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
	IL6000301	A. BUILDING: ______ B. WING ______	C 07/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF CHAMPAIGN	309 EAST SPRINGFIELD CHAMPAIGN, IL 61820

(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	Final Observations	S9999		

STATEMENT OF LICENSURE VIOLATIONS:

300.1210b)
300.1210d)3)
300.1210d)6)
300.1220b)2)
300.1220b)3)
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.
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:
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.
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

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/31/15

Illinois Department of Public Health

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S9999	Continued From page 1	S9999		

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:
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, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.
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.

These requirements are not met as evidenced by:

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S9999	Continued From page 2	S9999		

Based on observation, record review and interview the facility failed to implement increased security measures related to escalated exit seeking behaviors for one resident (R1) of eleven residents reviewed for exit seeking behavior. R1 entered a stairwell and was found sitting at the base of the stairs with injuries (closed head injury; hematoma of frontal scalp). The facility door alarm system failed to alert staff that R1 had entered a stairwell. This had the potential to affect 11 at risk residents (R1, R2, R3, R5, R6, R7, R10-R14).

The findings include:

R1's July 2015 Physician Order Sheet lists diagnoses that includes: Traumatic Brain Injury (TBI), Epilepsy, Grand mal status, Anxiety State, Depressive Disorder and other signs and symptoms involving cognition. The quarterly Minimum Data Set (MDS)dated 5/21/15 identifies R1 with severely impaired cognitive skills for daily decision making. R1 displays inattention, disorganized thinking, physical and verbal behavioral symptoms directed towards others 1-3 days per week. R1 is assessed as wandering on a daily basis. The MDS documents R1 requires extensive assistance of two persons for bed mobility and transfers between surfaces. R1 did not walk during the assessment and is independently mobile via wheelchair. R1 has upper and lower extremity impairment on one side. R1 had two falls with no injury during the assessment period.

R1's Progress Notes dated 7/5/15 at 8:40 am (LPN) E9 documented "Writer heard door alarm sounding. Patient was on north stairwell in

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S9999	Continued From page 3	S9999		

wheelchair. Redirected by two other staff members without difficulty. Encourage patient to wait in line to be transported."

On 7/5/15 at 9:57 am E9 documented "Patient becoming aggressive with staff making contact with (Certified Nurse Aide) CNA (E12)..Patient pushing on dining room door. Redirected from dining room door. Wheeled back to bedroom. Resident calm after contacting mother."

On 7/5/15 at 3:15 pm Registered Nurse (RN) E8 wrote " South elevator alarm is sounding and see pt(patient) enter the elevator and go there and get him out with another nurse aid. Tell pt not to get out and keep monitoring."

On 7/5/15 at 3:40 pm E8 documented " keep monitoring pt and see pt wheels (self) around the floor. I give 4 pm meds (medications) for (R4). After the meds given and I get out from the room and immediately go to look for (patient) pt. When I do not see the pt and sent two nurse aides (E6, E7) to look for and at same time I make a head count order through the phone...I hear (E6) call me at north stair door (third floor). I rush there and see a wheelchair lean forward at north entrance and then see the pt is sitting on the stair facing the second floor entrance..the nurse (E5) is assessing the patient..is alert and answers questions...slight skin abrasions noted at right hand and both knees, a red spot with a small skin cut noted at left front head, all extremities movable and help the pt walk down to second floor and put (R1) in (wheelchair) and back to 3rd floor."

The progress notes dated 7/5/15 4:20 pm document the physician Z2 was notified and a new order was given to send R1 to the

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emergency room for evaluation. R1's mother (Z1) was also notified of the transfer.

The Hospital Emergency Department Assessment dated 7/05/15 states "1. Closed head injury without loss of consciousness... 2. Fall down stairs...3. Hematoma of frontal scalp."

The 7/6/15 progress notes document R1 returned to the facility at midnight. On 7/6/15 7:21 am progress notes state "resident redirected from south stairwell. Patient pushed door. "... 7:45 am "Resident redirected from south elevator on third floor, Yelling out, " I want my mother, I want to go home." The 7/6/15 10:30 pm progress notes state " Patient is alert and sitting in wheelchair, ..15 minutes checking. pt wheeled himself most of the time but still had 4 times of trying to get in elevator and one time to open south stair door.."

On 7/7/15 at 2:15 pm Director of Nurses E2 stated on Sunday 7/5/15 she was notified by Nurse Manager E3 that R1 had gotten into the North Stairwell and they found him sitting on the stairs. They notified the doctor and an order was given to send R1 to the emergency room to be evaluated. E2 stated R1 did not have any major injuries.
E2 stated the protocol is if they have a person trying to leave the facility they assign a "1:1 alarm buddy" (staff member) to watch the resident until the behavior subsides and then the 1:1 is discontinued. E2 stated at that time it is not unusual for R1 to try to exit the floor on the elevator and R1 has pushed the stairwell doors open before. E2 stated she had personally witnessed R1 on the stairs on July 1, 2015. E2 heard the north stairwell alarm going off and went to the stairwell where she found R1 inside the stair well standing up out of the wheelchair. E2

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stated the staff was able to remove R1 from the stairwell and take R1 back to his room. E2 stated they placed R1 on 1:1 supervision at that time until the behavior subsided. E2 stated on 7/07/15 at 2:20 pm that R1 is no longer on 1:1 supervision.

There were no progress notes for 7/1/15, 2015 in R1's chart about R1 being found in the stairwell or that any 1:1 monitoring was being conducted. The 7/1-7/6 progress notes also make no mention of any 1:1 alarm buddy assignment after R1's attempts to leave the unit.

On 7/08/15 at 12:45 pm E2 stated she did not document the incident in the progress notes and E2 did not know why the nurse had not documented the 7/1/15 incident and interventions in R1's record.

On 7/8/15 at 1:00 pm E2 provided a written statement that E2 had heard the alarm on 7/01/15 at 1:45 pm and had observed a wheelchair inside the north stairwell landing and saw (R1) was standing on the landing about three steps down. E2 wrote she called for assistance and they walked (R1) back up the stairs and put (R1) in the wheelchair. E2 had written "(R1) was just standing and he was holding onto the stairwell with his right hand. " E2 wrote "When asked (7/01/15 approximately 1:45 pm) what (R1) was doing (R1) responded (R1) wasn't sure."

Registered Nurse (RN) E5 confirmed on 7/7/15 at 4:40 pm that E5 was working on the second floor and assessed R1 on 7/5/15 after being notified that R1 had fallen in the stairwell. E5 found the wheelchair at the top of the third floor landing and R1 was sitting at the top of the stairs on the second floor landing. E5 stated that R1 stated

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that he had fallen on the stairs. E5 stated R1 became really agitated and was yelling that (R1) didn't want to be there and to leave (R1) alone. R1 had an area on forehead and lip that E5 showed to RN E8 who came down from the third floor and took over R1's assessment.

Certified Nurse Aide (CNA) E6 confirmed on 7/08/15 at 10:00 am that E6 was working on the third floor 2-10 pm shift on 7/5/15. E6 stated earlier in the shift, R1 really wanted to talk to his mother and they assisted R1 to dial the number, with no answer. E6 said R1 was upset and went to the elevators twice. E6 left R1 with Registered Nurse (RN) E8 to answer call lights and was in a resident room when Nurse E8 asked if E6 had seen R1. E6 started looking for R1 and went to the North Stairwell door window and saw R1's wheelchair tipped forward at the top of the stairs on the landing. E6 saw R1 sitting at the top of the second set of stairs facing the second floor landing. E6 had not heard any stairwell door alarm sound.

On 7/8/15 at 11:15 pm CNA E7 stated E7 had come to work on 7/5/15 at 2:30 pm and was assigned to R1. E7 stated she was informed during report that R1 was having a bad day and R1 had been trying to get out of the dining room exit door earlier. E7 stated "All the staff have to keep an eye on (R1) because no one is assigned to do one to one monitoring of R1 any more. E7 stated "Somedays (R1) just wants Mom and will do anything to talk to her." E7 had last seen R1 at the Nurses Station by R1's room. E7 stated about ten minutes later Nurse (E8) was looking for R1. E7 had not heard any door alarm sound so E7 went down the North elevator. E7 stated as the elevator passed the second floor she could hear a staff calling for help stating the R1 was on

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the stairs. E7 stated R1's wheelchair was at the top of the third floor landing, the wheels were locked and the chair was tipped forward. E7 stated it looked like R1 had slid out of the wheelchair as the chair pad was on the stairs towards the bottom of the landing. E7 stated "We always listen for the alarms and we did not hear anything."

On 7/8/15 at 1:15 pm Licensed Practical Nurse (LPN) E9 stated she was working on 7/5/15 on the day shift. R1 was in the North Stairwell landing with the wheelchair. R1 had pushed open the door and R1 was found in the wheelchair on the landing and had not gotten to the stairs. E9 stated they did not implement 1:1 supervision of R1 after the incident. E9 stated "We all keep an eye on (R1) that's all we can do, we have several residents with (electronic monitoring bracelets) on the floor.. all you have to do is push on the stairwell door and it opens there are no locks, just an alarm that sounds different from the elevator alarm." E9 stated she did give report to second shift to watch (R1) because "(R1) was on the move."

The exit seeking profile book on 7/7/15 contained information for 10 residents (R1, R2, R3, R5, R6, R10-14) assessed at risk of exit seeking. R1's resident information profile did not include any information about repeated exit seeking attempts via stairwells and elevator. The facility added R7 to the list of at risk residents on 7/8/15 after an attempt to exit on the elevator.

On 7/7/15 at 1:45 pm the third floor north stairwell door was opened without putting in the bypass code. The door alarm sounded. The door opened onto a landing that was approximately 8-10 feet to the edge of a set of nine stairs that led to another

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landing and set of nine stairs to the second floor floor stairwell door. The stairwell is at the north end of the third floor not visible from the nurses station. There were two additional stairwell doors on the south end of the third floor that are also equipped in the same manner.

Maintenance Director E4 stated on 7/7/15 at 1:45 pm the doors to the stairwells on the second and third floor are alarmed with a door alarm but is not equipped with an electronic monitoring system or any magnetic lock system. E4 stated "I was asked to come in on Sunday morning (7/5/15) to change the egress code for the Dining Room Exit door because (R1) was trying to open the door. "

On 7/08/15 at 12:00 pm E4 stated he was not aware that R1 had gotten into the North Stairwell with out the door alarming. E4 was not informed or called in on 7/5/15 to check the alarms or change the bypass codes on the third floor stairwells. E4 checked all the doors including the stairwell doors during his routine check on Monday 7/6/15 and stated the alarms were functioning properly.

On 7/07/15 at 2:00 pm R1 was sitting in a wheelchair in the first floor lounge with Z1 (family). R1 was noted to have a 1/4 inch scabbed cut on his left forehead. There was no bruising around the area.

On 7/8/15 at 9:00 am R1 was asked about the fall in the stairwell. R1 denied getting in the stairwell or having a fall. R1 denied knowing how to put in an alarm code to enter the stairwell. R1 showed a scrape on his hand and stated did not know how the scrape got there.

R1's Care Plan dated 4/15/15 states

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"Wandering/Pacing related to:TBI (Traumatic Brain Injury), cognitive impairment, (electronic monitoring device) applied. Goal: Will wander only within certain boundaries. Interventions allow to wander in hallway on 3rd floor only. Redirect as needed..reassess daily for need for 1:1..Resident will be monitored frequently after 1:1 is completed. "

R1's 4/15/15 Care Plan states "Elopement risk (impulsiveness, mobility, easily confused/disoriented, history of elopement, cognitive loss r/t traumatic brain injury) related to:cognitive impairment." The approaches included activities that could be offered to R1 to redirect or engage resident. There was no intervention of increased supervision during exit seeking behaviors. R1's Care Plan did not address R1's repeated attempts to leave the third floor via the elevator or stairwells, the fall in the stairwell or any new interventions to prevent R1 from entering the stairwells without staff knowledge.

The facility Wandering Practice Guide dated 4/2008 states "Safe Wandering Interventions..Reassess patients with exit seeking/unsafe wandering behaviors regularly..During periods of agitation or increased frequency of behaviors the following interventions can be helpful in managing behaviors like exit seeking/unsafe wandering and may include, but are not limited to: one to one supervision; "an alarm buddy", supervised walking, activities based on patients personal preference.."

(A)

IMPOSED PLAN OF CORRECTION

NAME OF FACILITY: Heartland of Champaign

DATE AND TYPE OF SURVEY: Complaint 1563588/IL78424 conducted July 14, 2015

300.1210b)
300.1210d)3)
300.1210d)6)
300.1220b)2)
300.1220b)3)
300.3240a)

Attachment B
Imposed Plan of Correction

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.

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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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:

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, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

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.

This will be accomplished by:

I. All residents will be assessed to determine safety risk related to exit seeking behavior and results will be incorporated into individual care plans. If exit seeking behaviors are noted, increased security measures will be implemented until the resident no longer exhibits the behavior.

II. All policies and procedures related to the assessment and supervision of residents with exit seeking behavior will be evaluated and revised as needed to ensure compliance with Illinois Skilled Nursing and Intermediate Care Facilities Code. The facility will consult with the manufacturer, supplier or installer of the door alarms to ensure effective operation and maintenance of the alarms. The facility will develop and implement a preventative maintenance program to ensure the operation of the door alarms. This maintenance plan will also provide for a system to report immediately any door alarms that are not functioning to the administrator or responsible staff in the administrator's absence. The facility will develop and implement an action plan for the provision of resident safety to implement if the door alarms are not functioning.

III. All staff will be in-serviced on policies and procedures pertaining to the recognition and supervision of residents with exit seeking behavior, increased security measures to be implemented when a resident exhibits exit seeking behavior, appropriate actions concerning the operation and maintenance of door alarms, and the action plan to be implemented when a door alarm fails.

IV. Documentation of in-service training, assessments, policy and procedure review and development, and related follow up actions will be maintained by the facility.

V. The Administrator and QA committee will monitor items I through IV to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Within 10 days of receipt of this notice.

9/1/15/lo

Attachment B
Imposed Plan of Correction