| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145804 | A. BUILDING ______ B. WING ______ | C 04/12/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FAIRVIEW BAPTIST HOME | 250 VILLAGE DRIVE DOWNERS GROVE, IL 60516 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br>Investigation of Complaint #0670901 / IL21596<br><br>Fairview Baptist Home is in compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities.<br><br>A Partial Extended Survey was conducted. | F 000 | | |
| F9999 | FINAL OBSERVATIONS<br>LICENSURE VIOLATIONS<br><br>300.1210a)<br>300.1210b)3)<br><br>Section 300.1210 Nursing and Personal Care<br><br>a) The facility must 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 assessment and plan of care. 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.<br><br>b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:<br>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. | F9999 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Examples include:

Based on record review and interviews the facility failed to
Continually assess, monitor and document on 2 residents following injury and complaints of pain. This is for R1 and R3.
Notify 2 residents' physicians fully of a change in condition resulting from injuries. This is for R1 and R3.
Failed to notify family member of one resident's change of condition. This is for R1.

These failures resulted in:
R1 initially sustaining a spiral leg fracture and then having this same leg discovered to be outwardly rotated and at 90 degree angle at the knee. R1 expired 3 days later.
R3 sustaining a hip fracture and not being diagnosed and treated for the fracture for 14 hours.
A delay of evaluation and treatment for R1's fractured leg and R3's fractured hip.

Findings include:

1. Review of most recent Minimum Data Set ( MDS) dated 11/26/05 shows that R1 was 99 years old and admitted to facility on 12/20/1998, and current diagnoses include diabetes, heart disease, arthritis and dementia. This MDS shows that R1 required limited assistance with bed mobility, transfers, and walking in the room.
Review of incident report dated 2/8/06 and signed by E1 (administrator) and E2 (former director of nurses and risk manager) shows that on 2/7/06 at 9:30pm R1 was found in bed to have a left swollen thigh that was internally rotated. R1

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| **FAIRVIEW BAPTIST HOME** | **250 VILLAGE DRIVE DOWNERS GROVE, IL 60516** |

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| F9999 | Continued From page 2<br><br>complained of pain with just a slight touch. This incident report indicates R1's family member and physician were notified at 10:35pm and 10:45pm, respectively. Review of facility's investigation summary dated 2/7/06 states that the evening shift nurses aide, E3 (CNA) was transferring R1 with a sit-to-stand lift when R1's legs slipped out from under her. Upon putting R1 to bed and getting her dressed for the night, E3 noticed R1's left hip was swollen. E3 notified the nurse (E6) on duty about R1's leg. E6 then requested that E7 ( nurse) come with her (E6) to assess R1's leg at 10:30pm. It was noted that R1's left leg was swollen and internally rotated. The plan was to keep the resident comfortable through the night. The investigation goes on to say that nothing unusual was identified through the night with R1 sleeping off and on and being given pain medication. However, the 11pm to 7am CNA (E5) stated that R1's left leg was externally rotated and at a 90 degree angle when she (E5) came on duty at 11:00pm. The facility investigation stated that no conclusion has been made as to how R1 's leg became externally rotated at the knee and at a 90 degree angle. Review of all investigative information, nurses notes, all documents related to incident, facility, police and surveyor interviews of involved staff, do not indicate when R1's left leg came to be in this position. Per this investigative summary, the facility terminated both the night shift CNA (E5) and LPN (E7, nurse ) due to the inability to account for R1's condition.<br><br>Interview with Z3 (R1's physician) on 3/27/06 at 10:30am stated that the facility called him (Z3) late at night on the night of the incident, around midnight or 12:30am. Z3 was told that R1's left leg had some pain and swelling but the facility did | F9999 | | |

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not make it sound like a major thing. Z3 said he did not hear back from the facility for the rest of the night. Z3 stated he received a call from either the facility or the family member just before he (Z 3) was going in to see R1, between 9 and 10am. This caller informed Z3 about the current position of R1's leg (externally rotated and at a 90 degree angle). Z3 stated he (Z3) would have sent R1 out for an evaluation if he (Z3) had been informed during the night of R1's current position of the left leg. Z3 stated that he (Z3) does not see how R1 could have gotten her left leg in the position it was found (externally rotated and at a 90 degree angle) by herself. Z3 also stated that this injury certainly expedited R1's death because she (R1) stopped eating and had to be managed on high doses of narcotics for pain control as a result of the leg fracture.

Interview with E3 (nurses aide) on 4/6/06 at 2:00 pm stated that she (E3) had been putting R1 to bed around 8:45pm on 2/7/06. E3 had R1 up in the EZ stand and was going to transfer R1 to the bathroom but decided against that when E3 noticed that R1's legs looked weak. E3 put R1 to bed and while getting R1 into her night clothes, E 3 noticed that R1's left thigh was slightly swollen and painful to the touch. E3 stated she (E3) went and asked the nurse to come look at R1's leg right away and that she (E3) does not know why the nurses would document that R1's leg was not assessed by the nurses until 10:30pm, one and a half hours later.

Review of local police department investigation dated 2/15/06 on page one states the Deputy Coroner contacted the police department on 2/13 /06 and stated that the the recent fracture of R1's

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left leg was a spiral fracture, meaning there had been some rotation to the leg when it was broken . This report also states that the coroner believes this fractured leg definitely contributed to R1's death. R1 expired on 2/10/06.

Interview with Z1 (detective) on 3/13/06 at 9:30 am stated she (Z1) was conducting a death investigation following contact from the county coroner's office regarding R1's death. Z1 stated she (Z1) had interviewed multiple staff who had been involved in the care of R1 on the evening of 2/7/06 and morning of 2/8/06. Z1 stated that the interviews were conflicting as to when the leg was discovered to be externally rotated and by whom. Most likely it happened sometime after the night shift came on duty and before the day shift came on duty.

Interview with E1 and E2 stated on 3/13/06 at at 3:00pm that that the facility was trying to figure out how the fracture occurred and how the leg got into an "L" shape position. E2 also stated that that the facility has no transfer policy. E2 stated there was no restorative or physical therapy assessment done on R1. There was no comprehensive assessment as to R1's mobility, transfer and weight bearing ability. This was confirmed by E1 and E2.

Interview with Z2 (family member) on 3/13/06 at 9 :15am stated that another family member contacted her (Z2) on 2/7/06 about the incident with R1. Z2 said she spoke with E7 shortly thereafter about 11:00pm and was told that R1 just had a little bit of pain in her left thigh along with some slight swelling but was resting comfortably. Z2 stated when she saw R1 the next

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morning around 9:00am, she (Z2) was shocked to see R1's left leg in the shape of an "L", bending the wrong way at the knee. Z2 said R1 looked like she was in horrible pain and asked her (R1) where it hurts and R1 replied "my leg, my leg." Z2 stated that it was never conveyed to her (Z2) the current position of R1's leg and the extent of the pain. Z2 said she would have come to the facility immediately had she been informed of the true extent of the injury.

2. Review of facility incident report to IDPH dated 3/30/06 states that on 3/21/06 R3 was observed leaning over to pick up an object when she tipped over and landed with her head resting against the wall....no complaints of pain and extremities moved without difficulty. Through the night R3 complained of lower back pain, was given pain meds and sent out the next morning, 3/22/06 at 8 :30am when the pain did not lessen. R3 was admitted for hip fracture that resulted in surgery.

Review of nurses notes dated 3/21/06 at 6:15pm state that R3 was reaching for an object on the floor when she (R3) fell on left side, hitting her head against the wall....complained of low back and hip pain. ... Noted vacant stare approximately 30 seconds. Resident was unresponsive to verbal stimuli.....Call placed to portable x-ray to obtain series of low back, skull, and left hip. There is no other documentation regarding the noted verbal unresponsiveness of R3 following the fall and striking of her head. The neurological flow sheet dated 3/21/06 does not mention this episode of verbal unresponsive. The nurses note at 6:50pm states that the MD was notified of the fall, there is no mention that the physician was notified about the verbal

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unresponsiveness.

Interview on 4/11/06 at 9:50am with Z4 (R3's physician) stated that whenever the facility notified him of R3's fall and complaint of low back and left hip pain is when he (Z4) gave the order to send R3 to the hospital for evaluation. R3 fell on 3/21/06 at 6:15pm but was not sent to the hospital for evaluation until 3/22/06 at 8:30am. Z4 also said he (Z4) believes the facility told him only about the fall and not about R3 hitting her head and becoming verbally unresponsive for 30 seconds immediately after the fall.

Interview with E1 on 4/10/06 at 11:30am stated that the STAT portable x-rays that were ordered for R3 on the evening of the fall, 3/21/06, were not done because the x-ray company has a problem getting x-rays done later in the day.

(A)