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
	IL6004014	A. BUILDING: _____ B. WING _____	10/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALHAMBRA CARE CENTER	417 EAST MAIN STREET, BOX 310 ALHAMBRA, IL 62001

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S 000	Initial Comments Annual Licensure and Certification Survey Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 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	S 000	**Attachment A** **Statement of Licensure Violations**	

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S 000	Continued From page 1 care needs of the resident. 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: 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Requirements are not met as evidenced by:	S 000		

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Based on observation, interview and record review the facility failed to implement progressive interventions and provide safety interventions to prevent falls for 2 of 5 residents (R15, R241) reviewed for falls in the sample of 22. This failure resulted in R15 falling and sustaining a nasal fracture and head contusion.

Findings include:

1. R15's 2018 October Physician Order Sheet (POS) document a diagnosis in part of Alzheimer disease, delusional disorders, blindness both eyes, and nightmare disorder.

R15's Minimum Data Set (MDS) documents a Brief Interview of Mental Status score of 2, indicating she has severe cognitive impairment.

R15's Incident Report dated 12/18/2017 at 12:15 AM, documents, "Resident was found sitting on floor leaning against the dresser, personal alarm sounding. No visible injuries. Resident able to move all extremities. Within normal limits for resident. Assisted resident to standing position and resident able to ambulate with no complaints of pain." The Report documented Intervention as "Resident will be kept in common area for 1:1 care. Very anxious about something to do with grandpa. grandma." There was no intervention documented related to the prevention of further falls.

R15's Progress Notes dated 12/18/2017 at 12:20 AM, documents "Resident was found by certified nursing assistant (CNA) with personal alarm sounding leaning against the dresser sitting on the floor. Resident was agitated and crying out

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S 000	Continued From page 3 and screaming. Resident will be kept in common area for 1:1 care." R15's Progress Notes dated 12/18/2017 at 3:30 AM. "Resident was still at nurses' station, writer was at medicine cart, resident stood up, Nursing alarm sounding and started to fall to right side. This nurse stopped resident from falling hard but resident did bump head on floor. Resident has no open area but temple is bruising with small hematoma. Assisted resident to room, cold compress applied, resident unable to participate with neuro-checks at this time, weak and unable to understand request." R15's Incident Report dated 12/18/2017 at 4:08 AM, documents, "Resident was sitting in wheelchair at nurse's station, stood up, alarm sounding. Started to fall to right side. Writer fell with resident but resident still bumped head on floor, right temple area. Cold compress applied. Neurochecks started. Intervention: "Resident is in recliner with ice to right temple area. No complaint of pain or discomfort." There was no intervention documented related to the prevention of further falls. R15's Incident Report dated 01/30/2018 at 7:45 AM, documents, "Resident in café in wheelchair personal alarm in place. Alarm sounding and Certified Nursing Assistant (CNA) saw resident starting to fall out of wheelchair and eased resident to floor. Resident to floor. Resident has bruise to left check. Medical Doctor also notified via fax." There was no intervention documented related to the prevention of further falls. R15's Progress Notes dated 01/30/2018 at 11:34 AM, documents, "Resident in cafe in wheelchair personal alarm in place. Alarm sounding."	S 000		

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R15's Incident Report dated 02/08/2018 at 9:13 AM, documents, "Stood up in wheelchair and on lap protector, lost balance and fell to floor in hallway. Head injury noted. "Was sitting in high back wheelchair after breakfast; with lap protector in place and chair alarm on. Resident stood up in chair and fell forward pulling lap protector off during fall. Resident witnessed by Social Service Director (SSD) to fall prone to floor in hallway. Resident has laceration to upper area of nose 1 inch in length. Bleeding noted to left eye and nose. Resident alert and responds to staff, (911 called). Head and neck immobilized by First responders and resident voiced no complaints of pain. Power of Attorney (POS) called and is going to Local Hospital at this time." Event Report for 02/08/2018 documents "Lap buddy removed from chair." There was no intervention documented related to the prevention of further falls.

R15's Progress Notes dated 02/08/2018 at 12:16 AM, documents in part, "Resident personal alarm sounding, writer went to room, resident sitting on the floor by window on mat. Resident taken to bathroom, noticed abrasion to left side of back and abrasion and bruising to lower back, old skin tear to left elbow." There was no intervention documented related to the prevention of further falls.

R15's Progress Notes dated 02/09/2018 at 1:33 AM, documents, "Resident continues on Incident Follow Up related to fall with nasal fracture and head contusion. Purple discolorations/swelling to eyelids/nose and forehead."

R15's Progress Notes dated 02/09/2018 at 1:55 PM, documents, "resident moaning and crying."

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S 000	Continued From page 5 R15's Progress Notes dated 02/09/2018 at 1:50 PM, "Incident Follow Up with Nasal fracture and head contusion." R15's Progress Notes dated 02/10/2108 at 2:20 AM, documents, "fall with head injury. Purple bruising remains, right eye and left. Sterile adhesive strips to bridge of nose intact with some swelling and bruising." R15's Incident Report dated 04/27/2018 at 9:45 PM, documents, "CNA called nurse to resident's room. Resident noted on her left side next to bed on mat. Bed alarm clip and box still intact. Resident restless and refused vital signs. Skin assessment done with no injuries." There was no intervention documented related to the prevention of further falls. R15's Progress Notes dated 04/27/2018 documents, "CNA called nurse to resident's room. Resident noted on her left side next to bed on mat. Bed alarm and clip and box intact. No injuries noted." On 10/09/2018 at 4:01 PM V2, Director of Nursing (DON) stated, "The interventions for the falls are listed at the bottom of the Incident reports." There was no intervention documented related to the prevention of further falls for R15 after each fall. On 10/10/2018 at 3:40 PM, V20, Physician of R15 stated, "(R15) has Alzheimer disease and dementia and because of that she constantly has to be redirected and have supervision. The only change I could see related to her falls is to move (R15) closer to the nurses' station for closer supervision. Which the facility eventually was able to do. "	S 000		

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2. The MDS, dated 7/09/2018 documents R241 is moderately impaired with cognition, is independent with transfers, is ambulatory and has no limitation in range of motion. The EHR, (electronic health record) documents R241 has diagnoses, in part, as Alzheimer's Dementia, and Convulsions.

R241's Care Plan, dated as edited 10/01/2018, documents : has impaired decision making skills and is at risk for falls due to the use of psychotropic medications and uses a cane.

On 10/03/2018 at 12:12 PM, R241 was in bed. There were no side rails on the bed. A fall mat was on the floor.

On 10/09/2018 at 8:24 AM and 9:46 AM, R242 was in bed on his back on an alternating air loss pressure relieving mattress. There were no side rails on the bed. A fall mat was on the floor.

The Progress Note, dated 10/08/2018 at 5:35 PM, documents, in part, "Rolled out of bed onto mats on floor. Bed in low position with air mattress in place,"

The Event Report, dated 10/08/2018 at 5:35 PM, documents, in part, "Resident rolled out of bed onto his left side of his body with no injuries noted per nurse. Stated he had no pain occurring after this fall at this time." The intervention documented after the fall is , "More bed pads and long length cushion placed to right side of resident along right back side while left side bed was pushed up against the wall for better safety measures noted."

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S 000	Continued From page 7 On 10/09/2018 at 4:00 PM, V2, DON reported R241 got the alternating air loss mattress on 10/08/18, and they do not have the manufacturer's guidelines for its use because the mattress belongs to the facility. V2 reported R241's new mattress was not assessed for safety to prevent falls. The facility's policy and procedure, dated 12/2016 and entitled, "Fall Procedure and Policy" documents, in part, "Nursing is required to perform fall assessments on residents and placed on a prevention program if indicated upon admission and quarterly. Complete fall report with appropriate interventions in Matrix under the event section." (B)	S 000		