STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION
(Continuation Page)

ILLINOIS VETERANS HOME AT MANTENO — Facility Name
0042218 — I.D. Number

ONE VETERAN'S DRIVE, MANTENO, ILLINOIS 60950 — Address, City, State, Zip

02630 — Reviewed By
AUGUST 3, 2007 — Date of Survey

INCIDENT REPORT INVESTIGATION OF 4/29/07 (IL28470) — Type of Survey
02480, 02590 — Surveyed By

As a result of a survey conducted by representative(s) of the department, it has been determined the following violations occurred.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

340.1375a)3)A)
340.1375a)3)B)
340.1505a)
340.1505b)3)
340.1505e)

Section 340.1375 Personnel Requirements

a) Supervision of Nursing Services

3) The DON shall oversee the nursing services of the facility. This person's duties shall include:

A) Assigning and directing the activities of nursing service personnel.

B) Assuring that resident care plans are developed and maintained.

Section 340.1505 Medical, Nursing and Restorative Services

a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care shall be provided to each resident to meet the total nursing care needs of the resident.

b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven-day-a-week basis:

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3) Objective observations of changes in a resident's conditions, 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.

e) All necessary precautions shall be taken to assure that the resident's 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.

These requirements are not met as evidenced by:

Based on record review and staff interview the facility failed to:

1. Follow policy and procedures to have bed checks at least every two hours

2. Follow policy and procedures for fall assessments and conduct a thorough assessment of resident's falls and injuries and make recommendations to prevent a reoccurrence of falls and injury

3. Conduct a thorough assessment of urinary and bowel incontinence and develop specific plan, establish incontinence patterns for cognitively impaired residents

4. Analyze and assess thoroughly the progressions and regressions of identified goals for restorative ambulation programs.

5. Ensure systems are in place to ensure incidents and accidents are evaluated and plans of action are implemented to prevent a reoccurrence of accidents and injury.

These failures resulted in the death of R6.

R6 had incidents of falls, sustaining injuries on 11/14/06, 12/8/06, 12/15/06, 02/15/07 and 4/29/07. On 4/29/07 R6 was found at 6:50 a.m. in his room lying on the floor at the head of his bed with his right arm under the bed and his head between the headboard and the frame of his bed. R6 had no pulse or respiration when the staff noticed him in this position.

R6's Coroner's report of 5/24/07 and Death Certificate R6's immediate cause of death was noted:

(a) Positional Asphyxia,

CONT.

(b) Compression of the Neck,
(c) Entrapment over a Bed Frame.

This is for 1 of 6 residents (R6) in the sample.

Findings include:

The facility sent an incident report to the Illinois Department of Public Health on 4/30/07 involving R6 falling on 4/29/07 at 6:50 a.m. The facility found R6 lying on the floor in his room beside the bed. R6's elbow was lodged under the bed with head leaned against the bed frame. The color to R6's face and upper body gray with some discoloration to the lower extremities. There was blood noted on the floor around R6's right elbow. R6 had no pulse, no respiration and no blood pressure at the time of the finding.

E12, the Veterans Nurses Assistance Certified (VNAC) stated she normally did not work the assigned secured unit (R5 North) of R6 and was not familiar with the residents. E12 stated there was two staff working including her on the unit on 4/29/07 at 11:00 p.m. for 11:00 p.m. to 7:00 a.m. shift, and the other staff was E11, the Nurse. E12 continued to say a face check was done with all residents at about 2:15 a.m. At this time both staff started rounds and changed residents; E12 stated she personally changed R6's diaper on 4/29/07 at about 2:45 a.m. then she took a break from about 3:00 a.m. until about 5:00 a.m. when they stated to get patients up for the day.

E12 and E11 started at the opposite end of the unit from R6's room. They got to R6's room at about 6:30 a.m. E12 found R6 lying on the floor of his room with his head between the headboard and frame of his bed. E12 called for the nurse who examined R6 and told her R6 had expired.

E11, the Nurse on duty on 4/29/07 stated, she heard R6 coughing behind his closed door at about 1:00 a.m. but did not go to the room at that time to check on R6.

Interview of administrative staff reveal resident's doors on the secured unit are closed at night per residents request and privacy. Residents who reside on the (R5 north) secured unit do not have call lights due to cognitive deficits.

A review of the facility's policy: "Nursing Staff Responsibilities all staff;"

20 stated: "bed checks at least every two hours."

Record review of the facility's incidents recorded for R6 from 11/14/06 to 4/29/07, documented: R6 had four incidents of falls while in the facility.

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The report of **11/14/06** documents that at 3:40 p.m.

R6 was heard yelling; was found lying face down in the hallway. R6 was ambulating back from activity room. Fall was unwitnessed. R6 complained of pain to bilateral knees, bruising noted to bilateral knees.

R6 status post fall secondary to unsteady gait. Patient walked further than usual from activity hall to unit, will monitor ambulation.

The facility failed to identify how R6 would be monitored or how his unsteady gait would be addressed. A thorough investigation of R6's medication usage, change of condition or environment was not present in the report. Check marks were noted on the form with no explanation of which of the specific areas was evaluated.

On **12/8/06**, the incident documents: At 7:40 p.m. R6 was found sitting on the floor in front of his wheelchair. R6 states he slipped off edge of his wheel chair when repositioning self. R6 was assisted off the floor by a mechanical lift.

The facility's action taken by supervisor was: Monitor member (R6) closely for potential fall situations.

A physician's report documents: R6's blood pressure was on the low side and decreased diuretic medication and suggested R6 use a wheelchair only to transport for long distances and R6 be transferred to a regular chair after using wheelchair.

The investigation report did not identify how the facility was going to closely monitor R6's blood pressure.

On **12/15/06** the incident documents: R6 was found kneeling on the floor on his hands and knees with R6's walker tipped in front of him on the side. The bar of the walker was resting on R6's upper chest. A slight redness to R6's knees and upper chest was documented.

A physician's report of this incident documents: R6 sitting in manual wheel-chair positive hematoma to both knees no tenderness. The status post fall was secondary to unsteady gait. There was poor safety awareness, secondary to Dementia. This will be supervised. Exercise; continue physical therapy and occupational therapy. Physical therapy evaluation requested.

On **02/15/07** another incident documents: at 6:50 p.m. R6 was found on the floor in front of his wheelchair in TV area. R6 states he slipped from wheelchair. A small half inch skin tear to left hand was observed. R6 assisted off the floor with a mechanical lift.

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Action taken by supervisor: To monitor patient closely.

There was no investigation into why R6 was slipping from the wheelchair or why the recommendation to have R6 in a regular chair was not followed. The Physician documents: Status post fall; secondary to unsteady gait and getting up from wheelchair with unlocked brakes. Patient is to be toileted after meals.

Record review documents a physical therapy evaluation was conducted 10/25/06, which documents: Clinical impression R6 is not appropriate for skilled physical therapy. Ambulate with rolling walker on unit. A 12/20/06 physical therapy notation documents: R6 does not require skilled physical therapy; place in restorative ambulation program. R6 requires supervision for safety; ambulate with rolling walker; supervise.

On 12/29/06, Physician's order documents for R6 to have restorative gait program daily per P.T. referral.

A Physician's order, dated 4/24/07, states to discontinue restorative gait program, physical therapy screen due to R6's decline in gait. R6 is using a wheelchair on unit.

From interview with E2 (Director of Nursing) and E10, the (Restorative Nurse), the facility currently does not have systems in place for assessments to evaluate patients for restorative programs. The facility currently does not have systems in place that show a summary of the progression or regressions of residents' conditions while in the ambulation or other restorative programs. A plan of care is not developed to show measurable goals and objectives for restorative services.

In a fall risk assessment, dated 3/27/07, R6 scored 20. (Score of greater than 10 represents High Risk). A review of the facility policy: No. 6.11; Member "Fall Prevention program" identified: Rehabilitative / Nursing services shall complete a "Fall Assessment " on all new admissions or new admissions with a history of falls or any member that has experienced a fall while a resident of the facility.

There was no documentation that the facility followed this policy.

A 2/07/07 Physician's order document: Discontinue low bed with side mats on floor. Per staff interview this intervention was not used.

From interview with administrative staff and record review there was no evaluation why the low bed was not used or why and how the facility made the decision discontinue the use of the low bed and mat to floor.

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On 4/2007, Side Rail Evaluation was noted: R6 was in a High / Low bed in the up position because the member is not considered to be at risk for falls from the bed. There was no other documentation identified how this determination was made.

According to E2, R6's condition was deteriorating, and he no longer was an elopement risk. R6 was to be moved to the skilled unit on the following week before the accident.

In a review of R6's annual Minimal Data Set (MDS) dated 1/31/07, the facility indicates: Falls, Urinary Incontinence and Activity of Daily Living; Functional / Rehabilitation potential as 3 of the 11 identified concerns on the Resident Assessment Protocol (RAP) summary. The facility had no documentation of how these areas were assessed or evaluated for R6.

The MDS indicates R6 is frequently incontinent of bladder and bowel and has had accidents and falls in past 31-180 days.

A review of the 1/24/07 bowel and bladder assessment documents R6 is incontinent all shifts. The evaluation does not identify how R6 communicates his needs to eliminate or if he requires assistance of staff onto toilet.

The assessment documents R6 is unable to participate in a bowel / bladder program reason: uses adult brief and requires extensive assistance with changing. R6 has dementia and is combative and resistant during care and brief changes. Toilet as needed per R6's request after meals and prior to bed.

The assessment does not identify which specific function, bowel or bladder, it is referring to. The facility failed to identify R6's bladder incontinence patterns, describe what type of incontinence R6 has, patterns of fluid intake or to rule out infections.

The MDS area for Physical Function the facility identified R6 to require limited assist with a one person physical assist; for areas of bed mobility and transfers.

R6 requires supervision to walk in hall and corridor with extensive assistance of one person for assistance with toilet use.

The facility had no documentation of how R6 was assessed for these triggers. There are no RAP summaries available for these areas.

From interview with Z1 (Medical Director) the facility started a Fall Committee in January of 2007.

Z1 presented a fall committee report for R6's incident of 02/2007. The report documents:

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After dinner R6 was put to bed, but had to go to the bathroom and could not wait for a VNAC. So, R6 got up and tried to go himself but fell.

R6 was helped up and toileted and had a large bowel movement. It was felt that this problem was the wheelchair lock was not used. Recommendation: none identified.

(A)