Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004089	A. BUILDING: ____ B. WING ____	04/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVANA HEALTH CARE CENTER	609 NORTH HARPHAM STREET HAVANA, IL 62644

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S9999	Final Observations	S9999		

Final Observations

Statement of Licensure Violations

300.1210b)
300.1210d)6)
300.1220b)3)
300.3240a)

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. Restorative measures shall
include, at a minimum, the following procedures:

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.

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

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 REQUIREMENTS were not met as evidenced by:

Based on observation, interview, and record review the facility failed to investigate falls, failed to analyze root cause analysis of falls, and failed to implement new and/or resident specific interventions after falls for 5 of 7 residents (R3,

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S9999	Continued From page 2 R12, R15, R9, R1) reviewed for falls in the sample of fourteen. These failures resulted in R12 falling and sustaining a lumbar compression fracture and R15 falling and sustaining a hip fracture. Based on record review, observation, and interview the facility failed to ensure resident safety with the use of side rails for one of seven residents (R17) reviewed for safe side rail use, in the sample of 14. Findings include: A Fall Prevention Policy (date unknown), documents a fall investigative report will be completed after each fall; Care Plans will be updated after each fall review with the Interdisciplinary Team and the Care Plan Coordinator; all new interventions will be written on the care plan; the Director of Nursing is to observe for and react to trends in incidents On 4/21/14 at 2:00 p.m., E2 (Director of Nursing) stated "I'm not allowed to provide any fall investigations or fall logs to (the State Agency)." E2 stated, "This is a Corporate Office rule." On 4/22/14 at 10:45 a.m., E2 stated the facility could not provide the survey team with a list of falls for specified residents. E2 stated "(state surveyors) are only allowed to look at resident nurses notes and resident care plans." 1. Nurses Notes dated 3/23/14 at 6:20 a.m., document R12 was found lying on the floor mat in front of R12's bed.	S9999		

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S9999	Continued From page 3 A State Agency Notification form dated 3/24/14, documents R12 complained of left hip pain on 3/24/14 and R12 was sent to the hospital. An x-ray report dated 3/24/14, documents R12 had a Lumbar Compression Fracture. Nurses Notes dated 6/25/13 through 4/22/14, document R12 had falls on 8/24/13, 8/25/13, 9/11/13, 10/7/13, 10/28/13, 1/22/14, 2/28/14, 3/3/14, 3/13/14, 3/23/14, and 3/24/14. R12's Plan of Care dated 8/22/13, includes no new interventions implemented after R12's falls on 8/24/13, 8/25/13, 9/11/13, and 1/22/14. R12's Plan of Care dated 2/16/14, includes no interventions implemented after R12's fall on 10/7/13, and 10/28/13. R12's Plan of Care dated 2/14/14, includes no new interventions implemented after R12's falls on 2/28/14, 3/3/14, and 3/13/14. On 4/24/14 at 9:36 a.m., E2 (Director of Nursing) verified that R12's plan of care dated 2/14/14, does not document new interventions implemented after R12's falls on 8/24/13, 8/25/13, 9/11/13, 1/22/14, 2/28/14, 3/3/14, and 3/13/14. R12's Nurses Notes 8/24/13, 1/22/14, and 3/24/14, document R12's falls involved the floor matt next to R12's bed. R12's Plan of Care dated 8/22/13 and 2/16/14, do not document the removal of R12's fall floor matt next to R12's bed. On 4/21/14, 4/22/14, and 4/23/14, R12 has a matt on the floor next to the bed. On 4/22/14 at 2:20 p.m., R12's personal alarm	S9999		

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was sounding and R12 got out of bed, walked over the fall matt lying on the floor next to the bed and proceeded to walk across the room (approximately six feet) to the enclosed walker. R12 was assisted by staff back to bed.

On 4/22/14 at 4:23 p.m., R12's personal alarm was sounding and R12 was standing next to bed on top of the fall matt on the floor. R12 again was assisted to bed by staff.

On 4/24/14 at 9:36 a.m., E2 (Director of Nursing) stated E2 does not know why R12 has a matt on the floor next to the bed. E2 verified that the fall matt had contributed to R12 falling in the past, including R12's fall on 3/23/14 which resulted in a fracture.

R12's Plan of Care revision dated 3/23/14, documents to encourage resident to utilize call light and ask for assistance for placement of footwear.

On 4/24/14 at 9:36 a.m., E2 stated R12's Plan of Care Revision dated 3/23/14 was not an appropriate intervention for R12 due to severely impaired cognitive skills. E2 stated "actually the intervention I had in my documentation was to put (R12's) shoes in the closet at night."

On 4/23/14 at 2:15 p.m., E2 (Director of Nursing) stated "The Interdisciplinary team, which consists of Administrator, Director of Nursing, Care Plan Coordinator, Social Services Director, Dietary Manager, and Therapy, are responsible for fall investigations. After the investigation is done the new interventions are immediately communicated to the staff and documented on the care plans."

2. R15's Nurses Note dated 11/11/13 at 10:15

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p.m., documents R15 was in R15's room lying on back with legs straight out in front, back and head against recliner, and bedding down around R15.

R15's Nurses Note, dated 3/21/14, documents that at 3:20 p.m., R15 was in R15's room sitting on his buttocks with his legs crossed next to the bed.

R15's Care Plan, dated 2/1/13 and 11/14/13, document no new interventions for R15's accidents on 11/11/13 and 3/21/14.

R15's Nurses notes, dated 4/22/14, documents that at 3:00 p.m. R15 was lying on R15's right side in dining room with right upper extremity bleeding. At 9:15 p.m. R15 was admitted to Mason District Hospital.

On 4/23/14 at 8:45 a.m., E9 (Licensed Practical Nurse) stated, "(R15) fell yesterday and was admitted to Mason District Hospital with a hip fracture."

R15's Radiology report, dated 4/23/14, documents R15 has a mildly impacted femoral neck fracture.

On 4/24/14 at 9:50 a.m., E2 (Director of Nursing), confirmed that R15's care plans, dated 2/1/13 and 11/14/13, do not have new interventions for accidents on 11/11/13 and 3/21/14.

3. R3's Nurses Notes dated 6/24/13 through 4/23/14, documents R3 had falls on 6/24/13, 6/27/13, 7/17/13, 7/21/13, 8/7/13, 9/20/13, 10/29/13, 12/22/13, 2/11/14, 3/22/14, and 4/10/14.

R3's Plan of Care last updated on 4/11/14, does

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not document new interventions or evidence of investigation for R3's falls on 7/17/13, 8/7/13, 12/22/13, or 2/11/14.

On 4/26/14 at 9:36 a.m., E2 (Director of Nursing) verified R3's Plan of Care last updated on 4/11/14, fails to document R3's falls on 7/17/13, 8/7/13, 12/22/13, and 2/11/14.

4. A Physician's Order Sheet, dated 4/01/14, documents R1 has the current diagnosis of Lewy Body Dementia and a history of fall with hip fracture (11/05/13) . A Minimum Data Set, dated 3/16/14, identifies R1 as having severe cognitive impairment. R1's current Plan of Care (no date), documents R1 as high risk for falls and having an unsteady gait.

Nursing Notes dated 11/15/13, document R1 was found on the floor of the bathroom and R1 had indicated "I was trying to go to the bathroom and fell." The 11/15/13 Nursing Note states the fall was unwitnessed and R1's "(wheelchair) alarm turned off, therefore, (not) sounding....(Certified Nursing Assistant) reprimanded (at this time due to not) following proper procedure when (R1) was up this (morning)."

Nursing Notes document R1 fell on 12/18/13, sustaining a 7.5 cm (centimeter) by 1 cm abrasion to the leg, fell twice on 1/24/14 (11:00 a.m. and 8:10 p.m.) and fell on 2/14/14 while attempting to use the urinal. R1's current Plan of Care (no date) fails to reflect that these falls occurred or the development of new fall prevention interventions.

On 4/24/14 at 9:40 a.m., E2 (Director of Nursing) stated that the C.N.A. (Certified Nursing Assistant) caring for R1 on 11/15/13 was

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reprimanded for not turning on R1's personal body alarm that morning. E2 concluded, given the fact that R1 had just experienced a hip fracture from a fall on 11/05/13, proper utilization of the personal body alarm was imperative. E2 stated that the facility did not have documented evidence to support an investigation into R1's falls on 12/18/13, 1/24/14 or 2/14/14 or that new interventions were developed to prevent future falls.

5. A Physician's Order Sheet, dated 4/01/14, documents R9 has the current diagnosis of Dementia with Agitation. Minimum Data Sets, dated 3/09/14 and 8/30/13, identify R9 as having severe cognitive impairment with short term and long term memory loss. R9's current Plan of Care (no date), identifies R9 as high risk for falls and requiring the assist of two staff and a gait belt for all transfers.

Nursing Notes, dated 9/09/13, document R9 fell while being transferred from the toilet to the wheelchair and the nurse "noted floor wet from shower given earlier." The 9/09/13 Nursing Note does not identify how many C.N.A.'s were present during the transfer or which staff witnessed the fall. R9's current Plan of Care (no date) does not reflect the fall on 9/09/13 or the development of new fall prevention interventions.

Nursing Notes, dated 10/15/13, document R9 was found on the floor in the television room next to the couch. The current Plan of Care (no date) does identify that the fall occurred and instructs the staff to frequently remind R9 to ask for assistance with transfers and care needs.

Nursing Notes, dated 1/10/14, document R9 was on the floor in the shower room with the shower

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chair tipped forward. The Nursing Note does not identify how many staff were present or who witnessed the fall. R9's current Plan of Care (no date) does not reflect the fall on 1/10/14 or the development of new fall prevention interventions.

On 4/24/14 at 9:40 a.m., E2 (Director of Nursing) stated that the facility does not have any documented evidence to support an investigation into R1's falls on 9/09/13, 10/15/13 and 1/10/14. E2 stated the Care Plan intervention developed after the 10/15/13 fall was not appropriate for R9, given R9's cognitive impairment. E2 stated staff were instructed to maintain resident safety and ensure the floor was dry before transferring residents, after R9's fall on 9/09/13. E2 stated staff were instructed, after R9's 1/10/14 fall out of the shower chair, to use a larger shower chair because the shower chair staff had used was too small for R9. E2 concluded that two C.N.A.'s should have been present while showering R9 on 1/10/14.

6. R17's Physician Order Sheets, dated 4/2014, document R17 is to use bilateral 1/2 side rails for positioning and bed mobility.

R17's Nurse's notes, dated 4/15/14 at 7:30 a.m., document R17 was on hands and knees next to R17's bed. On 4/17/14 at 5:10 p.m., R17 was noted to have a 6 centimeter x 5.5 centimeter purple discoloration to her left lower face.

On 4/22/14 at 9:00 a.m., R17 was up in reclining wheelchair chair in dining room. There was a large dark purple bruise to left side of R17's face. The bruise extended from below the corner of left lower lip up to left ear and down R17's neck.

On 4/23/14 at 10:50 a.m., R17 was lying in bed

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on R17's left side with bilateral half side rails up and a bolster pillow on the right side between R17 and side rail. R17's bed was against the wall on R17's left side.

On 4/23/14 at 1:50 p.m., E8 (Certified Nursing Assistant) stated, "(R17) rolls around in bed that is why (R17) has side rails so (R17) doesn't roll out of bed. (R17's) family wants the bolster pillow in the bed to add extra padding since (R17) rolls around. (R17) is not able to grab the side rails and turn." E8 instructed R17 to grab the side rails and assist E8 to turn R17 in bed. R17 was unable to follow directions and participate in bed mobility.

R17's Care plan, dated 11/5/13, documents the need for use of side rails as an enabler that does not limit movement/accessibility. Bilateral top half side rails are used for bed mobility, positioning, and transfers.

R17's Physical Restraint Progress notes, dated 3/28/14, documents the half side rails aid against random movements that cause falls. R17 is not actively seeking getting out of bed independently.

On 4/24/14 at 9:50 a.m., E2 (Director of Nursing) stated, "(R17) now has a low bed and side rails removed for a new intervention because of the safety risk for (R17), related to R17's fall on 4/15/14."

On 4/24/14 at 1:50 p.m., R17 was lying in bed. R17's bed was in low position with a quarter side rail on R17's right side and a half side rail on R17's left side. R17 had a bolster pillow in place to R17's right side between the side rail and R17.

On 4/24/14 at 2:00 p.m., E10 (Licensed Practical Nurse) stated, "I was the nurse that discovered

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R17's bruise. The bruise to the left side of face was from (R17's) fall a few days before."

(B)

300.615e)
300.615f)

Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information

e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act)

f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender.

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These REQUIREMENTS were not met, as evidenced by:

Based on interview and record review, the facility failed to initiate Criminal History Background Checks within 24 hours of admission for one resident (R20) on the sample and three residents (R22, R23 and R24) on the supplemental sample; and perform the required website checks upon admission for one resident (R22) in the supplemental sample. This failure had the potential to affect all 55 residents living in the facility.

Findings include:

The State Police Criminal History Background Checks for R20, R23 and R24 were dated 4/22/14. The Background Check for R22 was dated 4/9/14. An undated list prepared by the facility for the last 10 residents admitted indicated that R20 was admitted on 3/6/14, R22 on 2/15/14, R23 on 2/17/14 and R24 on 2/18/14.

The Illinois State Police and Department of Correction sex offender website checks for R22 were dated 4/9/14.

E6 (Social Service Designee) stated on 4/23/14 at 2:30 PM that somehow E6 missed sending the request to the State Police for the Background Check for R22 back in February.

E1 (Administrator) stated on 4/23/14 at 11:30 AM that E1 conducted an audit of resident admission records recently in early April 2014, and found Background Checks missing for residents R20, R22, R23 and R24. E1 said that E1 then requested Background Checks from the State Police for those residents.

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S9999	Continued From page 12 The Centers for Medicare and Medicaid Services (CMS) form # 672, completed by the facility for the survey, indicated that the current resident census was 55. (B)	S9999		