

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014674	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/24/2017
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NAME OF PROVIDER OR SUPPLIER CALHOUN NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE #1 MYRTLE LANE HARDIN, IL 62047
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S 000	Initial Comments	S 000		
S9999	<p>Complaint #1741014/IL91909</p> <p>Final Observations</p> <p>Statement of Licensure Violations:</p> <p>300.610) 300.1210b) 300.1210d)6) 300.3240a)</p> <p>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.</p> <p>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.</p>	S9999	<p>Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X8) DATE 03/13/17
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S9999	<p>Continued From page 1</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>Based on observation, interview, and record review the facility failed to provide adequate supervision during toileting to prevent falls for 1 of 3 residents (R1) reviewed for falls in the sample of 3. This failure resulted in R1 falling and sustaining a head injury requiring sutures.</p> <p>Finding includes:</p> <p>R1's February 2017 Physician Order Sheet (POS), documents in part diagnoses of Unspecified Dementia without behavioral disturbance and seizure disorder.</p> <p>R1's History and Physical, dated 11/23/16, documents in part diagnoses of Psychosis, Anxiety disorder, Seizure disorder, blindness, and chronic pain.</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>R1's Minimum Data Set (MDS), dated 12/12/16, documents a Brief Interview of Mental Status (BIMS) of 13, indicating cognition intact. R1's MDS dated 9/19/16 and 12/12/16 documents R1 requires extensive assistance of 2 persons for toileting and "Section G, Functional Status. Coding: 2. Not steady, only able to stabilize with staff assistance," with regard to R1 moving on and off toilet.</p> <p>R1's Care Plan, dated 9/23/2016, documents R1 is a fall risk, has a history of multiples falls prior to admissions, poor safety awareness and visually impaired. The Care Plan documents on 10/5/16, R1 rolled off bed and interventions included a low bed, concave mattress, and anti-skid strips beside R1's bed. The Care Plan documents on 10/14/16, R1 fell attempting to get up independently, and 10/25/16 R1 was found beside the bed on the floor, and alarm was not sounding.</p> <p>The facility's Morse Fall Scale dated 11/15/16 documents R1 having a score of 105 (score of 46 or more indicating high risk for falls). R1's Morse Fall Scale dated 12/8/16 documents R1 having a score of 75.</p> <p>On 2/23/17, R1 had a yellow discoloration to the outer orbital of her right eye. An indentation on R1's mid forehead was visible and R1 stated that was where the sutures were recently removed.</p> <p>Facility Incident Report Form, dated 2/4/17 documents in part, R1 sustained a fall with a laceration, was sent to the ER (Emergency Room), where R1 received 7 sutures to R1's right mid forehead laceration. The Incident Report Form further documents "CNA (Certified Nursing Assistant) overhead a noise coming from resident</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>(R1) restroom upon entering (R1) on the floor lying on (R1's) Lt (left) side in front of the toilet facing the door."</p> <p>R1's Discharge instructions from ER, dated 2/4/17, documents R1 received sutures to the forehead, findings negative for fracture, was prescribed antibiotic medication, and instructed to follow up with R1's primary care physician.</p> <p>On 2/22/17 at 11:01 AM, E3, Assistant Director of Nursing, stated R1 was in the bathroom on 2/4/17 asking for privacy from E5, CNA. R1 called for CNA after losing balance while trying to pull up R1's pants and R1 should not have been left alone. E3 stated R1 continues to need assistance as R1 is legally blind and dependent on staff.</p> <p>On 2/22/17 at 1:00 PM, E5 stated that on 2/4/17 R1 asked for privacy in the bathroom. E5 stated she stepped outside of visual sight of R1, heard R1 yell out, and upon entering the bathroom, found R1 on the floor. E5 further stated, "If a cognitive resident doesn't want staff in the bathroom, a staff member can step out of the bathroom, but have to have visual sight on resident all the time."</p> <p>On 2/23/17 at 10:40 AM, E9, CNA, stated E9 works consistently down the hall in which R1 resides. E9 further stated R1 will stand up even when E9 has been in the bathroom with R1 during care, and "(R1) needs to have someone there even before the falls. While in the bathroom, have to ask (R1)" to grab the bar in the bathroom, even as you're cueing (R1) and you're waiting for (R1) to go to the bathroom, (R1) won't wait, (R1) just stands up."</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>On 2/23/17 at 10:55AM, E10, CNA stated E10 works consistently with R1 and knows R1 is impulsive, and "On a good day (R1) will stand up, grab the bar, even with me in there and tell (R1) to hold on, and (R1) automatically just stands up." E10 further stated, R1 is blind, and should not be left on the toilet alone.</p> <p>On 2/23/17 at 11:30AM, E11, Registered Nurse (RN), stated during the incident involving R1 on 2/4/17, R1 was trying to stand up unassisted after toileting, has a pad alarm on R1's wheelchair, is legally blind, and R1's condition may vary. E11 further stated because R1's pad alarm is not used on the toilet, R1 should not be left on the toilet alone and should be in visual sight during toileting.</p> <p>On 2/23/17 at 11:55 AM, E13, Director of Rehabilitation, stated R1 was screened on 2/6/17, which is what is done for all residents in the event of a fall, and R1 requires assistance of 1 with a gait belt with transfers off of the toilet.</p> <p>On 2/22/17 at 10:00AM, R1 stated R1 got up from the toilet, pulled pants down and put R1's left hand on the bar. R1 stated her pants to be around R1's ankle, and "so I let loose and I fell." R1 stated, "Said she'll (E5) be right back, I was already on the floor when (E5) came back." R1 further stated R1 was bleeding from the forehead. R1 said she has pain for a few days after the fall, and takes medication on a routine basis for pain.</p> <p>On 2/23/17 at 2:20PM, Z1, Physician, stated given R1's current situation and being legally blind, it's a safety risk, and that R1 should be visually checked on.</p> <p>The Facility's In-service, dated 2/15/17,</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>documents in part, "If a resident is not independent with transfers on PCG (Patient Care Guide), cannot be left alone on the toilet."</p> <p>R1's Patient Care Guide with a printed date of 2/22/17, documents in part, "Toilet 2. Assistance: 2=One Person Physical Assistance."</p> <p>Facility's undated policy documents "Accidents and Incidents will be analyzed for trends or patterns to enable the facility to enhance preventive measures to reduce the occurrence of incidents."</p> <p>(B)</p>	S9999		
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