

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/02/2016
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NAME OF PROVIDER OR SUPPLIER TIMBERCREEK REHAB & HEALTHCARE CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 2220 STATE STREET PEKIN, IL 61554
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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	Initial Comments Certification Survey	S 000		
S9999	Final Observations Annual Licensure Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 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	S9999	<h2>Attachment A</h2> <h3>Statement of Licensure Violations</h3>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE 12/20/16
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S9999	<p>Continued From page 1</p> <p>resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</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 300.3240 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)</p> <p>These requirements were not met as evidenced by:</p> <p>Failures at this level required two deficient practice statements.</p> <p>A. Based on interview and record review, the facility failed to ensure one of six residents (R8) reviewed for falls was safely transferred from bed to wheelchair in the sample of 19. This failure resulted in R8 falling and sustaining fractures of the second, third, and fourth fingers (left hand). The facility also failed to conduct a thorough</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>investigation of R8's fall and failed to accurately report the investigation results to the State Agency.</p> <p>B. Based on observation, interview, and record review, the facility failed to assess the risk for entrapment in the use of side rails for two residents (R8, R6) reviewed for side rails in the sample of 19 and six residents (R33-R38) in the supplemental sample. This failure has the potential to put residents at risk for entrapment, strangulation, or suffocation if residents become lodged within the rail</p> <p>Findings include:</p> <p>A. The facility's Abuse Prevention Program Policy (revised 10/14/2016) defines serious bodily injury as an injury "requiring medical intervention such as surgery, hospitalization..." and directs the Administrator or designee to investigate the incident resulting in the injury. The Abuse Policy documents "Within five working days after the report of the occurrence a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the Department of Public Health."</p> <p>The facility's undated Transfer Belts/Gait Belt Policy documents the gait belt is to be "placed around the resident's waist or applied around the upper chest just below the axilla (armpit) area," and "Grasp the secured gait belt to provide security and balance during the transfer."</p> <p>R8's Physician Order Sheet (POS) dated 11/2016 documents diagnoses of History of Falls, Cerebral Vascular Accident, and Hemiplegia. R8's Minimum Data Set dated 7/27/16 and 10/27/16</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>documents R8 is cognitively intact and requires extensive assistance with bed mobility, transfers, and dressing. R8's Fall Risk Assessment dated 8/2/16 and 9/22/16 document R8 is at high risk for falls. R8's Care Plan dated 7/27/16 (prior to R8's fall) documents "Use 1 (one) assist and gait belt for all transfers. Use additional assist as needed when Resident is not feeling well, feeling weak or dizzy."</p> <p>R8's Nurse's Notes dated 9/22/16 at 6:15am written by E17, Licensed Practical Nurse (LPN), documents "Res (resident) was being transferred to (geriatric) chair by CNA (Certified Nursing Assistant) when E16 (CNA) lost grip of res and (R8) fell to floor on L (left) side of body to bedroom floor resulting in S/T (skin tear) on L (left) hand and bruising. Res sent to (hospital) ER (Emergency Room) for further evaluation."</p> <p>R8's Hospital Radiology Report dated 9/22/16 documents "Acute mildly displaced fractures of the second and third distal phalanges and acute nondisplaced fracture of the fourth distal phalanx."</p> <p>R8's Hospital Records document R8 was admitted to the hospital on 9/22/16 for "Irrigation and debridement with open reduction and pin fixation left long finger open distal phalanx fracture."</p> <p>On 11/30/16 at 2:30pm, E17, LPN, stated (E17) did not witness R8's fall. E17 stated E16, CNA, was alone in the room with R8. E17 stated R8 told E17 that E16 "did not use the gait belt properly, it (gait belt) did not feel right when on, and felt like (R8) was going to fall."</p> <p>On 11/30/16 at 2:00pm, R8 stated a new CNA</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>(E16) dropped (R8) when transferring (R8) from the bed to the (geriatric) chair. R8 stated the gait belt was not secured correctly and (E16) "had it (gait belt) around (R8's) arm." R8 stated (R8) fell on (R8's) hand and had "a compound fracture of (R8's) finger and had to have a pin put in it."</p> <p>On 11/30/16 at 3:20pm, E16, CNA, stated on 9/22/16 (E16) was transferring (R8) from the bed to the wheelchair and "the gait belt slipped out of (E16's) fingers, the wheelchair moved, and (R8) fell to the floor." E16 stated the wheelchair was "not locked all the way," and that (R8) was very shaky that morning prior to the fall.</p> <p>On 11/30/16, E18, Corporate Administrator, provided the Final Investigation of R8's fall dated 9/29/16, written by E1, Administrator, and submitted to the State Agency on 9/29/16. The Final Investigation documents "The CNA transferring (R8) was correctly transferring (R8) at the time of occurrence."</p> <p>On 11/30/16, E19, Traveling Administrator, provided an outline of the investigation of R8's fall which documents "Root Cause (of the fall): "resident weakness to the leg."</p> <p>E16's "Job in Jeopardy" (disciplinary action) dated 9/22/16 and signed by E1, Administrator, on 9/26/16 documents "Your conduct has placed your job in jeopardy," "Fail(ed) to correctly transfer residents per policy." E16's "Job in Jeopardy" disciplinary action documents "Following suspension, (E16) was found at fault and terminated."</p> <p>E16's Employee Data Sheet provided by E18 on 11/30/16 documents E16's termination date as 9/24/16.</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>B. The Summary of FDA (Federal Drug Administration) Hospital Bed Dimensional Limit Recommendations dated 3/10/2006 retrieved from http://www.fda.gov/cdrh/beds/guidance/1537.html documents the dimensional limit (space) within the (bed) rail (identified as Zone 1) must be less than four and three quarters inches to prevent the risk of entrapment of resident's head or limbs.</p> <p>1. R8's Physician Order Sheet dated 11/2016 documents diagnoses of History of Falls, Cerebral Vascular Accident, and Hemiplegia. R8's Minimum Data Set (MDS) dated 10/27/16 and current Care Plan document R8 is cognitively intact, has limited use of all extremities, and requires extensive assistance with bed mobility. R8's Fall Risk Assessments dated 9/22/16 and 10/28/16 document R8 is assessed as high risk for falls. R8's Side Rail Assessment dated 10/28/16 documents R8 has poor bed mobility and difficulty with balance/poor trunk control.</p> <p>On 11/29/16 at 10:00am and 2:00pm and 11/30/16 at 9:45am and 2:00pm, R8 laid in the bed with bilateral half (top) side rails raised. R8's side rails contained no padding to prevent entrapment. On 11/30/16 at 9:45am, R8 used (R8's) right hand to attempt to turn self, and moved (R8's) legs. R8 stated (R8) uses the side rail to help move self in bed. On 11/30/16 at 10:30am, R8 transferred from wheelchair to bed with extensive assistance from E3 and E12, Certified Nursing Assistants (CNA), using a stand and pivot transfer. R8 was unable to use (R8's) left hand/arm and held the left hand with the right hand.</p> <p>On 12/1/16 at 9:15am, E11, Certified Nursing</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>Assistant (CNA), confirmed the following bilateral side rail measurements: width of the side rail 34 inches and height 19 inches. The side rail is divided into six sections (Zone 1), by three-quarter inch bars, resulting in five separate spaces measuring widths of 5.5 (five and one-half) inches, 5.5 inches, 7.5 (seven and one-half) inches, 5.5 inches, and 5.5 inches, and heights of 8 (eight) inches, 17.5 inches, 17.5 inches, 17.5 inches, and 8 inches. The height of the side rail extending above the mattress is as follows: 5 (five) inches, 7 (seven) inches, 9 (nine) inches, 7 inches, 5 inches. These spaces have the potential to cause entrapment or wedging of R8's head, neck, or limbs and cause serious injury or death.</p> <p>On 12/1/16 at 9:30am, E2, Director of Nursing (DON), walked to the doorway of R8's resident room, refused to enter the room to confirm the measurements of the siderails, and stated, "I believe you - I don't have to verify the measurements."</p> <p>2. R6's Physician's Order Sheet dated 11/29/16 documents a diagnosis of Cerebral Vascular Accident (CVA). R6's Minimum Data Sheet (MDS) dated 8/26/16 documents that R6 has impairments on both sides of lower extremities and requires limited assistance with bed mobility. R6's Care Plan dated 2/9/16 documents: "Restorative Nursing Program-Bed Mobility. Program/Need weakness, CVA (Cerebral Vascular Accident). Strengths/Preferences Resident able to grab hold of side rail and pull self over in bed." R6's Side Rail Consent dated 5/4/16 documents "Types of Side rail: Bilateral 1/2 side rails to be used at all times when resident is in bed. The intent of the side rail is to enable the resident to increase independence and</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>participation in bed mobility and/or transfer. Related physical condition weakness, CVA (Cerebral Vascular Accident)."</p> <p>On 11/29/16 at 11:00-11:05 a.m., R6 laid in bed with 1/2 side rails raised. Side rails contained no padding to prevent entrapment. On 12/1/16 at 8:15-8:25 a.m., R6 independently transferred self from wheelchair to bed grasping side rail with right hand during the transfer.</p> <p>The side rail is divided into five sections, by three-quarter inch bars, resulting in five separate spaces measuring widths of 6 (six) inches, 6 inches, 7.5 (seven and one-half) inches, 6 inches, and 6 inches, and heights of 8.5 (eight and one-half) inches, 16 (sixteen) inches, 18 (eighteen) inches, 16 inches, and 8.5 inches. The height of the side rail extending above the mattress is as follows: 7 (seven) inches, 8.5 inches, 9.5 (nine and one-half) inches, 8.5 inches, 7 inches. These spaces have the potential to cause entrapment or wedging of R6's head, neck, or limbs and cause serious injury or death.</p> <p>On 12/1/16 at 1:25 p.m., E9, Licensed Practical Nurse (LPN) stated "Everyone can pretty much fit their head through the side rails if they wanted to."</p> <p>3. On 12/1/2016 at 10:00AM, R33 was observed lying in bed with one half side rail up on the bed. R33 did not respond when asked why the rail was on the bed. Zone One (within the rails) measures: 5.5in. (inches) x10.0in., 5.5 x 17.0 in. and 7.5 x 17.5 in. R33 Minimum Data Set (MDS) dated 8/10/16 documents R33 is severely cognitively impaired and requiring supervision of one with bed mobility, and extensive assist of one with transfer.</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>4. On 12/1/2016 at 10:05AM, R34 was observed lying in bed with one half side rail up on the bed. R34 stated, "I use the rail to move and prop myself up when I'm eating." Zone One (within the rails) measures: 5.5in. x10.0in., 5.5 x 17.0 in. and 7.5 x 17.5 in. R34 Minimum Data Set (MDS) dated 9/03/16 documents R34 is moderately cognitively impaired and requiring limited assist if one with bed mobility, transfer and ambulation.</p> <p>5. On 12/1/2016 at 10:10AM, R35 was observed lying in bed with both half side rails up on the bed. R35 stated, "I use my rails to pull myself around in bed. I'm an amputee." Zone One (within the rails) measures: 5.5in. x10.0in., 5.5 x 17.0 in. and 7.5 x 17.5 in. R35 Minimum Data Set (MDS) dated 8/21/16 documents R35 is severely cognitively impaired and requiring extensive assist if two with bed mobility, totally dependant with two assist for transfer and unable to ambulate. R35 was lying on a low air loss mattress.</p> <p>6. On 12/1/16 at 10:12AM, R36 was sitting up in the wheelchair. The siderails in Zone One on R36's bed measure: 5.5in. x10.0in., 5.5 x 17.0 in. and 7.5 x 17.5 in. R36 stated, When I get in bed, I use the (bed) rails to move in bed. I use the urinal which they sit on the bedside table. I have to struggle to reach it when I'm in bed. They tell me I have to use the rails but they are difficult. The 10/10/16 MDS documents R36 as cognitively intact and requiring extensive assist of two with bed and transfer mobility.</p> <p>7. On 12/1/16 at 10:15AM, R37 was sitting up beside the bed. Zone One side rail up on the side of his bed measures: 8.5in.x 8.5in, 4.0in x 17.0in., 7.5in. x 17.0in. R37's 9/7/16 MDS</p>	S9999		
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S9999	<p>Continued From page 9</p> <p>documents him as severely cognitively impaired and as requiring extensive assist of two with bed mobility and as dependant on two assist for transfers.</p> <p>8. On 12/1/16 at 10:18AM, R38 was lying in bed. Zone One side rails up on both sides of the bed measures: 8.5in.x 8.5in, 4.0in x 17.0in., 7.5in. x 17.0in. R38's 9/7/16 MDS documents her as severely cognitively impaired and as requiring extensive assist of two with bed mobility and as dependant on two assist for transfers.</p> <p>On 12/2/16 at 9:08am, E19, Traveling Administrator, stated E21, Maintenance Director, is responsible for completing the undated "Siderail Zone Assessment Yearly" document for residents using siderails. E19 was unable to provide any resident siderail zone assessments.</p> <p>On 12/2/16 at 9:36am, E21, Maintenance Director, stated (E21) has not assessed any residents' siderails for the past two years that (E21) has been employed by the facility.</p> <p>(A)</p>	S9999		
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IMPOSED PLAN OF CORRECTION

Timbercreek Rehab and Health Care, Pekin
Recertification Survey, exit date 12-2-2016

300.610a)
300.1210b)
300.1210c)
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 shall include, at a minimum, the following procedures:

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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)

This will be accomplished by:

Attachment B
Imposed Plan of Correction

- I. The facility will conduct an investigation of the incident and take appropriate actions to prevent reoccurrence. Policies and Procedures for Resident Supervision, Resident Falls and Reporting to the State Agency will be reviewed and revised as necessary.
- II. 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. 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.
- III. All nursing and direct care staff will be in-serviced on patient transfer status and transfer belt/gait belt policy. Each employee whose duties might include transfer of residents using a transfer belt/gait belt shall provide a return demonstration of the skills covered in the above in-services not more than ten days after the in-service. These demonstrations shall be monitored by the facility's Director of Nursing Services who shall maintain documentation of staff performance.
- IV. All maintenance personnel will be in-serviced on the facility's policy for Side Rail Zone Assessment. Side rails must be replaced or modified as per the Summary of FDA (Federal Drug Administration) Hospital Bed Dimensional Limit Recommendations dated 3/10/2006 (retrieved from <http://www.fda.gov/cdrh/beds/guidance/1537.html>) for those residents requiring the use of side rails.
- V. The Director of Nursing (DON) and/or Clinical Nurse Leaders, will audit documentation in the medical record 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.
- VI. Documentation of in-service training will be maintained by the facility.
- VII. The Administrator, Director of Nurses, and Quality Assurance Committee will monitor Items I through V to ensure compliance with this Imposed Plan of Correction.

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