk for falls.</p> <p>R1's Fall Investigation Report documents R1 had a fall on 11/12/16 at 6:00 a.m. The same form under a section titled "Fall Team Meeting Notes" is blank. A new fall assessment was not completed for R1 after this fall.</p> <p>R1's electronic clinical note entry dated 11/24/16 at 11:05 a.m. documents (R1) "was sitting in his w/c (wheelchair)...(R1)fell from chair landing on his left side...(R1) did hit his head and c/o (complain of) head hurting, 911 called..." R1's clinical note dated 11/24/16 at 11:09 a.m.</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005615	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/01/2017
--	--	--	---

NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 6901 NORTH GALENA ROAD PEORIA, IL 61614
---	---

(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	<p>Continued From page 4</p> <p>documents "(R1) has two skin tears to left elbow measuring 1 cm (centimeter) x 1 cm... (R1) has rug burn to his left eye brow measuring 4 cm x 1 cm."</p> <p>R1's local emergency department record dated 11/24/16 documents: "Diagnoses this visit: concussion, without loss of consciousness, initial encounter scalp contusion, and skin tear on elbow."</p> <p>R1's electronic medical record has no evidence of the facility investigating, determining root cause, implementing an intervention to prevent further falls or completing a new fall assessment for R1's fall on 11/24/17.</p> <p>R1's clinical note entry dated 11/27/16 at 7:15 a.m. documents (R1) "stood up from wheelchair and fell to the ground...(R1) c/o head pain...(R1) c/o pain in the hip/pelvic area." local ambulance called for transport to hospital.</p> <p>R1's result report from the local hospital dated 11/27/17 at 9:27 a.m. "XR (picture) Hip 2 views bilateral...clinical history: ...(R1) fell out of wheelchair...Impression: Mildly displaced, acute right femoral neck fracture."</p> <p>R1's electronic fall care plan, dated 11/12/16, documents that the care plan and its current interventions were created on 11/12/16. R1's care plan has no documentation of new fall interventions being updated following R1's falls on 11/24/16 and 11/27/16.</p> <p>The facility's Accident/Incident Report documents that R1 had one fall from the time of admission on 11/10/16 to R1's discharge on 11/27/16. The report also documents that the one fall incident</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005615	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/01/2017
--	--	--	---

NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 6901 NORTH GALENA ROAD PEORIA, IL 61614
---	---

(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	<p>Continued From page 5</p> <p>occurred on 11/24/16 at 11:05 a.m. in the dining room.</p> <p>On 2/1/17 at 11:15 p.m. E1 (Administrator) and E2 DON (Director of Nursing) stated a fall assessment was not completed after each of R1's falls on 11/12/17, 11/24/17 and 11/27/16, and on 11/24/16 the fall investigation was not completed nor was a new intervention implemented. E1 and E2 also stated that R1's intervention for the fall on 11/27/16 was to send R1 to the hospital.</p> <p>2. R2's Nursing Admission Assessment dated 1/21/17 documents R2 was admitted on 1/21/17. The fall assessment portion of R2's nursing admission assessment was not completed and did not indicate a fall risk.</p> <p>R2's clinical note entry dated 1/28/17 at 3:05 p.m. documents R2 was found sitting on the foot pedal of R2's wheelchair and sustained a skin tear. R2's clinical note entry dated 1/28/17 at 5:30 p.m. documents R2 slid out of wheelchair while being pushed down the hall.</p> <p>R2's electronic medical record has no evidence of the facility investigating or determining root cause, for R2's falls on 1/28/17.</p> <p>The facility's Accident/Incident Report documents that R2 had one fall on 1/28/17 at 3:05 p.m. The additional fall on 1/28/17 at 5:30 p.m. was not documented on the accident/incident report.</p> <p>On 2/1/17 at 10:45 a.m. R2 was sitting in a wheelchair in R2's room and was unable to recall the details of R2's falls on 1/28/17.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005615	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/01/2017
--	--	--	---

NAME OF PROVIDER OR SUPPLIER LUTHERAN HOME, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 6901 NORTH GALENA ROAD PEORIA, IL 61614
---	---

(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	<p>Continued From page 6</p> <p>On 2/1/17 at 11:15 a.m. E1 Administrator and E2 DON (Director of Nursing) confirmed R2's admission fall assessment indicating fall risk was not completed and that investigations to both falls on 1/28/17 were not completed.</p> <p>3. R3's electronic medical record documents that R3 has had only one Fall Assessment completed on 11/11/16 which documented that R3 was at a low risk for falls.</p> <p>The facility's Accident/Incident log documents R3 sustained a fall on 11/19/16 at 9:30 a.m</p> <p>R3's Fall Scene Investigation Report dated 11/19/16 does not document an intervention for R3's fall.</p> <p>R3's electronic fall care plan, dated 11/21/16, documents that the care plan and its current interventions were created on 11/21/16. R1's care plan has no documentation of new fall interventions being updated following R1's fall on 11/19/16.</p> <p>On 2/1/17 at 8:50 a.m. R3 was sitting in R3's wheelchair in R3's bathroom. R3 stated when R3 fell on 11/19/16 R3 "had a urinary tract infection and was kind of out of it."</p> <p>On 2/1/17 at 11:15 a.m. E1 Administrator and E2 DON verified R3's fall scene investigation report dated 11/19/16 did not document an intervention to prevent further falls and a fall assessment was not completed after R3's 11/19/16 fall.</p> <p style="text-align: right;">(B)</p>	S9999		
-------	--	-------	--	--