

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6003917</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>07/14/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>H &amp; J VONDERLIETH LVG CTR, THE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1120 NORTH TOPPER DRIVE MOUNT PULASKI, IL 62548</b>
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S 000	Initial Comments  Annual Health  Statement of Licensure Violations	S 000		
S9999	Final Observations  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 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. Restorative measures shall include, at a minimum, the following procedures:	S9999		

**Attachment A**  
**Statement of Licensure Violations**

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE <b>08/05/17</b>
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S9999	<p>Continued From page 1</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</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident</p> <p>These requirements were not met as evidenced by:</p> <p>These failures resulted in two deficient practices</p> <p>A. Based on interview and record review the facility failed to use a mechanical lift as careplanned during a transfer for one (R11) of seven residents reviewed for a fall in the sample of 15. This failure resulted in R11 sustaining an impacted medial tibial plateau fracture.</p> <p>B. Based on interview and record review the facility failed to investigate and determine root cause analysis and implement fall interventions to prevent falls for one of seven residents (R19) reviewed for falls in the sample of 15.</p> <p>Findings include:</p> <p>A. Facility Fall Assessment, Risk Identification and Management Policy (Revised 3/20/12) documents: that the policy will help facilitate an interdisciplinary approach for care planning to appropriately monitor, assess, and ultimately reduce injury risk; factors related to risk will be addressed and care planned; each resident will</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>be assessed using the Minimum Data Set (MDS) upon admission, quarterly and any significant change assessment; and all staff providing care to the resident will have access to the care plan and interventions.</p> <p>R11's Physician Order Sheet/POS, dated 6/28/17, documents a diagnosis including Cerebrovascular Accident with right hemiplegia. R11's MDS, dated 1/3/17, 3/28/17 and 6/20/17, documents R11's cognition as severely impaired and unable to assess.</p> <p>Facility Occurrence Report (dated 2/26/17, 1:02 pm) documents that Z1 (Agency Certified Nursing Assistant/CNA) was the assigned caregiver to R11. Z1 assisted R11 to the bathroom, R11's knees buckled, and R11 "tripped on her own feet." Z1 then lowered R11 to the ground.</p> <p>R11's Progress Note (dated 2/26/17, 8:45 pm) documents "Since supper, [R11] has progressively indicated she has pain in her right knee. At bedtime whimpered when put into bed. Right knee larger than left."</p> <p>R11's Progress Note (dated 2/27/17, 11:30 am) documents that bruising to R11's right lower extremity is larger, covering the majority of the anterior portion, below knee and to upper ankle, dark purple in color, knee to foot with pitting edema, and that R11 complained of knee pain.</p> <p>R11's Care Plan (initiated 1/17/17), documents that R11 is a mechanical lift for transfers.</p> <p>R11's MDS (dated 1/3/17), documents that R11's Transfer and Toilet Use as extensive assistance with two person physical assist.</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>R11's Fall Scale Assessment (dated 1/3/17) documents that R11 is a high risk for falls.</p> <p>R11's Radiology Imaging Patient Report (dated 2/27/17) documents an impacted medial tibial plateau fracture.</p> <p>Z2's (R11's Attending Physician) Order (dated 2/27/17) documents an order for a right lower extremity knee immobilizer and non weight bearing.</p> <p>Z2's Order (dated 3/6/17) documents an order for a right lower extremity brace, to be removed for bathing and dressing, continue with non weight bearing and a mechanical lift for a transfer.</p> <p>On 7/13/17, at 2:15 pm, E2 (Director of Nursing/DON) stated that on 1/17/17, R11 became a mechanical lift (sit-to-stand) due to an illness.</p> <p>On 7/13/17, at 12:00 pm, E4 (Licensed Practical Nurse/LPN) stated that on 2/26/17, right after lunch, Z1 (Agency CNA) was attempting to transfer R11 to a commode that was located in the whirlpool bathroom. Z1 called for E4 to come to the bathroom and assist with R11. E4 stated that, "when I got there, [Z1] was the only staff present and [R11] was on the floor on her bottom, with her back against the toilet." E4 stated that, "[Z1] told me that [R11] was holding onto the grab bar and [R11's] legs gave out and [R11's] feet got tangled and I had to lower her to the ground."</p> <p>On 7/13/17, E4 (LPN) stated that Z1 (Agency CNA) was the only staff member that was performing R11's transfer.</p> <p>On 7/14/17, at 10:10 am Z1 (Agency CNA) stated</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>that, "I was taking [R11] to the bathroom and all of the sudden [R11] just fell on me and went down. I pulled the call light for help." Z1 also stated, that, "[R11] was a one person transfer to the bathroom and then after the fall they made her a mechanical lift."</p> <p>On 7/14/17, at 10:10 am, Z1 verified that Z1 had been an agency CNA at the facility for approximately 3 months and that no formal training is provided by the facility. Z1 stated that, " I did not look at the Care Plan and all the others girls just tell me how people transfer and tell me what to do."</p> <p>B. On 7/14/17 at 11:30 am, E7 Corporate Nurse stated the Full Occurrence Report is used to investigate root cause analysis and is where interventions for resident falls are documented. E7 stated "root cause analysis should be listed under Conclusion Statement," and "interventions should be documented under Recommendations" on the Full Occurrence Report. E7 also stated, all resident falls and interventions are to be documented on each resident care plan.</p> <p>The Progress Note, dated 7/8/17, documents R19 "was found in (R19's) room lying on (R19's) left side. CNA (Certified Nursing Assistant) found the resident approx (approximately) 15 minutes after she had toileted the resident and repositioned (R19) in (R19's) (geriatric chair)," and "one on one supervision provided to the resident at this time."</p> <p>The Full Occurrence Report, dated 7/8/17, does not include a root cause analysis of R19's fall.</p> <p>The Progress Notes, dated 7/10/17 documents "Called to resident room, resident on floor lying on (R19's) right side, slid out of recliner". There is</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>no documented root cause analysis and no fall interventions documented.</p> <p>The Full Occurrence Report, dated 7/10/17, does not include a root cause analysis or any interventions for R19's fall.</p> <p>R1's current Care Plan, dated 6/20/17 does not document or include interventions for R19's 7/8/17 and 7/10/17 falls.</p> <p>On 7/14/17 at 11:00 am, E5 LPN (Licensed Practical Nurse) Care Plan Coordinator, stated she was not made aware of (R19's) 7/8/17 or 7/10/17 falls, therefore there is no root cause analysis or interventions for R19's falls.</p> <p>(B)</p>	S9999		
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