

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6010342	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/03/2017
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NAME OF PROVIDER OR SUPPLIER DAYSTAR NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 CEDAR STREET CAIRO, IL 62914
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S9999	<p>Final Observations</p> <p>STATEMENT OF LICENSURE VIOLATIONS</p> <p>IRI of 2/17/2017/IL92078</p> <p>300.610a) 300.1210b) 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> <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</p>	S9999	<p style="text-align: center;">Attachment A Statement of Licensure Violations</p>	
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Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE 03/22/17
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S9999	<p>Continued From page 1</p> <p>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 300.3240 Abuse and Neglect</p> <p>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 REGULATIONS WERE NOT MET AS EVIDENCED BY:</p> <p>Based on interview and record review the facility failed to prevent abuse of unreasonable confinement and punishment with resulting mental anguish for one of 3 residents (R4) reviewed for abuse in a sample of 7. These failures resulted in psychosocial harm for R4, in that, a reasonable person would react to such physical restraint with such feelings as agitation, anxiety, frustration, fearfulness, humiliation and punishment.</p> <p>Findings include:</p> <p>Review of the initial report submitted to the State Agency (SA) from: E6, Director of Nursing (DON) dated February 17, 2017 at 10:47 indicates R4) was found on the morning of 2/17/2017 by the nurse on duty with her wrists entangled in her blanket. R4) was unable to untangle her arms</p>	S9999		
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DAYSTAR NURSING & REHAB CENTER 2001 CEDAR STREET
CAIRO, IL 62914

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S9999	<p>Continued From page 2</p> <p>due to her cognitive deficit. Upon encountering R4 the nurse on duty rectified the entanglement and noted discoloration to left forearm with redness to bilateral wrists. Immediate investigation initiated."</p> <p>During an interview with E1, Administrator on March 2, 2017 at 11:00 AM, E1 verified E16, Certified Nurse Aide (CNA) tied R4's hands together with bed linens to prevent R4 from clapping and disturbing others when E1 had talked with E16 about the incident. The administrator stated "I don't know what people are thinking when they do things like that."</p> <p>During an interview on February 28, 2017 at 4:10 pm with E15, Licensed Practical Nurse (LPN) the nurse that found R4's hands tied, E15 stated "The curtains were pulled beside R4's bed and I noticed R4's eyes were widened, bright, and she had a strange look on her face. Upon further observation I thought her arms were caught, then when I got closer to her I realized her hands were tied and the spread was in a knot. I went and got a witness (E18) then asked E16, CNA to step into the room and I asked him what he had done. R4's left wrist was swollen and had an imprint that appeared to be from the knot. E16 said he did not do anything wrong the resident was clapping he was just trying to keep her from waking up the other residents. R4 had tears in the corners of her eyes, her mouth was open, and she was working to get them (wrists) untied. There was discoloration, swelling on the inside of the wrist, and a thin strip raised under the left wrist. R4 did not complain of pain that morning."</p> <p>A review of E16's written statement dated 2/16/2017 indicates "At 4:15 AM R4 began to clap her hands very loud. To prevent her from</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>disturbing the facility I gently tied her hands in the blanket, not trapping her but preventing her from clapping. I was thinking this would be ok of the fact that it would prevent her from waking other residents."</p> <p>A review of E15's written statement says "On 2/17/17, I (E15) entered resident's (R4) room at 4:45 AM ... and observed Resident's (R4) wrists were tied together w/ (with) her bedspread. Resident (R4) was twisting her hands and wrists around in a attempt to free them. On exam redness darkening along left wrist, 5 centimeter (cm) wide wrapping around wrist 11 cm. Slightly raised along discolored area. No s/s (signs and symptoms) of pain w/ (with) palpation. After resident was stable writer report incident to E1. e of E1 spoke with E16 CNA and he was asked to leave the facility at that time."</p> <p>A review of E18's (CNA) written statement indicates "The nurse on duty called me into residents room (R4) to be a witness. Resident (R4) hands were tied together with a blanket that was on her bed. I witnessed the nurse question the Aid in question (E16) and he admitted he tied her hands up to keep her from clapping."</p> <p>A policy and procedure entitled "Prevention of Resident Abuse, Neglect, Mistreatment or Exploitation with an orginal date of 10/31/2016 states under Procedure Definitions: Each resident has the right to be free from abuse, corporal punishment and involuntary seclusion, and the facility's responsibilities to prevent no only abuse, but also those practices and omissions, neglect and misappropriation of property, that if left unchecked, lead to abuse... " and "Abuse" is defined as the willful infliction of injury, unreasonable confinement, intimidation, or</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>punishment with resulting physical harm or pain or mental anguish..."</p> <p>Review of R4's medical record reviewed 3/2/17, indicated that there was no assessment for the use of a physical restraint, no physician order for the use of a physical restraint, no verbal and/or written consent from the resident's legally responsible party for the use of a restraint as required per the facility's policy.</p> <p>Review of the Performance Correction Notice signed February 28, 2017 indicates E16 was suspended on 2/17/17 and terminated on 2/28/2017. Under Prior Notifications Final Written on date 2/28/2017 the following is written, "Termination of employment r/t (related to) abuse of a resident." Under Incident Description ad Supporting Details the following written on this same notice: 'Per E16) statement: 2/17/17 at round 4:15 AM., R4 began to clap her hands very loud. To prevent her from clapping her hands from disturbing the facility, "I gently tied her hands in the blanket, not trapping her, but preventing her from clapping. I was thinking this would prevent her from waking other residents. I now realize the severity of the situation..."</p> <p>Review of R4's most recent quarterly MDS (Minimum Data Sets) assessment dated 12/6/2016 reveals that R4 had a Brief Interview for Mental Status (BIMS) score of 99 which indicated R4 was unable to complete the interview and that same MDS scored C1000 (Cognitive Skills for Daily Decision Making) as a 3 which is defined as 'Severely impaired - never/rarely make decisions.' According to this same MDS R4 has a diagnosis of Obsessive/Compulsive disorder; Non-Alzheimer's Dementia; Manic Depression; and Dysphagia</p>	S9999		

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S9999	Continued From page 5 oropharyngeal phase. During an attempted interview with R4 on 2/24/2017 at 2:30 PM revealed due to R4's cognitive loss, R4 could not express how R4 felt about having her wrists tied together for approximately 30 minutes on 2/17/2017. (B)	S9999		
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