

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002208	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/11/2017
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NAME OF PROVIDER OR SUPPLIER COVENANT HLTH CR CTR-BATAVIA	STREET ADDRESS, CITY, STATE, ZIP CODE 831 NORTH BATAVIA AVENUE BATAVIA, IL 60510
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S 000	Initial Comments Complaint Investigation #1772837/IL93955 - F323 #1772825/IL93946 - F323	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 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	S9999	<p>Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE 05/25/17
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S9999	<p>Continued From page 1</p> <p>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>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>Theser requirements were not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to insure a resident was safely transferred by staff in accordance with facility policy. The facility also failed to ensure residents were monitored during toileting and failed to implement safety precautions documented in the resident record to prevent falls.</p> <p>This failure resulted in R1 sustaining bilateral femur fractures, being admitted to hospice and</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>expiring on May 11, 2017.</p> <p>This applies to 3 of 3 residents (R1, R2, R3) reviewed for falls.</p> <p>The findings include:</p> <p>1. The facility's Occurrence Report for R1's fall dated May 7, 2017 shows: "At 0500 (5:00 AM) staff RN called the supervisor to report that resident sustained a fall. Resident was laying on her back on the floor with the sling under her. At 0400 (4:00 AM) resident was agitated and restless. CNA was getting up resident with the [mechanical lift], the resident was fighting with the CNA, she was combative. When she got in the wheelchair, she slid off and fell on the floor on her back. [Z2] stated that he was transferring resident, resident was agitated and struggling for balance. When she got in the wheelchair she slid off the wheelchair and fell on her back."</p> <p>On May 9, 2017 at 11:20 AM, during initial tour of the facility, R1 was not in her room. E3 (CNA-Certified Nursing Assistant) said R1 was in the hospital. On May 10, 2017 at 1:58 PM, R1 was laying in bed. R1 was sleeping but arousable by staff. R1 was not interviewable due to confusion. E10 (RN-Registered Nurse) said R1 had been in the hospital since May 8, 2017 and returned to the facility several minutes earlier under the care of hospice due to injuries sustained during a fall several days earlier.</p> <p>R1' face sheet dated May 9, 2017 shows R1 was admitted to the facility in August 2011 with multiple diagnoses including muscle weakness, age-related osteoporosis without current pathological fracture, anxiety, depressive disorder, and spinal stenosis. R1's MDS</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>(Minimum Date Set) dated March 9, 2017 shows R1 has severe cognitive impairment, requires extensive assistance by two people for transfers and toileting, and is always incontinent of urine and frequently incontinent of bowel. The MDS shows R1 has functional range of motion impairment on both lower extremities, uses a wheelchair for mobility, and is unable to stabilize herself during surface-to-surface transfers (transfer between bed and chair or wheelchair) unless she has the assistance of facility staff. The MDS also showed R1 has a history of falls.</p> <p>On May 9, 2017 at 1:30 PM, E5 (RN-Night Supervisor) said, "I was called to [R1's] room by E11 (RN) around 5:00 AM on May 7, 2017. E11 told me [R1] had fallen. When I arrived in the room, [R1] was sitting in the wheelchair. She had fallen and hit her head. I immediately did a neurological assessment of [R1]. I was told Z2 (CNA) transferred [R1] using a mechanical lift but did not have a second person with him for the transfer. E11 said she had helped Z2 multiple times during the night but the one time Z2 did it alone [R1] fell. [R1's] injury could have been avoided, I don't know why Z2 transferred her by himself."</p> <p>On May 9, 2017 at 4:10 PM, Z2 (CNA) said, "I was taking care of [R1] on May 7, 2017 around 4:00 AM when she fell. She was agitated since about midnight, hitting the wall multiple times with her call light and fist, and crying out. I wanted to make her comfortable and I thought if I got her up in the chair, maybe she would be happier. The only mistake I made was transferring her by myself. I used the mechanical lift, and as soon as I put her in the chair, I moved the mechanical lift and she slid out of the chair. Her legs were out in front of her, her back was on the floor, and</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>the sling from the mechanical lift was under her. I know she is a two-person assist, that was my biggest mistake. I think they want us to have two people during transfers with the mechanical lift for safety and security purposes. I think I need two people so the person doesn't get hurt. If two people would have been there, one person could caught her or held her while I moved the mechanical lift."</p> <p>On May 9, 2017 at 1:50 PM, E2 (DON-Director of Nursing) said, "The facility's policy is that all mechanical lift transfers should be done with two staff members present."</p> <p>On May 9, 2017 at 3:40 PM, E8 (CNA) said, "On May 7, 2017 around 4:00 AM or 5:00 AM, I was across the hall from [R1's] room, helping another resident. I was not in the room when [R1] fell. E11 asked me to come help. [R1] was laying on the floor. The sling from the mechanical lift was under her. We raised her up and put her in the wheelchair. Z2 did not ask me to help him with any residents that evening. I asked Z2 if he knew he shouldn't use the mechanical lift by himself."</p> <p>On May 10, 2017 at 3:30 PM, E9 (CNA) said, "[R1] just got back to the facility. She is bedridden now. All we are supposed to do is turn her every two hours and let the nurse know if she is in pain. She was not bedridden before she fell. She could sit in her wheelchair and wheel around by herself. She would come out of her room to eat meals."</p> <p>On May 9, 2017 at 2:53 PM, Z1 (Physician) said, "The facility called me on May 7, 2017 and told me [R1] had fallen. I would expect the staff would follow the facility's policy for transfers. I was notified of [R1's] fractures the following day and we sent her to the hospital. Her fractures were</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>caused by the fall. Because of her prior weakness, it will be very hard for her to recover from this."</p> <p>Z4's (NP-Nurse Practitioner) documentation for R1 dated May 8, 2017 shows: "This is a 90 year old patient seen today for right knee swelling and BLE (bilateral lower extremity) pain. Patient slid off and fell on the floor on her back on 5/7/17. Upon exam, pt is alert and has a lot of pain on her lower extremities. Her right knee is swollen, no skin breakdown. Pt is in significant amount of pain even with slight touch or repositioning. Both lower legs with chronic swelling.Assessment/Plan: BLE pain, right knee swelling. Will do X-ray of both knees and legs today..."</p> <p>R1's X-ray results dated May 8, 2017 showed: "Left: subacute or acute fracture which is nondisplaced involving the distal femur. Right: There is a displaced fracture deformity involving the distal femur with angulation at the fracture site."</p> <p>Z6's (physician) documentation for R1 dated May 9, 2017 showed: "Bilateral distal femur fracture with history of fall. ...No surgical intervention as will not change her quality of life. She has been w/c (wheelchair) bound, needing [mechanical lift] for transfers.Addendum - d/w (discussed with) [Z7] (family member) and [Z8] (family member) this afternoon regarding hospice. Wanting to go ahead with same. Possibly return to [facility] tomorrow and start [hospice] care there."</p> <p>On May 11, 2017 at 2:56 PM, E6 (RN) said R1 expired on May 11, 2017 at around 10:45 AM.</p> <p>The facility's policy for full-body mechanical lifts,</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>revised November 2013 shows: "Policy: to enable two people to transfer a non-weight bearing resident safely. This device is used to aide in transfer, toileting, brief changes. [Full-body mechanical lift] transfers are always performed with two people assisting. Procedure: 1. Assemble equipment: evaluate that all equipment is in working order and battery is charged. Two staff members are required for use with transfer via [full-body mechanical lift]. ...16. Two staff members for lift with one standing next to resident during lift and through entire transfer. ...20. To lower resident, stand next to resident and push the down button on the device until resident is fully lowered. Ensure resident is safely positioned."</p> <p>2. The facility's occurrence report for R2, dated April 30, 2017 at 6:00 PM showed: "CNA called this nurse to [R2's] bathroom. Resident was lying on left side on floor. Did hit head per resident. Alert. Neuro checks wnl (within normal limits). ROM (range of motion) wnl. 1 cm. (centimeter) skin tear to right posterior elbow. Observed egg size bump on back of head in center. C/O (complained of) some nausea and slight headache. CNA was in bathroom with resident toileting. When resident finished toileting, resident stood holding onto bars around the toilet. When CNA turned to get wipe for cleaning resident, CNA observed resident on the floor lying on left side. CNA called for help STAT." On May 10, 2017 at 1:57 PM, R2 was sitting in her room. A wound was observed on her right elbow. The wound was open to air, and two sutures were present. R2's face sheet dated May 9, 2017 shows R2 was admitted to the facility on September 25 2016 with multiple diagnoses including unsteadiness on feet, muscle wasting and atrophy, cognitive communication deficit,</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>anxiety, dementia without behavioral disturbance, and difficulty walking.</p> <p>The May 2017 POS (physician order sheet) showed and order dated April 30, 2017, "Send to ER for eval and treat." R2 was sent to the local hospital and returned to the facility with sutures in her right elbow.</p> <p>On May 10, 2017 at 9:00 AM, E2 (DON) said, R2 fell on April 30, 2017 during toileting. "R2 was sitting on the toilet and the CNA turned away to retrieve wipes. R2 attempted to stand and fell. The CNA was inserviced on using a gait belt and having hygiene items close by."</p> <p>R2's MDS dated January 2, 2017 shows R2 has moderate cognitive impairment, requires extensive assistance with ADLs (activities of daily living), including toileting, and is frequently incontinent of bowel and bladder. The MDS shows R2 is only stabilize herself with staff assistance for moving from seated to standing position, moving on and off toilet and surface-to-surface transfers.</p> <p>R2's fall risk evaluation dated September 25, 2016 shows R2 is a fall risk, "Initiate fall prevention protocol for identified risk in any category. Initiate fall management Program. Fall Risk Care Plan." The fall risk assessment done on September 25, 2016 was the only fall risk completed by the facility to date. No quarterly fall risk assessments were documented, nor was a fall risk assessment done following her fall on April 30, 2017.</p> <p>R2's care plan dated September 30, 2016 showed: "[R2] is high fall risk and needs continuous monitoring during programs/activities</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>to help prevent future falls." R2's fall care plan did not show any interventions for the prevention of falls. R2's care plan had not been updated after her fall on April 30, 2017.</p> <p>On May 10, 2017 at 9:00 AM, E2 (DON) said fall risk assessments should be done for every resident on admission, quarterly, and after a fall. E2 said R2 was a high fall risk and her fall risk had not been reassessed since her admission in September 2016. At 12:00 PM the same day, E2 said R2's care plan should have been updated, as well as the touch screen used by the CNAs to determine transfer status and ADL care needs.</p> <p>3. The facility's Occurrence Report for R3, dated April 1, 2017 at 21:35 (9:35 PM) shows: "[R3] observed on the floor at approximately 21:35 laying on his right side with a laceration 4 cm. in length by 1 cm. width to the back of the head. Resident statement: I was returning from the bathroom and I don't know how it happened." The report shows R3 was sent to the local hospital for treatment. The report also shows no alarms were present at the time of the fall, and that the fall risk reassessment was completed and the plan of care for falls was completed following the fall.</p> <p>R3's face sheet dated May 9, 2017 shows R3 was admitted to the facility January 4, 2017 with multiple diagnoses including abdominal aortic aneurysm, history of falling, difficulty walking and dementia without behavioral disturbance. R3's MDS dated March 10, 2017 shows R3 has severe cognitive impairment, no behaviors of rejection of care, requires extensive assistance with ADLs and is frequently incontinent of bowel and bladder. The MDS also shows R3 is not steady during balance transitions and walking,</p>	S9999		
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S9999	<p>Continued From page 9</p> <p>and R3 is only able to stabilize himself with staff assistance.</p> <p>R3's fall risk assessment dated January 4, 2017 shows: "Score 12 - Initiate fall prevention protocol for identified risk in any category. Fall Management Program initiated. Fall Risk Care Plan - yes."</p> <p>On May 9, 2017 at 11:29 AM, R3 was sitting in his room in a recliner, sleeping. No chair alarm was present.</p> <p>On May 10, 2017 at 2:03 PM, R3 was sitting in his room in a recliner, sleeping. No chair alarm was present. R3's wheelchair was approximately 10 feet away from R3, and a chair alarm was visible on the seat of R3's wheelchair.</p> <p>R3 was briefly hospitalized in February 2017 and a fall risk assessment was completed but a score was never calculated to show R3's fall risk upon his readmission.</p> <p>The facility did not complete a fall risk reassessment following R3's fall on April 1, 2017.</p> <p>R3's Resident Summary Template dated May 9, 2017 showed: "Fall risk due to: unsteady, bed and w/c (wheelchair) alarm." The Resident Summary Template is the template visualized by the CNAs on the computer to confirm resident needs. E3 (CNA) demonstrated the use of the facility computer screen to visualize the resident's care needs, including transfer status and safety measures.</p> <p>R3 did not have a fall care plan in place at the time of his fall, nor was a care plan initiated following his fall on April 1, 2017.</p> <p>On May 10, 2017 at 12:00 PM, E2 said, "[R3's]</p>	S9999		

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S9999	<p>Continued From page 10</p> <p>fall risk was never calculated when he was readmitted to the facility in February, 2017. He had a care plan for falls prior to his hospitalization, however upon his return in February the care plan did not carry over to his active record." E7 (RN-Nurse Manager) was present during the interview and said, "We aren't using the alarms for [R3] because he always removes them and they aren't effective." E2 and E7 acknowledged the Resident Summary Template shows chair alarms and bed alarms should be in place for R3. E2 and E7 also acknowledged R3's medical record does not show documentation of R3's rejection of care regarding the use of alarms or alternative interventions to prevent falls.</p> <p>The facility's Fall Prevention Process Flow Chart dated September 10, 2010 shows: "Assessment of fall risk on admission.Ongoing assessment: Assess resident per facility protocol: changes in condition. Resident response to interventions. Communicate interventions to caregivers and family when any are removed, initiated. ...Ongoing care plan review and new interventions with any change of condition: Care plan developed or revised based on fall risk assessment and risk factors. If no changes in interventions, document reasons. Document revisions in chart and communicate to caregivers any changes."</p> <p>The facility's Post Fall Process Flow Chart dated September 2010 shows: "Assessment of fall risk on admission. ...Care Plan and Interventions: Immediate interventions. Care plan developed or revised based on cause/reason for fall as identified in post fall assessment, investigation and risk factors. If no change in interventions, document reasons. Document revisions in chart</p>	S9999		
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S9999	<p>Continued From page 11</p> <p>and communicate to caregivers."</p> <p>The facility's policy entitled "Falls and Fall Prevention in Skilled Nursing" dated February 17, 2017 shows: "Policy: It is the policy of the [facility] to enable all individuals the ability and right to achieve and maintain the highest level of function in the least restrictive environment. [Facility] is responsible for providing care in a manner promoting quality of life and safety. The resident environment will remain free from accident hazards as possible and each resident will receive adequate supervision and assistance devices to prevent accidents. Implementation and Guidelines: ...4. Comprehensive assessment of fall and fall risk potential. 5. Resident centered care plan with interventions to promote highest level of functioning in the least restrictive environment while maintaining safety. ...12. Post fall evaluation and assessment with updated care plan interventions. Thorough investigation of all falls with recommendations to prevent recurrence."</p> <p>(A)</p>	S9999		
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