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	IL6008965	A. BUILDING: _____ B. WING _____	08/29/2019

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ST JOSEPH HOME OF SPRINGFIELD	3306 SOUTH 6TH STREET ROAD SPRINGFIELD, IL 62703

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S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: Section 300.1210b)4 Section 300.1220a)b)2)7 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. 4) A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition. Section 300.1220 Supervision of Nursing Services a) Each facility shall have a director of nursing services (DON) who shall be a registered	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 nurse. b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, cognitive status. 7) Coordinating the care and services provided to residents in the nursing facility. This requirement is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to recognize, address, and provide nutrition/hydration for 5 of 11 residents (R11, R17, R18, R19, and R20), reviewed for dining assistance, in a sample of 20. Findings Include: 1. On 8/26/19 at 12:35 PM during the noon meal, R11 sat at the dining room table on the memory unit with her meal tray uncovered. On R11's plate was meatloaf, mashed potatoes with brown gravy, and carrots. There was no bread and butter noted on or near her tray. R11's weighted spoon and weighted fork was positioned to the right of her divided plate and R11 was not eating. No encouragement or assistance with feeding was offered until 12:50 PM, when V12, dietary aide, asked R11 if she was going to eat. At 12:55 PM, R11 consumed a couple of bites of her meat	S9999		

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loaf, put down the fork, and attempted to eat her meatloaf with a straw. At 1:00 PM, V12, dietary aide, informed V9, Certified Nursing Assistant (CNA), that R11 was eating with a straw. No further cueing, assistance, nor substitute was given to R11 throughout the entire noon meal.

R11's dietary assessment, dated 7/9/2019, documents R11 receiving chocolate health shakes daily, and requiring 1667 calories per day, including 74 grams of protein and 2220 cubic centimeters (cc) of fluid per day. The dietary assessment further documents R11 having dementia, anemia, and anxiety.

R11's Care Plan, revised on 8/4/19, documents R11 requiring assistance to complete her Activities of Daily Living (ADLs) due to her cognitive deficits and behaviors. The Care Plan further documents R11 being able to feed herself at times and needing staff assistance with meals, "Usually needs staff assist to get started, cues and assistance of 1 to complete the meal."

2. On 8/26/19 throughout the noon meal on the memory unit, R19 sat with her meal tray in front of her, uneaten. Her plate consisted of meatloaf, mashed potatoes and brown gravy, carrots, and various drinks. At no time during the meal service did V9 or V10, CNAs, offer assistance, cueing or a substitute to R19 throughout the noon meal.

R19's Physician Order's Sheet (POS), dated 8/28/19, documents R19 having a diet of regular texture and regular consistency. The POS further documents R19 having diagnoses of Down's Syndrome and Dementia without Behavior Disturbance.

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R19's dietary assessment, dated 6/7/19, documents R19 requiring 1863 calories per day and requiring 2490 cc of fluids per day.

R19's Care Plan, dated 5/20/19, documents R19 having cognitive impairment and requiring assistance with eating. The Care Plan further documents R19 "prefers a turkey sandwich with chips for lunch with a soda."

3. On 8/26/19 during the noon meal on the memory unit, R20 sat at the table with her meal tray in front of her from 12:45 PM through 12:55 PM without any fluids to drink. At 12:55 PM, V12, dietary aide, placed 2 glasses of fluids in front of R20's tray. During the meal time, R20 consumed a few bites of her food, and at no time did V9 or V10 offer cueing, assistance or a substitute to R20.

R20's POS, dated 8/28/19, documents R20 having a diagnosis of Alzheimer's Disease.

R20's dietary assessment, dated 8/26/19, documents R20 requiring 1307 calories per day with 56 grams of protein, and 1680 cc of fluids per day.

R20's Care Plan, revised on 8/26/19, documents R20 having memory loss related to her dementia, and to "Cue, reorient and supervise or assist as needed. Educate and encourage good nutrition and hydration."

On 8/26/19 at 1:05 PM, V12, dietary aide, calibrated the thermometer in an ice bath. V12 then placed the thermometer in R19's potatoes, and found the temperature to be 80 degrees. V12, dietary aide, then wiped the thermometer with an alcohol wipe, and placed the thermometer

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S9999	Continued From page 4 in R20's meatloaf and temperature read 70 degrees. On 8/26/19 at 12:34 PM, V11, dietary aide, stated he had forgotten to bring the bread and butter. At 12:45 PM, V12, dietary aide, brought the bread and butter to the dining area and began passing out the bread and butter to the residents. 4. On 8/26/19 at 12:10 PM, R17 was lying in bed in her room. When surveyor asked if she had eaten, R17 stated, "Waiting on tray." V5, CNA, and surveyor then walked into the dining room to retrieve R17's tray, which was found in the microwave, at which time V5 heated up R17's tray and walked it down to R17's room. After serving R17 her tray at 12:17 PM, R17 asked V5, "Can I have a half a glass of milk?" There were no fluids served to R17 at the time her tray was served. R17's dietary assessment, dated 8/16/19, documents R17 having a regular diet with mechanical soft/ground meat, requiring 1698 calories per day, with 79 grams of protein with 1975 cc fluids. R17's Care Plan, revised on 4/4/19, documents R17 having "nutritional problem protein-calorie malnutrition r/t (related to) CVA (Cerebral Vascular Accident/Stroke)." The Care Plan further documents R17 having a goal to "maintain adequate nutritional status." 5. On 8/28/19 from 11:45 AM until 12:04 PM, R18 sat with her meal tray uncovered in front of her with no assistance from staff. R18's plate consisted of pureed meat loaf, mashed potatoes and brown gravy, cook carrots, apple crisp, with various drinks. At 12:04 PM, V5, CNA, sat to	S9999		

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assist with feeding. There was no reheating of her food.

R18's Face Sheet, dated 8/27/19, documents R18 having Dementia, Major Depressive Disorder, and Cachexia.

R18's POS, dated 8/28/19, documents R18 having an order for house supplement three times a day, regular diet with pureed texture, regular consistency, for chewing difficult due to dental problems.

R18's Dietary Assessment, dated 7/22/19, documents R18 requiring 1280 calories, with 39 grams of protein and 1174 cc of fluid daily.

Monthly Weight Report, dated September 2018 through August 2019, documents R18 having weight on 9/2018 92.6 pounds and on August 2019 weighing 80.2 pounds.

R18's Care Plan, revised on 3/7/19, documents R18 having nutritional problems and having interventions to provide and if R18 is not eating the served food, offer an alternative entree' or other preferred food. The Care Plan further documents R18 having an self-care performance deficit related to cognitive impairment.

The Facility "Week At a Glance" menu, dated 2019, documents on 8/26/19, the following was to be served: meatloaf, mashed potatoes with gravy, carrots, apple crisp, bread with margarine, and beverages.

On 8/28/19 at 12:42 PM, V2, Director of Nursing (DON), stated she would expect residents to have drinks with their meal tray and would expect staff to feed residents and to cue residents when

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residents are not eating. V2 further stated, "No excuse for not feeding and not assisting the residents, especially on a memory care unit and to re-heat food or get a substitute if not eating."

The Facility Policy entitled Meal-Time Assistance, undated, documents "Purpose: Assistance will be provided to residents as needed. Assistance will be provided in a way that maintains the dignity and self-esteem of each resident. Procedure: Assistance includes: a. Cutting foods b. Preparing bread c. Cleaning up spills d. Opening containers e. Special utensils."

The Facility Policy entitled Assistive Devices, undated, documents "Purpose: Provide appropriate assistive devices to residents who need them to maintain or improve their ability to eat or drink independently and appropriate staff assistance to ensure that these residents can use the assistive devices when eating or drinking. Procedure: The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals."

The Facility Policy entitled Food Service to Residents, undated, documents "Purpose: 1. Residents in bed: b. The nursing staff will be responsible for taking food trays into the resident's room. e. The resident will be prepared by nursing staff to receive and eat their meal in bed. 2. Residents who require assistance in eating: b. Nursing services will be responsible for feeding the resident while the food is hot (or cold, depending on food item). 3. Residents eating in the dining room: a. All residents are encouraged to eat in the dining room. b. Resident trays are served by nursing personnel. c. Residents who

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require assistance with eating will be provided with assistive devices or provided help as needed. d. Residents who are unable to feed themselves will be fed with attention to safety, comfort, and dignity."

(B)

Section 300.3240a)b)c)e

Section 300.3240 Abuse and Neglect

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

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator.

c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative.

e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee.

These requirements were NOT MET as evidence

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S9999	Continued From page 8 by: Based on observation, interview, and record review, the facility failed to provide a safe resident environment and protect residents from abuse for 2 of 6 residents (R2, R3) reviewed for abuse, in the sample of 20. This failure resulted in psychosocial harm in that, a reasonable person would react to such a situation with feelings of anxiety, distress, fearfulness and humiliation. Findings include: On 8/27/19 at 12:45 PM, the video, dated 7/25/19 at 12:50 PM was observed with V1, Administrator, V4, Director of Plant Operations. The video showed R3 sitting in her wheelchair while V14, Licensed Practical Nurse (LPN), was pushing R3 in her wheelchair. R3 was sitting in the wheelchair with her left leg left crossed over her right leg. As R3 was being pushed in her wheelchair by V14, V14 rammed R3's left foot into the door frame of the TV/Sun room twisting R3's left foot sideways when entering through the doorway. R3 displayed facial grimacing and appeared to be mouthing, "OW, OW, OW" over and over. While V14 transported R3 in the wheelchair, R3's, right foot dragged on the floor, and there were no foot rests present on R3's wheelchair. V14 looked up at the camera and smiled into the camera after ramming R3's leg into the door frame. R3 was then pushed into the TV/Sun room by V14 and V14 walked out of the room without assessing R3's leg or locking R3's wheelchair. After leaving R3 in the TV/Sun room, the video shows V14 sitting at the nurse's desk on her personal phone. The video showed that R3 appeared to be in pain because of her facial grimacing and was leaning sideways in her wheelchair to the left. R3 pushed her wheelchair	S9999		

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backwards and slid out of her wheelchair onto the floor, sounding the chair alarm.

On 8/27/19 at 12:05 PM, V1 stated, "(V4) came to share the camera video, he handles all the video in the building. The first thing showed was (R3's) legs crossed and the LPN hooked her (R3) ankle on the doorframe and the look of pain on (R3's) face. The nurse then backed up and put (R3) in the TV room and didn't lock her wheelchair and left (R3) in an unsafe environment in her wheelchair and never completed an assessment on (R3). (V14) knew (R3) was in such pain from her ankle and then (R3) fell out of her chair. There was our nurse sitting at the nurse's station on her cell phone. This resident is not interviewable and the LPN rammed her ankle into the doorway causing great psychological stress to the resident. We called the police because it was devastating. When you see the video, it is 10 times worse than me just telling you about the harm caused to (R3). The LPN was turned into Professional Regulations."

On 8/27/19 at 12:45 PM, while watching the video, V1 stated, "Look at (R3), her little chin going up and down, devastating. OW, OW, OW, appears to be what (R3) is saying. Her left ankle appears to be bent all the way back. (R3) has an alert alarm on her chair and there is supposed to have foot pedals on the chair."

Fall investigation report, dated 7/25/19 documents, "DON, (V2, Director of Nurses) asked the Director of Plant Operations (V4), to review the cameras in regard to a fall that had occurred on second floor in the Resident Sitting Room. At 3:47 PM Director of Plant Ops sent an email to the Administrator regarding the review of the cameras. It is clearly noted that (V14) LPN,

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was taking Resident into the sitting room, rammed the resident's left leg (legs were crossed) into the door frame, knowing that the resident's foot hit the door and continued to push the resident into the room. Left ankle was hyper-extended and resident clearly experienced pain as verified on the camera. At approximately 4:15 PM Administrator notified (V14) by phone that she was being suspended pending investigation. Conversation was witnessed by (V15), Assistant Administrator. 4:55 PM Administrator notified Police Department. (V16), Chief of Police, arrived at facility and a case number was assigned. 7/26/19 investigation-(V14) did not document in the IR (Incident Report) anything regarding ramming the residents left ankle into the doorframe. No assessment completed. Did not lock the wheelchair or ensure the resident was left in a safe environment-resulting in the resident sliding out of her wheelchair-no injuries from fall. (V14) did not return to check on the resident and is noted to be on her personal phone at the desk during the time the resident was sliding out of her chair. As evidenced in video, resident incurred severe pain at the time the left ankle was rammed into the door frame. (V14) will be terminated."

Nurses Notes dated 7/25/19 at 3:45 PM, V17, LPN, documents, "writer was sitting at desk when she heard an alarm going off in resident tv room. Writer rushed in room and observed (R3) on floor lying on her left side Resident had an alarm pad in her chair with a chair cloth pad on top of it. Resident was assessed for ROM (Range of Motion) and for any pain and bruises. Writer and 2 west nurse aide assisted resident up to wheelchair via (full mechanical lift)."

Electronic Medical Record (EMR) for R3, dated

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S9999	Continued From page 11 8/28/19, documents, "(R3) was admitted to the facility on 3/25/17 with diagnosis: "Alzheimer's Disease, Fracture of unspecified part of neck of right femur, Major Depressive Disorder, Anxiety Disorder, and Unspecified fracture of the lower right radius." Care Plan for R3, dated 7/11/18, documents, "(R3) is at risk for injury r/t (related to) balance problems, lack of safety awareness. Transfer to recliner when in room. When up in wheel chair place her where she can be seen by staff." "9/19/18 Keep foot rest on wheelchair when transferring (R3)." R3's Fall Risk off Morse Form assessment, dated 4/16/19, documents R3 is at high risk for falls with a score of 50. High Risk being 45 and above. 2. On 8/27/19 at 12:30 PM, when V18, R2's Daughter, was asked about the report she made regarding bruises on her mother's hands on 1/25/19, V18 stated, "I reported the bruises on mom's hands. Mom told me the CNA was rough with her in the shower." On 8/27/19 at 12:45 PM, V1, Administrator, stated, "I lined my hands up to (R2's) hands and it shows finger prints and they matched up completely with mine. She was a partial mechanical lift, I believe (V19) pulled (R2) up by her hands." The Facility Self Report, submitted on 1/25/19 for R2, documents, "Administrator was notified by (V20), RN, (Registered Nurse)/Charge Nurse), that the resident had reported to a family member that a C.N.A. had treated resident resident roughly during her shower that morning. C.N.A.	S9999		

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(V19) had given the shower. Administrator went to resident's room. Bilateral bruises noted. Administrator took resident's hands, and bruises were in alignment with administrator's thumbs. Per the resident's plan of care, (partial mechanical lift), is to be used for all transfers. Resident was smiling during conversation with administrator. Resident was asked, 'How was your shower?' Resident stated, 'Not good.' 2:30 p.m.-Resident's daughter, (V18), submitted a written statement that her mother had said her shower was bad because someone had been rough with her during the shower. Daughter then noticed the bruises on her mother's hands. Skin assessment completed on this resident on 1/22/19 indicated no new areas. Nurse caring for resident on 1/25/19 did not notice any bruises to resident's hands during a.m. med (medication) pass. Conclusion: Based on resident statement that the C.N.A. had been 'rough' with her during her shower and the position of the bruises on Resident's bilateral hands, it was determined that the C.N.A. had caused the bruising during the shower or transfer during the shower. A (partial mechanical lift) is to be used for all transfers on this resident."

Facility interviews of staff working with R2 on 1/24/19, documents V20, Registered Nurse, (RN), V22, LPN, and CNA's V21, V23, V24, and V25 all documented they did not observe bruises on R2's bilateral hands.

Employee Disciplinary Action Form for termination documents, "On Friday 01/25/19, (V19) gave a shower to resident, (R2), and was noted by the resident as being rough with the resident which led the resident, (R2) to have bruises on her hands. When chatting with her daughter the resident stated that the bruise on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008965	A. BUILDING: _____ B. WING _____	08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH HOME OF SPRINGFIELD	3306 SOUTH 6TH STREET ROAD SPRINGFIELD, IL 62703

(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
S9999	Continued From page 13	S9999		

her right hand hurt a little. Resident (R2) is a (partial mechanical lift) and she does not require assistance from (V19) to help her get out of a seat and therefore (V19) should not have put her own hands on resident, (R2's) hands to assist. The investigation conducted led that these bruises on hands incurred by resident (R2) were new and didn't exist prior to 1/25/19."

Electronic Health Record (EHR) for R2, dated 8/28/19, documents, R2 was admitted to the facility on 10/25/16 with diagnosis, "Dementia, Fracture of Neck of Left Femur, Traumatic Subarachnoid Hemorrhage, Major Depression, Unspecified Abnormalities of Gait and Mobility, Muscle Weakness, and Guillain-Barre Syndrome."

Care Plan for R2, dated 8/8/18, documents, "Mechanical lift, (partial mechanical lift) for all transfers."

Facility policy, undated, entitled "Abuse Program Prevention," documents "Purpose: Protect the residents in this facility from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. Abuse is the willful inflection of injury, unreasonable confinement, intimidation or punishment resulting in physical harm, pain or mental anguish. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress."

(B)