

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004907	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/01/2018
NAME OF PROVIDER OR SUPPLIER JERSEYVILLE NSG & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SOUTH STATE STREET JERSEYVILLE, IL 62052		
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S 000	Initial Comments Complaint # 1843403/IL102898	S 000			
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)d)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	S9999			

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

06/19/18

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S9999	Continued From page 1 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 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	S9999			

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S9999	Continued From page 2 These Regulations are not met as evidenced by: Based on interview, observation, and record review, the facility failed to implement interventions and provide supervision to prevent falls for 2 of 10 residents (R1, R2) reviewed for falls in the sample of 16. This failure resulted in R1 sustaining a laceration to her right eye brow requiring 8 sutures, and R2 receiving a right hip fracture that required surgery. Findings include: 1. R2's Face Sheet, dated April, 2018, documents R2 was admitted to the facility on 4/17/18. R2's Minimum Data Set (MDS), dated 5/15/18, documented R2 having a Brief Interview for Mental Status (BIMS) score of 5, indicating severely impaired cognition. The MDS further documents R2 requiring assist with transfers, locomotion on and off the unit, and identifies R2 as being unsteady and only able to stabilize with staff assistance for balance and walking. R2's Physician Order Sheet (POS), dated April-May 2018, documented R2 having a history of falling and a diagnosis of a left hip fracture prior to admission to the facility. R2's initial Fall Risk Assessment, dated 4/17/18, documented in part, R2 having had 3 or more falls in the past 3 months. R2's Fall Risk Assessment dated 4/28/18, documented in part, a score of zero, indicating R2 not having any falls in the past 3 months. R2's Fall Risk Assessment dated 5/20/18, documents R2 having a score of	S9999			

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S9999	Continued From page 3 2, indicating 1 to 2 falls in the past 3 months. R2's Incident/Occurrence Report, dated 4/28/18 at 5:10 AM, documented R2 was found sitting on floor next to bed, with her incontinent brief removed. The Incident Report also documented interventions in part, "Canoe mattress for residents bed and more frequent checks." R2's Care Plan does not reflect an intervention for R2's fall of 4/28/18 until 5/1/18, which does not include frequent checks. R2's Incident/Occurrence Report, dated 5/20/18 at 7:19 PM, documents R2 was witnessed on floor during evening dining hour. The report also documents, R2 was assisted back to bed. The Report further documents R2's family and physician were notified of the incident. R2's Pain Assessment, dated 5/20/18, documents R2 having a pain rating of 2, with the description of "hurt," and location of her right leg. R2's May 2018 Medication Administration Record (MAR) documents, "Acetaminophen Oral Tablet 500 MG (milligrams) one tablet every 4-6 hours as needed for pain." The MAR further documents R2 may receive Acetaminophen 650 mg one suppository per rectum as needed every 4 to 6 hours for pain. The MAR does not reflect R2 received any pain medication after the 5/20/18 incident. R2's Progress Note, dated 5/21/18 at 4:40 AM, documented that R2 notified staff that her incontinent brief was wet. The note also documented, "when CNA (Certified Nursing Assistant) attempted to change resident, resident began screaming in pain and holding right leg, hip	S9999			

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S9999	Continued From page 4 area." The note further stated R2 was noted to have external rotation with shorting noted to her right leg, and resident "protecting" her right leg. R2's Progress Note, dated 5/21/18 at 11:06 AM, documents in part, "(R2) was admitted with hip and pelvic fracture. Will be receiving surgery on 5/22/18." R2's Incident/Occurrence Report new interventions, dated 5/22/18, documented, "Anti roll backs installed on wheelchair." On 5/29/18 at 3:00 PM, V15 and V16, CNA's, were attempting to transfer R2 from the bed to bathroom, and R2 began to stand without assist. V15 and V16 redirected R2 to not stand up from bed until assisted. V15 and V16 stated they care for R2 on a frequent basis when working and that R2 continues to self transfers at times. On 5/29/18 at 3:15 PM, V17, CNA, stated she was assisting residents within the central dining room on 5/20/18 around 6:30 to 7:30 PM, when she observed R2 sitting on the floor. V17 stated she informed V8, Licensed Practical Nurse (LPN), of the incident. On 5/30/18 at 10:15 AM, V8, LPN, stated during the 5/20/18 incident, R2 was assisted back into her wheelchair. V8 further stated she performed an assessment and re-located R2 to front of nurse's station. V8 stated she did perform a total body assessment and obtained vital signs, but did not document it. On 5/30/18 at 9:35 AM, V14, LPN, stated R2 self transfers without requesting assistance even prior to right hip fracture.	S9999			

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S9999	Continued From page 5 On 5/29/18 at 9:25 AM, V3, LPN, stated the new frequent check intervention for R2's fall of 4/28/18, could not be presented for review, as it was not documented. On 5/30/18 at 11:50 AM, V3, LPN, stated she was aware R2's Care Plan having an intervention of frequent checks for R2's initial fall on 4/28/18, and being the only intervention prior to the incident of 5/20/18, in which R2 sustained a right hip fracture. On 5/31/18 at 2:15 PM, V3, LPN, stated she was aware of R2 having a Left hip fracture prior to admission to facility on 4/17/18. 2. R1's Care Plan, dated 1/30/2018, documented in part, R1 being admitted to the facility for skilled nursing and therapy services, with contributing factors including, "fractured pubis, dementia, anxiety." R1's Care Plan, edited on 4/18/2018, documented in part, "Problem: Psychoactive medication (R1) receives psychoactive med to treat anxiety and depression, placing her at risk for significant side effects from med. Monitor for dizziness; (sig) lightheadedness." R1's Care Plan, edited on 5/15/2018, documented in part, "(R1) is at risk for falls or trauma, r/t (related to) unsteady balance, and use of multiple meds & dx (diagnoses) which include: hx (history) of falls prior to facility admit, use of psych (psychotic) medications." R1's POS, dated 1/30/18, documented R1 having received an order for the antipsychotic Risperdal 0.25 mg daily and the antidepressant medication Trazodone Hydrochloride 50 mg at bedtime.	S9999			

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S9999	Continued From page 6 The Falls Details Report, dated 3/3/18 at 5:45 AM and 3/22/18 at 6:15 AM, documented R1 was "visually observed on floor," in her room. Interventions listed for 3/3/18 was to lower R1's bed and "Res (resident) was advised on the importance of using call light for help." R1's MDS, dated 5/4/18, documented a BIMS score of 4, indicating severely impaired cognition. The MDS also documents R1 requiring extensive assistance of two for toileting and bed mobility, transfers, and uses a wheelchair for mode of transportation. The MDS further documented R1 having limitations to her lower extremity (hip, knee, ankle, foot), being unsteady and only able to stabilize with staff assistance for balance and walking, and being frequently incontinent. R1's Care Plan, edited 4/18/2018, documented R1's approaches in part as, "Assure safety prior leaving room, and place any requested or anticipated item in esy (sig) reach, such as, not limited to: bedside table." R1's Incident/Occurrence Report, dated 5/10/18 at 6:00 AM, documented in part, "Noted Res laying on Rt (right) side," with incident occurring in her room. The Report further documented R1 was unable to participate in a pain assessment "due to dementia." The Detailed Incident Summary, dated 5/11/18 at 3:15 PM for incident occurring 5/10/18, documented in part, "(R1) was found laying on the floor next to bed. Resident was on her landing strip next to her bed, however she had struck her head on a night stand next to her bed. Resident stated 'she needed to go to the bathroom.' BM (bowel movement) on the floor when fall occurred. Ambulance called for	S9999			

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S9999	Continued From page 7 laceration to right eyebrow." The Summary was authored by V2, Director of Nursing (DON). R1's Progress Notes Report, dated 5/10/18 at 10:30 AM, documented in part, "ER (Emergency Room) called to notify res received 8 sutures to laceration above right eye." R1's Progress Notes Report, dated 5/17/2018 at 1:13 PM, documented R1 had 8 sutures removed. On 5/30/18 at 5:50 PM, R1 was sitting in the dining room eating her dinner, with her legs crossed eating fish and drinking from her cup during the evening meal. On 6/1/18 at 11:10 AM, R1 was sitting in her wheelchair in her room, and was pleasantly confused. She had bruising and a scar noted to the right upper corner of her eye, and the bruising appeared to be resolving. She was unable to answer how she sustained the injury to her eye, and was not able to utilize her call light when asked if she could use the light. On 5/31/18 at 2:00 PM, V3, LPN, stated after R1's fall of 5/10/18, the facility implemented having R1 be one of the first residents up in the morning, to have staff toilet her upon rising, hourly bed checks from 9:00 PM until 6:00 AM, as well as moving her environment so as to not have the bedside table next to her bed. V3 further stated the facility did not have documented frequent checks, but that facility is now ensuring the hourly checks are documented. On 5/31/18 at 8:55 AM, V20, Physician for R2 and on-call physician for R1, stated he would expect the facility to follow interventions	S9999			

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S9999	Continued From page 8 implemented for fall prevention for residents. The Facility's Incident Report Tracking and Analysis policy and procedure, dated July 2014, documents in part, "Policy: It is the policy that incidents will be tracked and analyzed for trends and patterns to aide in preventing future reoccurrences." It continues under Procedure: "8. The tracking log, and analysis sheets should be retained so it can be analyzed for patterns or trends. Look for patterns in the time of day." It further documents, "10. Once the analysis is completed an action plan is created to address any patterns. On an individual basis, the resident with numerous falls is referred to the Fall Program for intervention." The Facility's Falls Management policy and procedure, dated December 2016, documents in part, "It is the policy to assess and manage resident falls through prevention, investigation, and implementation and evaluation of interventions. Unless there is evidence suggesting otherwise, when a resident is observed on the floor, a fall is considered to have occurred. iv. Action Taken - list any steps that were taken after the fall to care for the resident." The Facility's Fall Program policy and procedure, dated July 2014, documents in part, "Policy. The Program is designed to decrease the number of falls in the facility. An episode where a resident lost his/her balance is considered a fall. The risk for fall will be addressed on the resident's plan of care and discussed with the interdisciplinary team. It continues, "6. Each resident on the program will be monitored to ensure:" and continues, "b. Pathways in the room are clear and free of clutter. 7. Facility staff will assist in monitoring residents."	S9999			

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JERSEYVILLE NSG & REHAB CENTER

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S9999 Continued From page 9

S9999

The Facility's Facility Self Report policy and procedure, dated July 2014, documents in part, "7. The reporting facility's documentation must include the following information:" and continues, "c. A description of the resident(s) injury. d. What corrective action the facility has taken to prevent the incident from reoccurring."

(B)