

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6010136	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/01/2017
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NAME OF PROVIDER OR SUPPLIER CROSSROADS CARE CTR WOODSTOCK	STREET ADDRESS, CITY, STATE, ZIP CODE 309 MCHENRY AVENUE WOODSTOCK, IL 60098
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S 000	Initial Comments Incident Report Investigation of 5/22/2017/IL94345 Statement of Licensure Violations	S 000		
S9999	Final Observations 300.610a) 300.1210a) 300.1210b)5) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
		06/23/17

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S9999	<p>Continued From page 1</p> <p>and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)</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 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>5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.</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. (A, B) (Section 2-107 of the Act)</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>These requirements were not met as evidenced by:</p> <p>Based on Observation, Interview and Record Review the facility failed to ensure safety was provided for residents during care and transfers. This failure resulted in R1 sustaining a left humerus fracture during care and transfer after a shower.</p> <p>This applies to 2 of 3 residents (R1 & R3) reviewed for safety in the sample of 3.</p> <p>The findings include:</p> <p>1. On May 31, 2017 at 9:15AM, R1 stated, "She put me in a shower chair and rolled me into the shower. She did the shower and rolled me out of the shower. There was a railing I was holding onto while I was standing so she could dry me off. My legs gave out and I don't know why and I went into this falling position. I was scared and kept holding on. She told me she had me and to let go. I felt a snap in my left arm and went to the ground. Six firemen had to pick me up. She didn't have a belt around me and I was scared of falling so I held on." R1 stated he is unable to walk in therapy and can only stand for 30 seconds. R1 states it takes 3-4 people to transfer him and one of the people is from therapy.</p> <p>On May 31, 2017 at 9:34AM, E4 (Certified Nursing Assistant - CNA) stated, "E5 (CNA) gave R1 a shower and I went in to help stand R1 and transfer him from the shower chair to the wheelchair. R1 was standing, facing the wall and holding onto the bar. E5 was on his left side and I was on his right side. There wasn't a gait belt. There was a shower chair behind him, he stood up and his legs gave out. R1 was leaning to</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>the left with all his weight to the left. The snap happened or sound happened in the midst of everything. R1 was already down and I had to tell him to let go. R1 is fairly new, I believe 2 people to transfer. All transfers when they are assists we are to use a gait belt."</p> <p>On May 31, 2017at 9:45AM, E5 stated, "I gave R1 a shower. I dried R1 off while he was standing in front of a grab bar. R1's legs buckled. I tried to push a chair up under him but he said his legs won't move. E4 and I had to guide R1 down. R1 was holding onto the grab bar. I told him to let go and he didn't. I heard a noise and told him to let go. We tried to get him to go back but he was sliding to the left. R1 didn't have anything on. I should have used a gait belt."</p> <p>On May 31, 2017 at 11:40AM, E2 (Director of Nursing - DON) stated, "I did an investigation and they did not use a gait belt. I told them they should use it and that it was policy."</p> <p>R1 was admitted to the facility on May 12, 2017 and the Nurses Notes for R1 showed, "May 21, 2017 - R1 was found on the floor next to the bed and stated he tried to get up from the wheelchair and lost his balance, no injuries noted. Mechanical lifted to the bed and body check done; May 22, 2017 - R1 was in the shower with staff and he tried to get up out of the shower chair and lost his balance. Staff grabbed him and lowered him to the floor due to the fact that he was very heavy. R1 complained of arm pain and his left arm made a snapping noise when he went down. R1 was assessed on the floor and was very anxious. 911 was called."</p> <p>The Care Plan dated May 22, 2017 for R1 showed, "R1 has an ADL (activities of daily living)</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>performance deficit related to activity intolerance and impaired balance; Resident requires extensive assistance of 1-2 staff to move between surfaces; The resident is at risk for falls related to deconditioning, gait/balance problems." The fall care plan does not show that R1 had a fall on May 21, 2017 and shows R1 had a fall on May 22, 2017 only. There was no evaluation of possible causes of the fall on May 21, 2017 or interventions for that fall on the care plan.</p> <p>The Kardex for R1 that showed an admission date of May 12, 2017 and a print date of May 31, 2017 showed a section for "accidents - fall risks" with nothing written inside the box to show he had a fall on May 21 and 22, 2017; the assistive devices to be used were not marked. The Kardex for R1 did show he is "Not steady during transitions/walking" when "moving from seated to standing; walking; moving on and off toilet; and surface to surface transfer."</p> <p>On May 31, 2017 at 10:14AM, E6 (CNA) stated, "R1 is not as steady as he should be. I always have my gait belt. I get a coworker or therapy for transfers. I use a gait belt for transfers and ask the resident what their limitations are and what they can do. I explain what I am going to do. There is a Kardex in the room and I can look for that information."</p> <p>The electronic medical record on May 31, 2017 showed diagnosis including muscle weakness, difficulty walking, abnormalities of gait and mobility, lack of coordination and stage 4 pressure ulcer to the right heel.</p> <p>The Physical Therapy Plan of Care for R1 dated May 13, 2017 showed his standing balance was able to be maintained for less than 1 minute with</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>a goal to reach 15 minutes.</p> <p>On May 31, 2017 at 11:56AM, E3 (Director of Rehabilitation) stated, "R1 transfers with minimum to moderate assist for us (therapy) theirs (nursing) is an extensive assist of 2 people. Physical therapy assessments are different than the minimum data set. We always told the staff to use gait belts with R1; we have x-large gait belts." R1 is now a max of 2 for transfers and possibly a mechanical lift. " E3 stated staff is to use a gait belt for all transfers and are advised to use a gait belt.</p> <p>The Minimum Data Set dated May 19, 2017 for R1 showed extensive, 2 plus person physical assistance is needed for transfers and bed mobility; ambulation in R1's room did not occur.</p> <p>The facility's Gait Belt policy (October 2003) showed, "Gait belts should be used by all staff when ambulating or transferring a resident with an unsteady gait.</p> <p>2. On May 31, 2017 at 1:11PM, R3 was in a reclining padded wheelchair. E7 (CNA) and E8 (CNA) put a gait belt around R3's waist. They put there arms behind R3 and under her legs and lifted her from the wheelchair to her bed. E8 stated, "We transfer her like this because the mechanical lift scares her and she screams. We are able to lift her to bed."</p> <p>On May 31, 2017 at 3:14PM, E2 (Director of Nursing - DON) stated, "I don't think R3 stands. I think her source of transfers should be a mechanical lift." E2 stated that lifting R3 was not safe.</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>The Minimum Data Set for R1 dated April 24, 2017 showed total dependence on staff for transfers.</p> <p>The Care Plan dated May 31, 2017 for R3 showed, "Resident will be transferred at all times using a mechanical lift. R1 does not bear weight."</p> <p>(B)</p>	S9999		
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