STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146123	A. BUILDING _____ B. WING _____	03/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH NURSING HOME	401 9TH STREET LACON, IL 61540

(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) COMPLETION DATE
F 323	Continued From page 10 current 1/29/13 careplan with the new interventions to address the individual falls. There are no prioritized measurable outcomes noted on the Fall Prevention/Intervention Careplan to monitor resident progress.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.1210b) 300.1210d)6) 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 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.	F9999		

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F9999	Continued From page 11 This Requirement was NOT Met as Evidenced by: Based on observation, record review and interview, the facility failed to implement interventions and provide adequate supervision and assistance to prevent 11 falls for one of eight residents (R7) reviewed for falls on the sample of 16 residents. R7 fell and received a laceration to the forehead requiring staples. Findings include: R7 has a diagnoses including Dementia, Difficulty walking, and Paralysis Agitans found on the admission sheet of 7/19/12. R7 was observed in an enclosed walker from 11:00-12:00 pm on 3/18/13, 10:00 am to 11:30 am, and on 3/20/13 from 9:30 am to 11:00 am with frequent attempts to stand up. At intervals R7 was transferred to a high back wheelchair after being toileted to "reduce agitation" as verified by the charge nurse, E9, on 3/20/13 9:30 am. R7 is not interviewable with diagnosis including Dementia, Paralysis Agitans, and Depression as noted on the Admission Sheet of 7/19/12. R7's Minimum Data Set (MDS) of 7/16/12 notes under Section G Functional Status R7 to be needing extensive assistance of two plus persons physical assist for walk in room and corridor. Under Section J Health Conditions noted that R7 has had falls since admission. R7's admission minimum data set of 7/26/12	F9999		

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F9999	Continued From page 12	F9999		

section J. coded falls without fractures being addressed on the care area assessment for falls as follows: "Note 1: (R7) is at a very significant risk of falls related to his medication, impaired balance, impulsiveness/anxiety related to new environment and Parkinson tremors, dementia, depression, his need for physical support to walk, unsteady gait, and total hip replacement. Fall risk assessment score rated R7 as a high risk for falls. Fall interventions are in place and (R7s) fall on the day of admission was addressed with a anti-roll back device due to falling while pushing off of the unlocked wheelchair. No injury noted. (R7) does have poor safety awareness and strength and physical ability. Will continue to monitor safety throughout stay."

R7's Current Careplan of 1/29/13 " Mobility-Ambulating" states "I require extensive assist of two staff at times to maintain my balance and safety. I can walk safely in an arm-in arm fashion with the extensive assist of two staff members. I use an enclosed walker due to my extensive fall history secondary to my bouncy-lurching gait. Release me from the enclosed walker every two hours that I am in it."

R7 has 26 recorded falls since admission from 7/19/13 through 2/18/13 with "Resident Incident Report" filled out for each occurrence with an investigation summary and interventions suggested.

E3, Registered Nurse/Careplan and MDS Coordinator, on 3/19/13 at 1:00 pm verified that the resident incident reports are kept in her office and not available to floor staff to refer to the up-dated careplan interventions.

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F9999	Continued From page 13 R7 has a physician order of 9/26/12 " an ambulating walker for when resident is walking unsteady as needed indefinitely to increase mobility." Physical Therapy notes of 10/9/12 for R7 states " High fall risk Left side weakness and decreased use on the left upper extremity. PT (physical therapy) consulted regarding appropriate fit of ambulating walker for (R7). (R7) is a 70 year old with a diagnosis of frontal dementia. (R7) has had multiple falls in facility. Resident placed in ambulating walker to decrease fall risk. (R7) has tipped the merry walker on three occasions. Resident currently uses a ambulating walker that is 291/2 inches high (arm height) the walker comes to mid thigh level on (R7). At this time (R7's) center of gravity is above the level of the ambulating walker. (R7) would benefit from walker being waist high in order to place his center of gravity within the balance of support of the ambulating walker to reduce the risk of tipping. Interview with E10, Physical Therapy Assistant, on 3/21/13 at 11:15 am stated that the therapy department was not asked to evaluate the use of the enclosed ambulating walker before first initiated, rather facility did not request consultation until 10/9/12. E10, PTA, verified that in her opinion the first " enclosed ambulating walker should have been evaluated by the therapy department before use because it is a restraint." E10, PTA, stated when R7 was discharged from physical therapy on 11/1/12, he was not appropriate to use a enclosed ambulating walker due to increased lethargy as written in the	F9999		

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F9999	Continued From page 14 discharge summary of 11/1/12 "Patient has been unable to participate in therapy since 10/26/12 due to increased lethargy - not able to progress at this time." E10, PTA, verified that the facility "had not requested any other evaluations of R7's falls and/or enclosed ambulating walker use since 10/9/12." The following ten Resident Incident Reports noted falls from 10/3/13 through 2/18/13 involving R7 in the ambulating walker without up-dating the careplan with new interventions: 1. 10/3/12 Resident was trying to get out of the ambulating walker et tipped over on to the floor with no intervention for fall/ incident for R7 but did educate a staff person without describing what was taught.. 2. 10/4/12 10:00 pm Resident attempting to stand up in enclosed ambulating walker and was off balance tilting walker to the-fall stopped by chair. No apparent injury noted." The intervention suggested "assist resident out of enclosed ambulating walker when agitated." 3. 10/4/12 10:15 pm Resident in family lounge just out of site of nurse's station. Heard something fall found resident face down on floor-overturned enclosed ambulating walker. The intervention was "to Emergency room for evaluation-resident out of enclosed ambulating walker for the rest of night and all the next day." Report sent to the regional health department office on 10/5/12 states R7's injuries as "Resident had the skin above his right eye derma bonded, an x-ray of left elbow which was negative and a Computed tomography of the brain and spine	F9999		

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F9999	Continued From page 15 which is also negative. 4. 10/11/12 9:00 am Resident scooted down to the foot rest of recliner. The suggested intervention is "taller enclosed ambulating walker ordered per Physical Therapy evaluation." 5. 12/24/12 at 6:15 PM -"Resident found in hall on right side in enclosed ambulating walker. Right temporal area has a approximate two inch laceration. Bleeding quickly stopped with direct pressure." with an intervention to "staff education to assist - out every 2 hours" 6. 1/1/13 at 10:55 am "Resident tipped his enclosed ambulating walker forward, falling forward onto his arm and face. He has a lip laceration from his teeth through the lower lip... He is awake and responding right brow has a contusion in the same spot as the contusion on 12/24/12. The intervention suggested was "close supervision while in enclosed ambulating walker x one week if no further falls." 7. 2/18/13 5:50 PM "Resident tipped (enclosed ambulating walker.)" The suggested intervention is "staff ed. staff lunch, walk, and toilet" E4, Licensed Nurse, 3/19/13 10:00 am clarified the written intervention that the" staff were educated to walk and toilet the resident (R7) before going to lunch." From the "Notification of Resident Incident" sent to the regional public health office "(Z1, physician for R7) was in the building and assessed the resident. Orders were received by Z1 to "send (R7) the emergency room for suturing." R7 received seven staples to the laceration on the right forehead.	F9999		

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F9999	Continued From page 16 Interview with Administrator, E1, on 3/21/13 verified that "even when the resident continued to fall after the second enclosed ambulating walker was initiated, the facility did not request the physical therapy department for an evaluation of the falls and/or enclosed ambulating walker safety. No interdisciplinary restraint reduction program for use of the enclosed ambulating walker was developed in the careplan." The facility's fall prevention program policy of 2/28/12 states that " Procedure: c. Ongoing communication between all members of the healthcare team is essential for implementation of a appropriate fall prevention plan.". E4, Licensed Practical Nurse, (Falls Coordinator) on 3/19/13 at 10:00 am verified that 13 out of the 26 resident incident reports starting from 9/24/12 through 12/22/12 did not get recorded on the current 1/29/13 careplan with the new interventions to address the individual falls. There are no prioritized measurable outcomes noted on the Fall Prevention/Intervention Careplan to monitor resident progress. (B) 300.625a Section 300.625 Identified Offenders a) The facility shall review the results of the criminal history background checks immediately upon receipt of those checks. If the results of the	F9999		

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F9999	Continued From page 17 background check are inconclusive, the facility shall initiate a fingerprint-based check unless the fingerprint-based check is waived by the Director of Public Health based on verification by the facility that the resident is completely immobile or that the resident meets other criteria related to the resident's health or lack of potential risk, such as the existence of a severe, debilitating physical, medical, or mental condition that nullifies any potential risk presented by the resident. (Section 2-201.5(b) of the Act) The facility shall arrange for a fingerprint-based background check or request a waiver from the Department within 5 days after receiving inconclusive results of a name-based background check. The fingerprint-based background check shall be conducted within 25 days after receiving the inconclusive results of the name-based check. This REQUIREMENT was not met, as evidenced by: Based on interview and record review, the facility failed to obtain a fingerprint-based criminal background check for one resident (R22) with an initial inconclusive name-based criminal background check out of ten recently admitted residents. This failure had the potential to affect all 79 residents in the facility. Findings include:	F9999		

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F9999	Continued From page 18 Of ten recently admitted resident screening records, the name-based criminal background check dated 2/5/13 for R22, admitted on 2/4/13, indicated a "Hit." No other conviction information was attached to the cover sheet for the background check. E5 (Social Service Designee) stated on 3/20/13 at 11:10 AM that when she received R22's background check, it contained the face sheet plus a several page conviction list for a person of a different name and race who had the same birthday as R22. E5 said she talked with E1 (Administrator) about the matter at the time, and they decided to discard the conviction list pertaining to the wrong person. E5 said that the Illinois State Police was never contacted to clarify the matter. E5 stated at noon on 3/20/13 that she just arranged for a fingerprint background check to be done for R22 that afternoon. The facility resident census according to the Centers for Medicare and Medicaid Services (CMS) form # 672, completed by the facility, was 79. (B)	F9999		