

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002729	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/04/2018
NAME OF PROVIDER OR SUPPLIER EDWARDSVILLE NSG & REHAB CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 401 ST MARY DRIVE EDWARDSVILLE, IL 62025		
(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
S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610 300.1210a) 300.1210b)5) 300.1210c) 300.1210d)3)6) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a	S9999		

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health

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

TITLE

(X6) DATE

05/25/18

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S9999	Continued From page 1 comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,	S9999			

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S9999	Continued From page 2 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations were not met as evidence by: Based on observation, interview and record review, the facility failed to provide supervision, reassess, monitor effectiveness of interventions and revise interventions as needed to prevent falls for 1 of 2 residents (R20) reviewed for falls in the sample of 28. This failure resulted in R20 falling multiple times and sustaining a left clavicle fracture, multiple hematoma's to the head and multiple bruises over the body and skin tears. Findings include: The Physician's Order Sheet (POS), dated 05/02/18, documented R20 had the following	S9999			

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S9999	Continued From page 3 diagnoses, in part as, Dementia with behaviors, Cerebral Ischemia, Aphasia, Alzheimer's Disease, Insomnia, Major Mood Disorder, Anxiety Disorder and Psychosis not due to substance or known psychotic condition. R20's Minimum Data Set (MDS), dated 02/06/18, documented R20 had a Brief Interview for Mental Status (BIMS) score of 2, indicating (R20) was severely cognitively impaired. The MDS documented R20 required supervision while walking in the corridor and required extensive assist of at least one staff for eating, dressing, toilet use and personal hygiene. The Care Plan, dated 04/15/18, documented R20 was identified as being at risk for falls related to wandering, impaired safety awareness, incontinence, psychotropic medications, falls. It documented R20 has a shuffling, left side leaning gait especially when tired. There were multiple interventions, in part as, one on one for one hour, neuro checks, direct supervision and to assist to supervised area and give a busy box for activity. On 4/24/18 at 9:00 AM, R20 was observed in bed on R20's back fidgeting with the blankets. Upon entering the R20's room and greeting R20, R20 did not respond or answer/respond to any questions. On 4/24/18 at 12:00 PM, R20 was observed sitting in regular chair at the assisted table in dining room waiting on lunch service. R20 was served the lunch meal at 12:30 PM. At 1:30 PM, R20 was observed wandering ambulatory up and down hallways unassisted by staff. There were no staff specifically supervising R20. R20 had a blank stare with shaking jaw and would drool at times.	S9999		

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S9999	Continued From page 4 On 04/25/18 at 9:25 AM, R20 was ambulating up and down halls. R20 occasionally would go into other resident's rooms. R20 was observed with R20's bottom lip/jaw shaking and drooling. At times staff will wipe R20's chin. At 1:20 PM, R20 was observed ambulating up and down C hall unassisted. R20 was ambulating with head down looking at floor. At 1:30 PM, R20 was observed ambulating down D hall and wandered into Room D-10, stood with blank stare at the resident who was in bed asleep and then walked out. There was no staff in the hallway at this time supervising R20. On 4/25/18 at 2:14 PM, R20 was observed wandering up and down hallways without staff supervision and wandering in and out of other resident's rooms. There were no observed times during the survey that R20 was assisted to a supervised area and/or given an activity to do. Nurse's notes from 06/01/17 to 05/02/18 documented 26 falls with varying injuries, including skin tears, bruises, Wheaton's and fracture of left clavicle. R20's Nurse's Note, dated 6/9/17 documented "resident found lying on floor in bedroom." The Note documented resident was put in site of nurse and staff would continue to monitor. On 08/14/17 at 12:00 PM, a Nurse's Note documented R20 had fallen and staff had heard R20's head hit the floor. It documented a hematoma to the left side of head. Also on 08/14/17 at 3:21 PM, a Nurse's Note documented R20 fell resulting in a two inch skin tear right arm. Both of these Nurse's Notes documented R20 would be placed on 30 minute visuals for the next	S9999			

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S9999	Continued From page 5 three days. R20's Nurse's Note, dated 8/14/17 at 4:59 PM, documented R20 tripped over another residents wheelchair and slid down the door and hit R20's right arm. The Note documented R20 sustained a two inch skin tear to R20's right arm. The Note documented "New order to monitor T/H." On 10/13/17, a Nurse's Note documented R20 fell hitting head and causing a left sided hematoma to the head. The Note documented after the incident R20 was placed on one to one with nurse." R20's Care Plan, with addition made on 10/13/17, documented "Tripped over chair at nurse's station. Hematoma I (left) side of head (now resolved)." The Care Plan Intervention, dated 10/16/17, documented "Stationary easy chair." R20's Nurse's Note, dated 11/10/17 documented R20 fell while reaching for a blood pressure cuff. The Note documented R20 fell forward and hit R20's head on the wall. The Note documented R20 was placed on one to one with the nurse. R20's Care Plan Intervention, dated 11/10/17 documented "Will offer busy box throughout the day." The facility had no documentation they completed investigation into the falls above to determine root cause analysis of falls and to determine if interventions were effective or needed to be revised. The only incident/accident report investigation provided by the facility as evidence of completed investigations for these falls was the incident which occurred on 02/06/18 that resulted in R20 sustaining a fracture.	S9999			

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S9999	Continued From page 6 The Preliminary Report to Illinois Department of Public Health, dated 02/06/18 was faxed to the Department at 11:33 PM. It documented on 02/06/18 at 11:00 AM, R20 fell while ambulating down hallway. It documented the physician was not notified until 10:00 PM that evening at which time an X-ray was ordered of the left shoulder. The Bio Tech X-ray report, dated 02/06/18, documented a distal clavicular fracture of the left shoulder. On 02/06/18 at 11:00 AM, a Nurse's Note documented R20 was ambulating quickly down the hallway, lost footing and fell into the wall hitting shoulder and head. It further documented noting a bump to left side of head and slight redness to left shoulder. Interventions were one on one with nurse for an hour, offer snack and drink and toilet. Nurse's Notes also documented R20 had fallen on 02/05/18 and 02/07/18 with no apparent injuries. Interventions for 02/05/18 were to toilet as needed and there were no documented interventions for 02/07/18. R20's Care Plan Intervention, with initiation date of 2/7/18, documented "direct supervision when up/amb (ambulating)." On 04/27/18 at 10:30 AM, V1, Administrator, stated that there were no other records/investigations the facility had on the other 25 falls. On 04/27/18 at 3:00 PM, V18, CNA stated R20 "Falls all the time." She said "sometimes (R20) was hard to keep track of because R20 wanders everywhere." On 05/02/18 at 12:40 PM, V16, Physician, stated	S9999			

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S9999	Continued From page 7 the facility does not have enough staff to supervise 100% of the time due to staff cuts, call-offs and simply being busy with other residents. V16 stated V16 was told that restraining a resident with a lap cushion or other devices to prevent falls was illegal. After explaining to V16 that this was not true, V16 said that's probably the only way to keep R20 from falling. V16 stated R20 does not have safety awareness due to decreased cognition. The Falls Clinical Protocol, dated September 2012, documented under "Treatment/Management: 1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling." (B)	S9999			