

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL6008866	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  C 08/18/2017
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NAME OF PROVIDER OR SUPPLIER  ST ANTHONY'S NRSG & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 767 30TH STREET ROCK ISLAND, IL 61201
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(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
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S 000	Initial Comments  Complaint Investigation  1724851/IL96100 1724940/IL96194	S 000		
S9999	Final Observations  Statement of Licensure Violations  300.1210b) 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. Restorative measures shall include, at a minimum, the following procedures:  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.	S9999	<h2>Attachment A</h2> <h3>Statement of Licensure Violations</h3>	

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

TITLE

(X6) DATE

09/05/17

Illinois Department of Public Health

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S9999	<p>Continued From page 1</p> <p>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)</p> <p>These requirements were not met as evidenced by:</p> <p>Based on record review and interviews, the facility failed to maintain a door alarm in the "on" mode for one (R1) of three residents sampled for fall risk. On 7/28/17 R1 wheeled self into the back stairwell on the third floor and fell down one flight of stairs. R1 suffered a "Left parafalcine acute subdural hematoma and Intraventricular hemorrhage."</p> <p>Findings include:</p> <p>R1's current Minimum Data Set (MDS) dated 5/23/17 notes R1 to have a diagnosis of Alzheimer's disease and Parkinson's disease. MDS notes that R1 has a history of wandering and uses a wheelchair for means of mobility. R1 scored a five out of a total of 15 on the BIMS (Brief Interview for Mental Status) test, indicating that R1 is severely cognitively impaired.</p> <p>Facility incident report form dated 7/28/17 reads, "Resident (R1) had fall evening of 7/28/17. Physician notified and order received to send resident (R1) to ER due to hip discomfort. Neuros and vitals WNL (within normal limits) immediately follow. Pelvic x-ray - (negative) at ER, however CT (Computed Tomography Scan) noted multiple hematomas/Hemorrhages."</p> <p>Hospital Neurological notes that R1 had, "Fall with Left parafalcine acute subdural hematoma,</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>Intraventricular hemorrhage."</p> <p>On 8/17/17 at 2:20 P.M. E6 (Certified Nurse's Aide) stated that on 7/28/17 at approximately 6:30 P.M., staff noticed that R1 was unable to be located. At that time a facility wide search began. At approximately 6:42 P.M. R1 was found by E6 in the back stairwell, lying at the landing of the stairwell and bleeding from R1's head. E6 stated that R1's wheelchair was at the top of the stairs and the alarm on the door to the stairs had been shut off. E6 stated that R1 was confused and unable to state what exactly had happened. E6 stated that the door alarm is never to be shut off in order to alarm if a confused resident was to open the door.</p> <p>On 8/11/17 at 11:10 A.M. E1 (Administrator) stated that through her questioning staff, E1 had found out that staff must have shut off the alarm prior to R1 opening the door and falling down the back stairwell. E1 stated that the door alarm should not have been turned off and that the alarm has been glued permanently in the "On" position.</p> <p>(A)</p>	S9999		
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