

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002950	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/09/2018
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

FAIR HAVENS CHRISTIAN VILLAGE

**1790 SOUTH FAIRVIEW AVENUE
DECATUR, IL 62521**

(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 First Certification Revisit to Survey date 6/20/18 Facility Reported Incident of 5/21/18/IL103326	S 000		
S9999	Final Observations Licensure Violation 300.1210a) 300.1210b)5) 300.1210c) 300.1210d)6) 300.3240a) 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 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	S9999		

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health

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

TITLE

(X6) DATE

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S9999	Continued From page 1 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, 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 300.3240 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 interview and record review the facility failed to use a gait belt during a transfer for one of	S9999			

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S9999	Continued From page 2 four residents (R15) reviewed for falls on the sample of 15. This failure resulted in R15 sustaining a laceration to the head which required emergency services for staples. Findings include: R15's plan of care for falls dated 6/11/18 documents R15 is at risk for falls related to muscle weakness, anxiety, degenerative arthritis, fatigue, history of falls, chronic pain, wheelchair use and assistance required for activities of daily living. R15's plan of care documents an intervention dated 6/18/18 that states, "Staff to provide extensive assistance of one (person) with a gait belt and wheelchair." R15's Incident/Accident Report or Unusual Occurrence report dated 8/3/18 documents on 7/30/18 at 6:29 PM, "(R15) was being assisted to the bathroom by a staff member (V11) (Certified Nurse's Assistant) when (R15's) legs gave out and (R15) missed the handle to the commode." This report also documents that R15 had a laceration to the back of head and was sent to the emergency room for evaluation. R15's emergency room notes dated 7/30/18 documents R15 has a laceration to the back of the head and is noted to have pain to the back of the head. This report also documents that two staples were used for the closure of the laceration to the back of the head. R15's post fall investigation form dated 7/30/18 documents that a gait belt was not used. R15's post fall huddle form dated 7/30/18	S9999			

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S9999	Continued From page 3 documents under how to prevent further falls that, "educating (R15)/care giver on proper safety and making sure gait belt is used during transfers." On 8/18/18 at 2:03 PM, V11 stated on 7/30/18 V11 transferred R15 from the wheelchair to the toilet. V11 stated R15 was almost to the toilet when R15 stated R15 just couldn't do it. V11 stated R15 leaned towards and collapsed and R15 hit head on the door frame in the bathroom. V11 stated V11 did not use a gait belt during the transfer. V11 stated R15 buckles R15's legs frequently and R15 has been weaker. V11 stated that a gait belt was supposed to be used for transfers with R15. On 8/18/18 at 4:16 PM, V12 Registered Nurse/Unit Supervisor stated V12 investigated the R15's 7/30/18 fall. V12 stated R15 fell on 7/30/18 due to losing balance in the bathroom. V12 stated V11 assisted R15 with the transfer. V12 stated V11 did not use a gait belt when V11 transferred R15. V12 stated if any resident requires assistance then a gait belt should be used. V12 stated if V11 would have used a gait belt when transferring R15 then V11 would have been able to hold onto R15 better. V12 stated that R15 sustained a laceration due to the fall. V11's Disciplinary Report form dated 7/30/18 documents that V11 failed to use a gait belt with a resident (R15) during transfer causing injury. (B)	S9999			