

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000814	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/29/2017
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NAME OF PROVIDER OR SUPPLIER HEDDINGTON OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 2223 WEST HEDDING AVENUE PEORIA, IL 61604
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S 000	Initial Comments Conditional Licensure Follow-Up to Survey 11/10/16, Complaint 1626385/ IL 89710. Statement of Licensure Violation:	S 000		
S9999	Final Observations 300.610 a) 300.1010 h) 300.1010 i) 300.1210 d)6) Section 300.610 Resident Care Policies a) 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 300.1010 Medical Care Polices h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan	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
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S9999	<p>Continued From page 1</p> <p>of care for the care or treatment of such accident, injury or change in condition at the time of notification. (B)</p> <p>i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid procedures. (B)</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care d) 6)</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>This requirement is not met as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to provide adequate supervision to two residents (R3, R4) at high risk for falls, and failed to follow a policy for properly securing residents into the facility van (R2), which affected three of three residents (R2, R3, R4) reviewed for falls in a sample of nine. These failures resulted in R3 falling while getting out of bed and sustaining an acute subdural hematoma to the right side of the brain and a subdural versus epidural hematoma on the left, plus an additional small left arachnoid hemorrhage. These failures also resulted in R4 falling from the</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>wheelchair and sustaining a comminuted displaced fracture involving the proximal left humerus (shoulder).</p> <p>Findings include:</p> <p>A Falls and Fall Risk, Managing policy dated 2/2017 states, "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. If falling recurs despite interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant."</p> <p>A Safety and Supervision of Residents policy dated 2/2017 states, "Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Monitoring the effectiveness of interventions shall include the following: evaluating the effectiveness of intervention; modifying or replacing interventions as needed. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment."</p> <p>1. R3's Physician's orders dated 3/2017 document R3 has diagnoses which include Unspecified Dementia with Behavioral Disturbances and Psychotic Symptoms, Cerebral Vascular Disease, Seizures, Dizziness.</p> <p>R3's Minimum Data Set (MDS) assessment dated 3/13/17 documents that R3 is severely</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>cognitively impaired, totally dependent on two people for transfers and toileting, does not ambulate, and has functional limitation in range of motion to the right and left lower extremities.</p> <p>R3's Fall Risk Assessment dated 2/23/17 documents R3 is disoriented or has intermittent confusion, has fallen three or more times in past three months, is chair bound at least 95% (percent) of the time, has balance problems with standing and walking, has decreased muscular coordination. The assessment also documents R3 is at high risk for falls.</p> <p>R3's care plan dated 12/28/16 documents, "Resident has impaired decision making related to diagnosis Dementia as evidenced by confusion and memory loss. Resident is at risk for falling related to use of psychotropic medication, history of falls, impulsivity, poor safety awareness related to Dementia. Resident is noncompliant with asking staff for assistance and frequently will attempt to transfer self independently." R3's care plan documents the following fall prevention measures, "10/21/16, 15 minute checks X 72 hours until further notice; 11/2/16, Will continue 15 minute checks indefinitely; 11/4/16, 15 minute checks indefinitely and low bed; 11/9/16, will continue with low bed and 15 minute checks, resident continues to place self on floor; 12/28/16 observe frequently.</p> <p>R3's initial fall investigation dated 3/10/17 documents that at 3:30p.m. on that date R3 sustained an unwitnessed fall with injury stating, "Conclusion: Resident continues to attempt self transfers. Attempted to transfer self from bed and found on floor sitting upright with legs outstretched in front of him. Stated he hit his head on floor, was attempting to get into drawer</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>in his room. Noted bruise three cm (centimeter) round to forehead."</p> <p>R3's nurses' notes dated 3/11/17 documents R3 was sent to the hospital for evaluation and treatment following R3's fall with head injury after R3 began having episodes of vomiting.</p> <p>R3's hospital progress notes and documentation of a Computed Tomography (CT) Scan report dated 3/11/17 document R3 sustained, "Acute bilateral extra-axial hematomas, mixed density subdural on the right, and subdural versus epidural on the left. Small acute left subarachnoid hemorrhage. Severe mass affect with brainstem deformation and 1.5cm subfalcine deviation."</p> <p>A fall log dated 12/15/16 to 3/27/17 documents that on 3/16/17 at 5:30a.m., "Resident found lying on floor mat bedside bed with legs wrapped in blankets still on bed and trunk lying on floor mat. Had complained of back pain and sent to ER (emergency room) for eval." The fall log also documents that later that day (3/16/17) at 8:40p.m. R3, "Crawled from bed onto floor mat. Behavior. Does frequently. No injuries noted. Will add to care plan that resident may crawl from bed as resident is not falling. Resident is intentionally crawling from bed, related to behaviors."</p> <p>On 3/27/17 at 12:15p.m. R3 was laying in bed facing to the right. R3's eyes were partially closed and R3 did not respond to verbal stimuli. R3's Power of Attorney (Z1) stated that R3 had rapidly declined approximately one week ago. Z1 stated that R3 had been his usual self then quickly declined to an almost unresponsive state. Z1 stated that previously R3 would very frequently</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>try to get out of bed. Z1 stated that R3 had fallen "so many" times. Z1 stated that R3 had hit his head when he fell on 3/10/17 and had a large bruise on his forehead caused from the fall.</p> <p>On 3/28/17 at 11:08a.m. E5 (Unit Coordinator) stated that R3 verified that R3 was unable to walk and has fallen many times. E5 also stated that R3 has the behavior of crawling from the bed. E5 stated that at the time of R3's fall on 3/10/17, R3 was alone in his room but that staff were checking on R3 every 15 minutes. E5 stated, "I had told staff to get him up and put him in the common area but that's not on the care plan. It's a chronic behavior (for R3) to get out of bed. R3's had multiple reminders not to get out of bed without help. He's been a challenge." E5 also stated, "It's unrealistic to check residents more than every 15 minutes with 40 residents on the unit."</p> <p>On 3/29/17 at 9:40a.m. Z2 (Nurse Practitioner) stated R3's "Acute bilateral extra-axial hematomas, mixed density subdural on the right, and subdural versus epidural on the left. Small acute left subarachnoid hemorrhage. Severe mass affect with brainstem deformation and 1.5cm subfalcine deviation," were the result of R3's fall on 3/10/17. Z2 stated, "R3, especially this last four months, has required more supervision to prevent falls." Z2 verified that R3 had taken an rapid decline in the past week following R3's fall with head injury on 3/10/17."</p> <p>2. R4's Physician's orders dated 3/2017 document R4 has diagnoses which include Cerebral Palsy, history of Falling, Conversion Disorder with Seizures or Convulsions.</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>R4's Minimum Data Set (MDS) assessment dated 2/20/17 documents R4 is severely cognitively impaired and is rarely/never understood, has disorganized thinking, and has behavioral symptoms not directed towards others. R4's MDS also documents R4 requires extensive assistance for transfers, toileting, does not walk, has a functional limitation in range of motion to the upper and lower extremities, and uses a wheelchair for mobility.</p> <p>R4's Fall Risk Assessment dated 2/23/17 documents R4 is disoriented or has intermittent confusion, has fallen three or more times in past three months, is chair bound at least 95% (percent) of the time, has balance problems with standing and walking, has decreased muscular coordination. The assessment also documents R4 is at high risk for falls.</p> <p>R4's care plan dated 11/2016 documents that R4 has, "Short attention span, Diagnosis Mental Retardation. Has periods of anxiety and agitation. Cognitive Loss/Communication. Resident has been noted as having increased negative behavior (i.e. (that is) throwing items or signs and symptoms agitation expressed by physical movements) when someone can not understand her and she wants her needs met now." R4's care plan also documents, "Observe for conditions/behaviors which place resident at increased risk for falls and modify as able for prevention. Staff to be mindful of resident when she is having increased behaviors and keep her under close supervision. Staff to monitor/observe more closely in dining room at meal times. Resident frequently places self on floor purposefully. Resident has had multiple falls, some of which were not true falls but resident wanting to crawl on the floor as evidenced by</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>purposeful movement and verbal confirmation of such."</p> <p>R4's Nurses' notes dated 3/11/17 at 9:50a.m., document , "Resident was observed crawling on hands and knees in common area between wheelchair and couch at 9:00a.m. by CNA (Certified Nurse Aide). Resident stated, 'I wanted to get on the couch! My shoulder hurts!' and then proceeded to flailing around on the floor. Resident placed back in wheelchair after assessment with assistance of four staff members." The Nurses' notes document that an order was received from R4's physician's office to obtain an Xray to R4's left shoulder. R4's nurses' notes at 10:00a.m. documents that the X-ray company was notified with orders for R4's X-ray. R4's Nurses' notes at 3:30p.m. document that R4's X-ray was not obtained until that time, five and one half hours after R4 fell and R4's Physician ordered the X-ray. The Nurse's notes do not document that R4's Physician was notified there was a delay in obtaining the X-ray. R4's Nurses' notes at 4:30p.m. document R4's X-ray results were obtained, called to R4's Physician (Z3) who ordered the facility to send R4 to the emergency room for treatment.</p> <p>R4's fall investigation Full Report dated 3/11/17 documents that R4 had an unwitnessed fall at 9:00a.m., on 3/11/17 and had last been seen by staff at 8:50am. The report states, "Resident has a history of falls, decreased mobility. Resident's care plan, 'Has history of falling out of wheelchair, throwing self out of wheelchair is a continuous behavior, exhibited behavior crawling out of bed,' etc (et cetera). The report lists the root cause of R4's fall as, "Due to resident action or internal risk factors."</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>On 3/28/17 at 1:40p.m. E9 (Certified Nurse Aide/ CNA) and E10 (CNA) were assisting R4 into the bathroom. R4 was crying out unintelligibly and flailing her arms. R4 required extensive assistance of two people to stand and transfer from the wheelchair to the toilet. E9 stated that R4, "Gets this way when she is agitated." E9 and E10 stated they had been working on 3/11/17 when R4 fell. E9 stated that R4 was wheeled into the common area after breakfast, then left there by herself while staff returned to the dining room to bring additional residents to the common room. E9 stated, "When we got back, she was on the floor and complained about her shoulder as soon as we got her up. She stayed in bed until X-ray came. She kept saying her shoulder hurt." At 2:02p.m. E10 stated, "R4 gets really anxious at times and R4 was anxious on the day she fell. It was a very busy time. She had gotten out of her wheelchair and tried to climb on the couch."</p> <p>R4's X-ray report dated 3/11/17 documents R4 sustained a comminuted displaced fracture involving the proximal left humerus with local soft tissue swelling.</p> <p>On 3/27/17 at 12:40p.m. E5 (Unit Coordinator) stated, "R4 has had many falls. R4 has Mental Retardation and frequently throws herself out of the wheelchair, it's a behavior." E5 stated that all residents are on frequent observation and that R4 did not have any additional supervisions such as every fifteen minute observations. E5 stated, "Normally there's staff supervising in the common area unless they are providing care in another resident's room, toileting, showering, or during meals. At 9:00a.m. (time of fall) that's after breakfast. That's a busy time. On 3/28/17 at 11:08a.m., E5 (Unit Coordinator) verified R4 fell from the wheelchair on 3/11/17 at 9:00a.m., while</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>seated in the common area. E5 stated that R4 fell while in the common area while no staff members were present because it was after breakfast and staff members were transporting residents from the dining room to the common area. E5 stated that R4, "has a history of throwing herself out of the wheelchair. A behavior when she's upset." E5 verified R4's X-ray was not obtained for five and one half hours after R4 fell. E5 also verified R4 sustained a fractured left shoulder during the fall. E5 also stated, "It's unrealistic to check residents more than every 15 minutes with 40 residents on the unit."</p> <p>On 3/29/17 at 09:40a.m. Z2 (Z3's Nurse Practitioner) stated that R4's left shoulder fracture was the result of R4's fall on 3/11/17. Z2 stated, "R4 has Cerebral Palsy, Mental Retardation, and Mental Illness. R4 gets her head and body moving and flings herself from the wheelchair. R4's fracture should have been obvious to the staff. I had no idea it took so long to R4's X-ray." Z2 stated the nurse should have called the X-ray company to check on when the X-ray would be taken, then notified the Z3 so R4's treatment would not have been delayed. Z2 stated that if she had known it was going to take five and one half hours, Z2 would have sent R4 to the hospital right away after the fall.</p> <p>3. R2's fall investigation dated 1/17/17 documents, "Resident was sitting on her electric wheelchair on the facility bus, and as the bus turned the corner her wheelchair tipped sideways and caused her to hit the left side of her head." The fall investigation documents as a recommendation, "Resident and staff encouraged to have resident ride in a manual wheelchair when needing to ride on the facility bus if resident would agree."</p>	S9999		
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S9999	<p>Continued From page 10</p> <p>On 3/28/17 at 2:55p.m., R2 was in the common area sitting on an electric scooter type wheelchair. R2 verified that R2 was sitting on her electric scooter in the facility's van on 1/17/17 when R2's scooter tipped to the side causing R2 to hit her head on the side panel of the van. R2 stated that the facility had wrapped straps around R2's scooter but that it was not tightly secured.</p> <p>A manufacturers Users Instructions dated 1/2012 for the facility's van documents that the vans' four point system to secure passengers in place, "Should only be used with forward facing wheelchairs."</p> <p>On 3/27/17 at 11:00a.m., E4 (Activities Director) stated that E4 is in charge of the facility's resident safety in the facility's van. E4 verified that R2's electric scooter tipped to the side while riding in the facility's van on 1/17/17, causing R2 to hit her head on the inside panel of the van. E4 stated that the van driver had used the four straps attached to the floor of the van to secure R2's scooter stating, "The van driver tried to secure the scooter by criss-crossing the four straps but the scooter still had too much movement. She didn't actually fall out of scooter. We still wrote up an incident report because it shouldn't have happened." E4 verified that the straps are designed to be used with manual wheelchairs and not three wheeled electric scooters. E4 stated that one of R2's wheels actually lifted off the floor during the incident.</p> <p>(A)</p>	S9999		