

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001739	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2020
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1507 7TH STREET LINCOLN, IL 62856
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S 000	Initial Comments Annual Licensure and Certification Survey. F689 G cited	S 000		
S9999	Final Observations 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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	S9999		

**Attachment A
Statement of Licensure Violations**

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/24/20

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S9999	<p>Continued From page 1</p> <p>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:</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 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>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</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>months.</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. (Section 2-107 of the Act)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on observation, record review and interview the facility failed to effectively communicate individualized fall interventions, implement fall interventions consistent with the resident's needs, and revise the fall care plan for one of one resident (R54) reviewed for falls with injury. These failures lead to staff not properly removing R54's wheelchair foot pedals and R54 falling out of her wheelchair face first, causing a laceration to the forehead and a large hematoma (blood collection under the skin due to trauma) to the forehead.</p> <p>Findings include:</p> <p>1. The facility's Fall Prevention policy dated 07/2019 documents, "Policy: Each resident will be assessed for risks of falling and will receive care and services in accordance with the level of risk to minimize the likelihood of falls. High Risk Protocols: Provide interventions that address unique risk factors measured by the risk assessment tool. Provide additional interventions as directed by the resident's assessment, including but not limited to therapy services referral. Each resident's risk factors, and</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>environmental hazards will be evaluated when developing the resident's comprehensive plan of care. Interventions will be monitored for effectiveness. The plan of care will be revised as needed. When any resident experiences a fall the facility will review the resident's care plan and update as indicated. Document all assessments and actions."</p> <p>R54's current Physician's Order Sheets document R54 has diagnoses of Dementia and a history of falls with fractures. R54's MDS (Minimum Data Set) Assessment dated 8-21-20 documents R54 is severely cognitively impaired and R54 requires extensive assistance of two staff for transfers to and from the wheelchair. R54's Fall Assessment dated 8-17-20 documents R54 is at a high risk for falls.</p> <p>R54's Post Fall Management Quality Assurance Form dated 1-26-18 documents, "(R54) had her foot on the wheelchair pedal and attempted to stand up, causing the wheelchair to flip forward. (R54) landed on the floor face first. (R54) had abrasions to forehead, nose, and upper lip. (R54) had a hematoma to the forehead. Plan of Action to Prevent Reoccurrence: Keep wheelchair legs off unless transporting (R54)."</p> <p>R54's Occupational Therapy Plan of Care dated 6-16-20 (start of care) through 6-29-20 (end of care) documents, "Reason for referral: Address (R54's) wheelchair positioning due to consistent leaning in her wheelchair. (R54's) positioning in her wheelchair is becoming more unsafe at this time. Discharge Plans and Instructions: Lateral side support always needed in the wheelchair to help decrease leaning and promote upright sitting. Wheelchair pedals would help, also. Also, if (R54) appears to be excessively leaning,</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>(R54) should lay down for a rest." R54's current Plan of Care does not include any documentation/interventions related to R54's positioning or use of foot pedals.</p> <p>R54's Post Fall Management Quality Assurance Form dated 7-12-20 at 2:50 PM documents, "(R54) was lying face down with the right side of her face on the ground and left side of her face up. (R54's) wheelchair legs were underneath her thighs and both arms were crossed underneath her. Blood was seen on (R54's) forehead and (R54) was in visible distress. 911 called. (R54) was transferred to the emergency room. Based on assessment and direct observation at the location of the fall, the fall management team determines the following new interventions and recommendations to be implemented: Occupational therapy to evaluate for wheelchair positioning. Cause of fall: Leg pedals."</p> <p>R54's Emergency Room Report and Diagnostic Testing dated 7-12-20 document, "(R54) found face down on floor. Large hematoma to forehead. Frontal forehead laceration." R54's Post Fall Huddle dated 7-12-20 documents, "Interventions to prevent further falls: Needs bigger wheelchair with adjustable back or a therapy evaluation." R54's Medical Record does not include a therapy evaluation since the fall date of 7-12-20.</p> <p>On 09/28/20 from 9:05 AM to 11:30 AM, R54 was in a room across from the nurses' station. R54 was sitting in a wheelchair, asleep, and was leaning to the left side.</p> <p>On 10/01/20 from 8:45 AM to 9:59 AM, R54 was in a room across from the nurses' station. R54 had a rolling table in front of her. R54 was sitting</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>in wheelchair and leaning forward onto the tray with her head lying on the tray. R54 was sleeping this entire time. V8 (CNA/Certified Nursing Assistant/CNA) and V22 (CNA) were present during this time and did not approach R54 or attempt to lay R54 down.</p> <p>On 09/30/20 at 10:33 AM, V2 (Director of Nursing) stated, "The reason (R54) fell out of her wheelchair and sustained a laceration and hematoma is because the staff forgot to remove her wheelchair pedals. (R54) leans forward and picks at the floor. When (R54's) wheelchair pedals are on she pushes off the pedals which cause her to fall. (R54) sits up straight when the wheelchair pedals are off. (R54) had a prior fall from pushing herself off her wheelchair pedals and falling flat on her face. I did not know that therapy had recommended wheelchair pedals. Had I known I would have told therapy that the wheelchair pedals cause her to fall. I am not sure how therapy's discharge instructions are communicated with the staff. We (facility staff) are still unsure about who put the wheelchair pedals on her wheelchair. The only time (R54) should have wheelchair pedals on is during transport. (R54's) care plan does not include any documentation about (R54's) wheelchair positioning or (R54's) wheelchair pedals. The staff need to lay (R54) down anytime she is sleeping in her wheelchair."</p> <p>On 09/30/20 at 11:38 AM, V16 (LPN/Licensed Practical Nurse) stated, "(R54) should not have pedals on her wheelchair. The pedals cause her to push forward and fall."</p> <p>On 09/30/20 at 11:50 AM, V17 (LPN) stated, "On 7-12-20 me and (V21/CNA/Certified Nursing Assistant) found (R54) in the day room on the</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>floor. (R54) was lying face down with a puddle of blood on the floor. We did not move (R54) because she had sustained a head injury. I immediately called 911 and sent (R54) to the emergency room for treatment. (R54) had wheelchair pedals on her wheelchair which put her at risk for falling. (R54) bends over and pushes herself over by using the wheelchair pedals. When we found (R54) she was crying and was in visible distress."</p> <p>On 09/30/20 at 1:08 PM, V3 (Memory Care Director) stated, "Last month the staff came to me and said (R54) was really leaning to the left side. I decided to send (R54) to therapy for an evaluation. I was told by therapy that (R54) is to have a left side wedge cushion on her wheelchair. We were not given any instruction on the wheelchair pedals. (R54) has had previous falls due to her pressing on the wheelchair pedals which causes all her weight to press forward and causes her to fall. The root cause of the fall on 7-12-20 was that the staff left the foot pedals on her wheelchair and they were not supposed to. If I would have known therapy's recommendations, I would have informed them that (R54) should not have foot pedals because it causes her to fall. (R54) had not fallen for over a year because staff always knew not to have foot pedals on her wheelchair. (R54's) fall caused a huge hematoma to the center of her forehead and a laceration in the middle of the hematoma. (R54's) care plan does not include any instructions on (R54's) positioning or use of pedals while in the wheelchair. I am not sure why the occupational therapy evaluation was not done after (R54's) fall on 7-12-20."</p> <p>On 09/30/20 at 1:50 PM, V18 (Occupational Therapist) stated, "The evaluation I had done on</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>6-16-20 was due to (R54) leaning to the left side in her wheelchair. This evaluation had nothing to do with (R54) falling. I was not aware of (R54) leaning forward in her wheelchair and pushing off her wheelchair pedals. Had I known that (R54) pushes off her wheelchair pedals and falls, I would have screened (R54) differently for positioning and for falls. The biggest issue I see is that the staff needs to lay (R54) down whenever she is sleeping in the wheelchair. I was not aware of the facility wanting a therapy evaluation after (R54's) fall on 7-12-20. "</p> <p>On 09/30/20 at 2:00 PM, V19 (Therapy Director) stated, "I was not informed that (R54) needed a therapy evaluation after (R54's) fall on 7-12-20. Had therapy staff know we would have definitely done it."</p> <p>On 09/30/20 at 2:28 PM, V20 (MDS Coordinator) stated, "I was not aware of therapy discharge interventions regarding (R54's) wheelchair positioning. I would not have care planned those interventions."</p> <p>(B)</p>	S9999		