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
	IL6008015	A. BUILDING: ______ B. WING ______	C 12/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSHORES HLTH & REHAB CTR	578 WEST COMMERCIAL STREET MARSEILLES, IL 61341

(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	Final Observations	S9999		

STATEMENT OF LICENSURE VIOLATIONS

300.1210b)
300.1210c)
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.

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

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 REGULATIONS WERE NOT MET AS EVIDENCED BY:

Based on interview and record review, the facility failed to provide supervision and identified interventions to prevent a fall for one of three residents (R1) reviewed for falls in a sample of three. This failure resulted in R1 sustaining a laceration to head obtaining two staples at local

Attachment A
Statement of Licensure Violations

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S9999	Continued From page 1	S9999		

hospital.

Findings include:

A facility Incident Report dated 11/27/16 by E4, Registered Nurse (RN), documents that on 11/27/16 at 5:15p.m., E3, Certified Nursing Assistant (CNA), found R1 on the floor in R1's bathroom, sustained a laceration to her head and was sent by ambulance to the local hospital Emergency Room for treatment and two staples to close the laceration.

The facility's Incident Investigation Worksheet, dated 11/27/16 by E4, RN at 5:30p.m., identifies R1's 11/27/16 incident as "Unwitnessed" and documents that R1 is cognitively impaired.

The facility's "State Report" dated 12/02/16 by E1, Administrator, addresses R1's fall incident of 11/27/16 and includes the following documentation:
" On 11/27/16, (R1) was observed on the bathroom floor with an open contusion to the head. Incident was unwitnessed."
"(R1) was transported to (local hospital Emergency Room) where she received two staples to the occipital area of the head."
"(R1) is an (elderly) "resident with a history of CVA (Cerebral Vascular Accident, anemia and hemiplegia..."
"Upon investigation, (R1) was discovered taking herself to the bathroom. (E3) CNA assisted her immediately and resident was safely assisted to toilet. (E3) left resident for a few minutes...and resident had again tried to transfer herself independently."
"According to care plan intervention, resident was not to be left alone in bathroom due to poor memory, confusion and impulsive, unsafe

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S9999	Continued From page 2 transfers." R1's Fall Risk Evaluations, dated 11/11/16 and 11/27/16, state R1's Risk Scores of 50 and 48, respectively, indicate R1 is at "High risk for falls." R1's current care plan addressing falls states "(R1) is at risk for falls due to generalized weakness secondary to CVA and confusion related to dementia" and the following fall intervention, dated 11/18/16 : "Do not leave resident alone in bathroom". R1's "Resident Status Sheet", kept on the inside of R1's closet, includes the following highlighted, hand-written statement in the "Bladder" portion of the care card: "Do not leave resident alone in restroom." R1's Resident Status Sheets also identifies R1 as a "High Fall Risk" under "Special Care Needs/Requests". On 12/13/16 at 12:10p.m., E2, Director of Nursing (DON) stated that R1 is confused and R1's fall care plan includes "numerous interventions in place" for prevention of falls. E2 also verified R1 had fallen in the bathroom on the evening of 11/27/16 and has had a history of falls in the facility. E2 stated the majority of R1's past falls occurred due to R1's self-transferring herself. E2 also stated that Resident Status Sheets or "cue cards" are found on the inside of each residents closet and are used as references for staff members in order to identify each resident's specific needs, i.e., manner of transferring, incontinence needs, cognitive status, safety issues, fall risks and other risk factors and interventions for CNA's and Nursing staff. E2 verified that E3, CNA did not follow R1's care plan interventions and should not have left R1 unattended in the resident's bathroom.	S9999		

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S9999	Continued From page 3 On 12/13/16 at 2:50p.m., E3, CNA verified that E3 left R1 unattended on the toilet in the bathroom while she went to the room door "to find help" in transferring R1 back to her wheelchair. E3 stated she heard R1 fall and found R1 on the floor in the bathroom with blood on her head and on the floor. E3 stated that, at the time of R1's fall on 11/27/16, E3 was unaware that R1 could not be left alone in the bathroom. E3 verified she was aware that Resident Status Sheets are posted on the inside of each resident's closet for reference regarding the residents needs and cares. (B)	S9999		