Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006985	A. BUILDING: _____ B. WING _____	C 06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OTTAWA PAVILION	704 EAST GLOVER STREET OTTAWA, IL 61350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Incident Report Investigation of 6/17/17 IL95131 Statement of Licensure Violations	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210c) 300.1210d)6) 300.3240a) 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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:	S9999	**Attachment A** **Statement of Licensure Violations**	

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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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These requirements were not met as evidenced by:

Based on interview and record review, the facilty failed to follow their plan of care to ensure safety alarm devices were in place to prevent falls for one of three residents (R1), reviewed for falls in a sample of three. These failures resulted in R1 falling and fracturing R1's left arm.

Findings include:

Facility electronic Physician Order Sheet (POS), date range 6/1/17-6/30/17, documents R1 was admitted on 6/9/17 with the diagnoses of "signs and symptoms involving cognitive functions and awareness following cerebral infarction and weakness."

R1's Minimum Data Set (MDS), dated 6/16/17, documents the following: "(R1) is moderately impaired; and requires extensive assistance with two person assist for transfers."

R1's current careplan documents the following: "(R1) is a new admit to the facility and orient to

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facility and surroundings; (R1) has a deficit in ADL (activities of daily living) abilities and requires staff assistance with all transfers; and (R1) is at risk for falls and will continue with a tab alarm and a pressure pad for safety."

R1's facility nurses notes dated 6/16/17 at 1:50pm, 6/15/17 at 7:20pm, and 6/15/17 at 1:38am document R1 had a fall with no injuries.

R1's facility skilled charting notes, dated 6/17/17 at 2:22pm, document the following: "(R1) has short-term memory impairment; impaired decision making ability; confused; extensive assistance for balance; assistance with transfers; poor safety awareness; keep in high visibility area with alarm in place."

R1's facility nurses notes, dated 6/17/17 at 8:02pm documents "(R1) was on the floor of (R1's) room complaining of left shoulder pain. (R1) stood up and took a few steps because (R1) wanted to change (R1's) clothes."

R1's incident report, dated 6/17/17 and revised 6/26/17, documents "(R1) stood up from sitting in (R1's) wheelchair (which has a pressure alarm) and took a few steps. (R1) said (R1) wanted to change (R1's) clothes." It also documents "R1's fall alarm is in place, and R1 has a history of falls, confusion, and gait imbalance."

R1's X-Ray from local hospital, dated 6/17/17, documents R1 has a "nondisplaced humeral neck fracture of left humerus."

On 6/29/17 at 3:10pm, E7 Certified Nurses Aid (CNA) stated the following: "(R1) was in his room in the recliner with his pressure alarm under him; the alarm is cordless and the alarm box was

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outside of (R1's) door when I heard it alarming; when I first saw (R1) earlier (in the night) he was in his recliner, but when I answered the alarm he was sitting at the edge of his bed; I turned off the alarm because he was at his bed and I went to take care of another resident; I did not put on his tab alarm or move his pressure alarm; and when (E8 CNA) went into (R1's) room he was on the floor."

On 6/30/17 at 7:10am, E8 CNA stated the following: "I had put (R1) in his room earlier in the night with his pressure pad under him; I was taking care of another resident when I heard (R1's) alarm going off but then it stopped; I knew it was (R1's) alarm because he had a distinctive ring set to his alarm; E7 CNA told me she had turned off (R1's) alarm; and the pressure pad was not under (R1) when he was in bed because it was in his recliner."

6/30/17 at 10:57am, E9 CNA stated the following: "I was in with another resident when I heard (R1's) alarm going off; I know it was (R1's) alarm because it had a specific alarm; I went in to check on (R1) when I was done with my other resident and (R1) was on the floor; E7 CNA told me she had silenced (R1's) alarm; and (R1) transferred himself from his chair to his bed and then fell because the alarm wasn't under him on the bed."

(B)