

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6013882</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/16/2014</b>
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Z9999	<p><b>FINDINGS</b></p> <p><b>STATEMENT OF LICENSURE VIOLATIONS</b></p> <p>350.620a) 350.1210 350.1230d)1) 350.1230d)2) 350.1230d)3) 350.3240a)</p> <p>Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.</p> <p>Section 350.1210 Health Services</p> <p>The facility shall provide all services necessary to maintain each resident in good physical health.</p> <p>Section 350.1230 Nursing Services</p> <p>d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 2) Basic skills required to meet the health needs and problems of the residents. 3) First aid in the presence of accident or illness</p> <p>Section 350.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a</p>	Z9999		
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Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Z9999	<p>Continued From page 1</p> <p>resident. (Section 2-107 of the Act)</p> <p><b>THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY:</b></p> <p>Based on record review, observation, and interview, it was determined that the Governing Body failed to ensure that the facility's policy and procedure provide guidance and clear directives to ensure that clients receive emergent and non emergent medical care by qualified staff in a timely manner. The failure to have a procedure in place resulted in delay in care from 6/7/14 to 6/9/14 for 1 of 1 (R1) individuals in the sample who obtained multiple bruises and abnormal breathing after a fall resulting in a diagnosis of right side fractured ribs and right basilar density secondary to infiltrate versus contusion to the lung. The following facility requirements were not met for the same client:</p> <p>a.) The facility's policy and procedure does not ensure the facility's operating procedures provide emergency medical care without delay of treatment as the policy references the House Manager, Qualified Intellectual Disability Professional (QIDP) to notify the Registered Nurse "if necessary" in the event of client injuries, illness and medical emergencies.</p> <p>b.) The facility's policy and procedure directives require the Direct Support Person (DSP) to give notification to the QIDP first in the event of individuals injuries and illnesses and to make a determination if an injury or illness is a medical emergency or not.</p> <p>Findings include:</p>	Z9999		
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Z9999	<p>Continued From page 2</p> <p>Facility Policy No: 5.57 titled, Physical Injury and Illness/Individual Medical Emergencies includes the the following directives for client injuries, "Individuals served by the agency shall receive timely and effective medical services for physical injuries and illnesses and medical emergencies."</p> <p>The procedure that give directives to staff is as follows, "In the event that an individual sustains an injury or illness, staff on duty shall conduct observation and take appropriate action consistent with the following:</p> <p>A. As soon as the injury or illness is determined to be a medical emergency, the DSP is to call 911 and follow the steps F of this policy.                      B. Observe the individual to determine basic information necessary for nurses or physicians to make further judgements.                      C. Notify the House Manager, QIDP (Qualified Intellectual Disability Personnel) or Administrator for consultation and direction.                      D. The House Manager, QIDP, or Administrator shall notify the RN (Registered Nurse) for consultation and direction, if necessary. If the DSP is unable to reach any of these supervisors they may contact the RN for consultation and directions.                      E. If the House Manager, QIDP, Administrator or RN is not available in a timely manner, a designated DSP may call the local hospital emergency room for consultation. Instructions and/or suggestions from the emergency room shall be communicated to the House Manager, QIDP, or Administrator prior to implementation unless the delay could harm the individual.</p> <p>The same policy includes directives to non licensed staff to make a determination whether or not a client's injury or illness is a medical</p>	Z9999		

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Z9999	<p>Continued From page 3</p> <p>emergency or not. The policy also failed to include directives to non clinical staff for nurse/physician notification in the event of client injuries. The policy also requires a non clinical person to provide "consultation and directions" to Direct Support Persons regarding an individual's medical illness and/or injury.</p> <p>Facility Policy No: 7.02, titled Nursing Services states, "All individuals shall receive proper treatment of minor accidents and/or illnesses through the R.N. Consultant." "Purpose, #1. To provide quality health care 24 hours per day to individuals in need." "#4. The following procedures shall be used to report minor illnesses or injuries to the R.N. Consultant. a). DSP observes, or individual approaches DSP with minor illness or injury. b.) DSP relays the symptoms to the R.N. Consultant via telephone, if immediate need or writing, and documents on a progress note (GP-15) when appropriate. RN consultant shall make a decision based on given information and the DSP shall document RN's response."</p> <p>Policy 7.02 for Nursing Services conflicts with Policy 5.57 for Physical Injury and Illness/Individual Medical Emergencies for a systematic way to report and provide treatment to individuals who live at the facility.</p> <p>Observations were made of R1 on 6/26/14 at 12:20pm, R1 was accompanied by E2 DSP entering the home after returning from an outing. R1 has a shuffled gait, ambulates with rather rapid, short steps and a forward thoracic bend. It was also noted that he ambulates with his head leaned in the downward position but lifts his head forward when redirected by E2. No adaptive equipment was observed utilized with ambulation</p>	Z9999		

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Z9999	<p>Continued From page 4</p> <p>on 6/26/14 or 6/27/14 from 10am to 3pm or on 7/1/14 from 9:30 to 5:15pm. E2 was observed leaving the dining room where R1 was sitting eating lunch to go back and forth to the kitchen where E2 was not in her view at least twice on 6/26/14.</p> <p>Record review include an Individual Service Plan dated 8/7/13 which states R1 is a 50 year old male with a mild level of intellectual functioning, an Intellectual Quotient (IQ) of 50, and several diagnoses including Schizophrenia Disorder, Frontal Dementia, Astigmatism, Hypertension, Cataracts, and Degenerative Disc Disorder. The physician order sheet dated 6/1/14 list several medications for R1 including: Lithium 600mg every am and 900mg at 9pm each day. Lorezapam 0.5mg TID (three times a day) last dose is given at 8pm. Clozapine 300mg at 7am, 5pm, and 9pm. Hydrochlorithiazine 12.5mg daily. Acetaminophen 325mg 2 tablets every 4 hours as needed for pain.</p> <p>A progress report dated 6/7/14 written by E3, DSP includes documentation of injuries to R1. E3 reports "I noticed bruises on R1 at 9:35am on the upper left jaw- size of a quarter, left side of chin- the size of a quarter, right upper arm about inch and half, left knee- a lot of bruising, right knee has 4 quarter size bruises open." "I informed E4, QIDP of R1 having problems standing, all the bruises and problems breathing. E4 stated she called the nurse and the nurses direction was to have E2, DSP schedule R1 an appointment. I gave the phone to E2 and E4 gave the same information. E4 (QIDP) was also informed that R1 had to be carried and E4 informed E2 to call around to other group homes to try and locate a</p>	Z9999		
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Z9999	<p>Continued From page 5</p> <p>wheel chair to assist R1."</p> <p>A hospital admission note states R1 was admitted on 6/9/14 (2 days later) for generalized weakness, rule out pneumonia, multiple falls, and right rib fractures.</p> <p>A PA (posterior-anterior) chest X-ray dated 6/9/14 includes an impression: "acute rib fractures involving the right 6th and 11th lateral ribs. There is gross evidence of hemo/pneumo thorax. Right basilar density secondary to infiltrate versus contusion noted on AP film."</p> <p>A MRI (magnetic resonance imaging) was done on the same visit with clinical indicator as weakness the results showed, " age appropriate changes."</p> <p>A CAT (Computed Axial Tomography) SCAN was done on the same visit with a clinical indicator as unsteady gait, right sided weakness." The results were normal.</p> <p>A xray of the "pelvis and frog view" dated 6/9/14 was done with normal results.</p> <p>A discharge note dated 6/10/14 includes instructions that R1 was discharged back to the group home with a prescription for Ceclor (antibiotic) 500mg three times a day, wound care instructions, monitor gait, and follow up with neurologist, primary physician, and psychologist.</p> <p>An interview was conducted with E7 (Registered Nurse) on 6/26/14 at 2:07pm. E7 was asked if she received a call from the facility on 6/7/14 regarding R1's injuries and reports that he was not breathing normal. E7 states that she did receive a call from E4 maybe around 11:00am not sure of exact time, E7 informed her that R1 "was stumbling around and was sick, she said as far as I know he didn't fall because E3 (DSP) is just a</p>	Z9999		
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Z9999	<p>Continued From page 6</p> <p>drama queen." E7 states she instructed E4 to send R1 to the emergency room and did not hear back from the facility regarding his status until 6/10/14 when she got post hospital instructions.</p> <p>An interview was conducted with E6 (Licensed Practical Nurse) on 6/26/14 at 2:07pm. E6 was asked when did she first learn of R1's injuries and reports that he was not breathing right and how did she respond. "E4 (QIDP) texted me Monday (2 days later on 6/9/14) around 9:04am, she said could you come and check R1, he had fallen, he has slurred speech, and he is too weak." Surveyor asked E6 how did she respond?, E6 stated she informed E4 she could have the staff call Z1 (physician)'s office and get an appointment for him. E6 was asked if the symptoms presented to her regarding R1 would require emergent care rather than a doctor's appointment and if she had come in to assess R1?. E6 states "sometimes Z1 will take them into the office the same day" and "no, I didn't need to assess him."</p> <p>Further investigation reviewed through incident reports reviewed, a total of 13 falls with injuries and 6 that required hospital emergency department admission as follows:</p> <p><b>INCIDENT #1</b></p> <p>9/24/13 nursing note, "it was reported by staff that R1 fell at home over the weekend and has a lump on right hip. there is no discoloration and skin intact, Right hip is swollen with large lump which is hard. Walking with shuffled gait more than usual." Hospital discharge form indicated R1 was hospitalized from 9/26/13 to 9/28/13 for injuries from a fall.</p> <p>The progress report (GP-15) dates the incident</p>	Z9999		
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Z9999	<p>Continued From page 7</p> <p>occurrence as 9/22/13 (Saturday) but was not completed by the staff member on duty, E8 (DSP) until 4 days later on 9/26/13.</p> <p>The incident report failed to include documentation of any staff interviews of staff who were working in the home at the time of the incident by the QIDP/Administrator.</p> <p>R1 failed to receive assessment by medical personnel for injuries or possible pain associated with injuries until 2 days after his injuries or a safety plan to prevent future falls.</p> <p><b>INCIDENT #2</b></p> <p>10/11/13 (Friday). A hospital history and physical note dated 4/21/14 includes R1 was admitted to the hospital on 10/11/13 because of recurrent falls and there were no fractures found during that visit. There is no additional information found in R1's record this hospitalization or any post discharge instructions given to the staff to monitor the individual in the home.</p> <p><b>INCIDENT #3</b></p> <p>A nursing quarterly note dated 2/13/14 states R1 had a fall at the day training site on 1/23/14 and first aid was administered. The facility was unable to find any additional documentation regarding this fall.</p> <p><b>INCIDENT #4</b></p> <p>A nursing quarterly note dated 2/13/14 states R1 also had a fall at the facility on 1/25/14 and first aid was administered. The facility was unable to find any additional documentation regarding this fall.</p>	Z9999		
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Z9999	<p>Continued From page 8</p> <p><b>INCIDENT #5</b></p> <p>2/8/14 (Saturday) nursing note, "it was reported by staff R1 took a fall in the home hitting his head (right side) and right shoulder. He was taken to hospital emergency room 2:30am treated for contusions due to fall and released. CAT SCAN of head without contrast and X-ray right shoulder-reports pending."</p> <p>A progress note with required date and time is blank regarding this incident. E10 DSP, documented there were no witnesses to the fall. The same note includes a statement by E4 (QIDP assigned to home) under follow up, "R1 came home that night with just bruises."</p> <p>An emergency room note dated the same day written by Z2 (Emergency Department Physician), states, "R1 presents to the emergency department after a mechanical fall backwards and sustaining shoulder pain."</p> <p>A Safety Committee meeting minutes dated 2/10/14, included are the committee findings of the above incident which includes:</p> <ul style="list-style-type: none"> <li>a. R1 has a history of falls at night.</li> <li>b. R1 forgets to put on his glasses and turn the lights on when he uses the restroom and during this particular incident R1 fell getting up from the toilet.</li> </ul> <p>The committee's considerations are "the staff will encourage R1 to turn the light on when he get up, staff will encourage R1 to wear his glasses when he get up at night, staff will monitor R1 when he get up at night, and R1 will encourage R1 to walk slower and watch where he is going."</p> <p>The March 2014 QIDP monthly notes failed to include any information regarding the above incident, previous falls, or address R1's gait imbalances.</p>	Z9999		
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Z9999	<p>Continued From page 9</p> <p><b>INCIDENT #6</b></p> <p>4/20/14 date of incident on progress note written by E11 (DSP) however; the date and time that the note was written is blank. E11 states, "R1 was getting out of the van and fell to the ground, once he got up he began stumbling again and shaking once he got to the door he fell twice in the dining area."</p> <p>A hospital emergency department note dated the same day includes R1 received sutures to a right cheek laceration and was discharged back to the facility.</p> <p>The clinical record failed to include any directives to the Direct Support Staff for wound care or signs and symptoms of complication that may arise from the wound.</p> <p>Safety Committee meeting minutes dated 4/22/14, include committee findings of the above incident as:</p> <ul style="list-style-type: none"> <li>a. R1 has been treated for unsteady gait in the past.</li> <li>b. He has been reminded to take full steps, keep head up, and watch where he is going.</li> </ul> <p>The committee's considerations are, "the staff will encourage R1 to taken longer steps, keep his back straight and his head up, and pay closer attention to where he is going, staff will also escort and offer support to R1 when he is walking, and R1 will be seen by the doctor to rule out any medical issues.</p> <p>The May monthly QIDP notes failed to include any information regarding Incident #6 or address previous falls or gait imbalances.</p>	Z9999		

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Z9999	<p>Continued From page 10</p> <p><b>INCIDENT #7</b></p> <p>4/21/14 (Saturday) date of hospital admission history and physical note, states that R1 was admitted through the emergency department, "where he was taken to from the group home with history that he has been lethargic sick the day before this present admission. The next day, he continued to be lethargic and could hardly ambulate and was bent over most of the time while he was sitting in the wheelchair." The same assessment includes a recurrent large right thyroid cyst, Z1 (physician) includes an impression, "R1 has hypothyroidism which is probable not related to graves disease. It could be secondary to lithium therapy, which has been known to cause perturbations in thyroid function as well as goiterous enlargement. A chest xray was performed and was negative for any rib fractures. A CAT (Computed Axial Tomography) SCAN was done with clinical reason of "frequent falls and contusion to right orbit from 4/20/14 ER visit."</p> <p>A physical therapy evaluation was done during this admission and discharge recommendations to the facility staff were as follows:</p> <ol style="list-style-type: none"> <li>1."Return to group home with increased supervision due to impulsivity and increase ROF (risk of fall)."</li> <li>2."May benefit from outpatient physical therapy to further address balance deficit though uncertain how much carry-over would occur."</li> </ol> <p>The facility was not able to provide evidence that R1's supervision level was increased as recommended.</p> <p><b>INCIDENT #8</b></p> <p>4/24/14 at 3:30am, date of progress note written</p>	Z9999		
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Z9999	<p>Continued From page 11</p> <p>by E10 (DSP) states, "R1 screamed when I got to him he was on the floor (on his back) yelling he couldn't get up. He was heading to the restroom, I tried to help him up. He refused to hold any weight. I went to get a chair for him to use and when I returned he was in bed." The same note also indicates that the nurse was not notified. The record further includes R1 was not assessed by a nurse until 4/28/14 (4 days later).</p> <p>4/27/14 (Sunday) at 11:05pm, nursing note written by E6 (Licensed Practical Nurse) states, "resident had gotten sick to stomach and vomited in bathroom. Only 1 emesis reported, temperature 98.9, pulse 72, blood pressure 135/88, respirations 14. RSD, E4 notified, instructed staff to give water and take vitals." "Staff to notify RSD if any symptoms arise or vomiting continues after work."</p> <p><b>INCIDENT #9</b></p> <p>5/18/14 (Sunday) at 10:55am, date of progress note written by E12 (DSP) states, "R1 was walking from church bus started running with little steps. He fell right as I told him to slow down and take long steps. Skinned both right and left knees. Washed with antibacterial soap."</p> <p>A Safety Committee meeting minutes dated 5/18/14, includes findings of the above incident which as:</p> <ol style="list-style-type: none"> <li>R1 was walking to the house and he was walking with a shuffled gait.</li> <li>R1 was walking too fast and he fell and scraped his knees.</li> <li>R1 needs to work on taking long short steps that he has been working on in physical therapy.</li> </ol> <p>The committee considerations are staff needs to</p>	Z9999		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6013882</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/16/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>EAGLE COURT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1890 EAST EAGLE STREET KANKAKEE, IL 60901</b>
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Z9999	<p>Continued From page 12</p> <p>remind R1 to take slow, long steps when walking, continue physical therapy, and staff will informally monitor R1 for worsening symptoms.</p> <p>Physical therapy notes sent to the facility states the following: 5/5/14- R1 is a fall risk 5/15/14- R1 has decreased safety awareness 5/20/14- requires care giver assistance for ambulation.</p> <p><b>INCIDENT #10</b></p> <p>Fall #1. According to staff interview (see below interview), R1 had two falls this day approximately 30 minutes apart. The records failed to include written documentation of fall #1.</p> <p>Fall #2. 6/7/14 (Saturday) at 9:35am, date of progress note written by E3 (DSP) upon starting shift at 9:30am, "noticed the following bruises on R1 at 9:35am.</p> <ol style="list-style-type: none"> <li>1. upper left jaw the size of a quarter</li> <li>2. left side of chin the size of a quarter.</li> <li>3. right upper arm about inch and half.</li> <li>4. left knee a lot of bruising.</li> <li>5. right knee has 4 quarter size bruises open.</li> </ol> <p>The bruises had antibiotic put on them by E2 (DSP).</p> <p>I, E3 informed E4 (QIDP) of R1 having problems standing, all the bruises and problems breathing. E4 stated she called the nurse and the nurse direction was to have E2 schedule R1 an appointment. I gave the phone to E2, and E4 gave E2 the same information. E4 was also informed that R1 had to be carried and E4 informed E2 to call around to other group home to try and locate a wheelchair to assist R1. After R1 sat up for a while his breathing got better."</p>	Z9999		
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Z9999	<p>Continued From page 13</p> <p>R1 was not assessed by licensed clinical personnel until 6/9/14 At 12: (2 days later) when he was admitted to the hospital emergency department.</p> <p>The history and physical form dated 6/9/14 completed by Z1 (physician) states, "the history given was that he had fallen at the group home and he complained of a headache. There was no loss of consciousness. He was also noted to have an intermittent cough the last two days before this present admission." "The patient is not able to give detailed answers to systemic review questions. He complains of a mild headache, on the left side of his face. He complained of pain in the chest area, worsening with coughing and deep breathing present."</p> <p>Tentative diagnosis written by the same physician are: a. history of recurrent falls. b. fracture of 6th rib and 11th right rib. c. probable right basilar pneumonia."</p> <p>A chest xray completed during the same visit showed fracture of 6th and 11th right rib. According to the discharge notes R1 was discharged the next day on 6/10/14.</p> <p><b>INCIDENT #11</b></p> <p>6/11/14 (day after discharged from hospital with diagnosis fracture 6th and 11th rib) a nursing note written by E7 (registered nurse) states "received progress note this am. note states R1 bed had to be changed and when he stood up and moved a little he fell over. Staff texted RSD (resident service director) but no instruction or reply documented. according to report body part affected was scarring to right knee."</p> <p>A Safety Committee meeting minutes dated 6/12/14, included are the committee findings of</p>	Z9999		
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Z9999	<p>Continued From page 14</p> <p>the above incident which includes:</p> <p>a. R1 has fell in the past. He is currently seeing a physical therapist in order to improve his strength and decrease his chance of falling. His fall was likely due to his shuffled gait.</p> <p>Committee considerations are R1 is on a safety plan with increased monitoring to prevent further falls, R1 will follow up with his physician , R1 will continue with physical therapy, when released by his physician, and staff will be trained on the injury and illness policy.</p> <p><b>INCIDENT #12</b></p> <p>6/12/14, a progress note written by E2 (DSP) states "R1 had just finish brushing his teeth went into his room to put items up. He was coming out of his room tripped over his shoe and fell on his right side again and open up same wound that was affected already, staff asked R1 was he ok, and helped him get up off the floor and guided him to the chair in the room.</p> <p>The same progress note includes a conclusion/resolution to the incident as "staff asked R1 was he ok and said he has to be careful when walking and to hold his head up. Witnesses present during the incident listed on the progress note was "Residential Service Director (RSD)," E4. E4 is the same RSD involved in the 6/7/14 incident when R1 fell and was later diagnoses with fractured ribs. The note also states the nurse was notified.</p> <p>A physician order sheet dated 6/16/14 written by E5 give directives to the facility for R1, "close supervision while ambulation."</p> <p><b>INCIDENT #13</b></p>	Z9999		
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Z9999	<p>Continued From page 15</p> <p>6/30/14, a progress note written by E13 (DSP) states, "R1 was walking into his room and tripped over his feet and fell. body part affected was a cut to the knee." "cleaned the wound and put a sterile pad and medical tape over the wound.</p> <p>The following facility's staff were asked what was the facility's policy and procedure in the event of client injuries or medical illness.</p> <p>E1 (Facility representative) states on 6/26/14 at 1:30pm "a staff can take an individual to the Emergency room if it is a medical emergency otherwise they can contact the Q(QIDP) and then the Q can contact the nurse." E1 also verified that the nurses telephone number is not listed in the home for access to staff to call if needed.</p> <p>E3 (DSP) states on 6/26/14 at 6:20pm, "E4 (RSD), told us to always call her first and she would call the nurse."</p> <p>E2 (DSP) states on 6/26/14 at 1pm "we call the RSD first and then she get in touch with the nurse. I don't even think we even have the nurse phone number in the house."</p> <p>E7 (Registered Nurse) stated on 6/26/14 at 2:20pm, "staff have to go through the Q first, we are told we are too busy to get calls, If we could have gotten the full picture of what was going on with him, we would have told them to send him straight to the ER."</p> <p>E6 (Licensed P{practical Nurse) stated on 6/26/14 at 2:30pm, "we are told that the Q is the coordinator of care so all calls go to them first."</p> <p>A document titled "staff Interview", dated 6/12/14, signed by E1 and E2, includes a statement by E2, "When asked what the policy is regarding resident injury, E2 stated; call QMRP, Admin, RN, Exec and if it is bad injury/illness send to ER.</p>	Z9999		



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Z9999	<p>Continued From page 16</p> <p>When asked why this was not done E2 responded; cause RSD don't send them to ER. When asked why didn't they call someone other than E4, E2 responded, I don't know."</p> <p>The facility failed to have clear directives from management to staff regarding clients receiving medical care in the event of injuries or illness.</p> <p>Review of the above safety committee meeting minutes revealed that The facility failed to:</p> <ul style="list-style-type: none"> <li>a. address the type and frequency of monitoring that would be provided to R1.</li> <li>b. address if and how R1's diagnosis of Dementia would impact his ability to remember safety instructions given to him.</li> <li>c. address if physical therapy evaluation would benefit R1's gait instabilities.</li> <li>d. address if additional lights in R1's room would assist in preventing further falls.</li> <li>e. address how the facility's resolutions to R1's fall would be monitored for effectiveness, who would be responsible for the monitoring, or when revisions would take place if effectiveness was not obtained.</li> </ul> <p>Through record review, quality committee meeting review, safety committee meetings review, quarterly nursing notes review, monthly QIDP reports for March, April, and May review and, Individual Service Plan review, the governing body failed to maintain a reproducible system to identify trends and patterns for the recurrent falls of R1:</p> <p>The Facility's Quality Committee policy #5.29 #7 sates the committee will review all incidents and accidents, including injuries and bruises and bruises of unknown origin, involving individuals and staff to ensure that no patterns or trends are</p>	Z9999		

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Z9999	<p>Continued From page 17</p> <p>occurring. Committee will implement a plan of correction when necessary to prevent future incidents or accidents however; when the committee met on 3/31/14 listed under "Patterns and/or Trends noted is R1 was seen last quarter by his physician for gait issues" There is no plan of correction noted.</p> <p>The safety committee meeting minutes fail to show a system or any evidence of how the recommendations for prevention of future falls are carried over to the staff that work directly with R1.</p> <p>The monthly QIDP notes for March, April, and May failed to identify the falls at all.</p> <p>The governing body failed to have a system in place to identify if revisions to the Individual Service Plan are taking place in the event of medical decline as referenced in the above incident reports 1 through 13.</p> <p>The ISP dated 8/7/13 failed to include any revisions to the plan or a specialized team meeting to identify patterns or trends to aid in prevention of further harm to R1.</p> <p>(A)</p>	Z9999		

IMPOSED PLAN OF CORRECTION

EAGLE COURT  
IRI OF 6/10/2014/IL70550  
DATE OF SURVEY: July 16, 2014

- 350.620a) The facility will provide all services necessary to maintain each resident in good physical health.
- 350.1210
- 350.1230d) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the Administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.
- The facility will notify the resident's physician of any accident, injury, or change in a resident's condition that threatens the health, safety or welfare of a resident.

Direct care personnel will be trained in, but are not limited to, (1) detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention, and (2) Basic skills required to meet the health needs and problems of the residents.

The facility owner, licensee, administrator, employee or agent will not neglect a resident.

A responsible staff member will be on duty at all times who is immediately accessible, and to whom residents can report injuries, symptoms of illness, and emergencies. The consultant nurse will provide consultation on the health aspects of the individual plan of care and will be in the facility not less than two hours per month.

This will be accomplished by the following:

- I The facility will review, and revise as necessary, its policies and procedures to address, at a minimum, the following items.
  - A. Monitoring of residents with a history of falls, detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.
  - B. When direct care staff should notify nursing of a significant change in a resident's condition in the event that an individual sustains an injury or illness.
  - C. When nursing staff should notify a physician of a significant change in a resident's condition, with emphasis on a resident who sustains an injury or illness;

- D. Assessments and documentation to be completed by nursing staff following a resident's return from the hospital, including those assessments that are to be performed in person; and
- II. Mandatory inservices will be conducted with direct care staff to address, at a minimum, the following items:
  - A. Protocols for properly assessing a resident who has fallen, including proper documentation of those assessments; and
  - B. Notification of nursing staff when there has been a significant change in a resident's condition, including falls, injuries or illness
- III. Mandatory inservices shall be conducted with nursing staff to address, at a minimum, the following items.
  - A. Proper review, documentation and implementation of facility's policies and procedures and guidelines;
  - B. Performance and documentation of assessments when a resident falls sustaining injuries and has a history of falls with injuries.
  - C. Notification of physicians regarding any significant change in a resident's condition.
- V. The Administrator shall be responsible for ensuring that all aspects of this plan of correction are implemented.

COMPLETION DATE: Within twenty-one (10) days of receipt of this plan of correction.

350.3240a) The facility shall implement measures to ensure that no its residents are protected from any abuse or neglect by its owners, licensees, administrator, employees or agents.

Any facility employee who becomes aware of abuse or neglect shall IMMEDIATELY report the matter to the facility administrator.

The facility shall bar any employee from contact with residents pending the outcome of a complete investigation whenever an initial investigation of suspected abuse, based on credible evidence, indicates that the employee is a perpetrator of abuse.

This will be accomplished by:

- I. A committee shall be established to review existing policies and procedures concerning abuse and neglect, and to formulate or revise any needed policies and procedures that facility staff will follow. This committee will ensure that the facility's policies and procedures address at a minimum, the following items.
  - A. Recognition of situations that could be interpreted as abuse or neglect;
  - B. Proper reporting procedures for staff to follow;
  - C. Techniques to be utilized in the facility's internal investigation of the situation;
  - D. Notification of local law enforcement when appropriate; and
  - E. Disciplinary or precautionary action to be taken with any employee suspected of involvement in an abusive or neglectful act.
- II. All staff will be trained, by mandatory inservice, in the facility's policies and procedures concerning abusive situations. This inservice shall include, but not be limited to:
  - A. A thorough review of the facility's revised policies and procedures concerning abuse and neglect;
  - B. Identification of situations which can be considered abuse or neglect;
  - C. Each employee's individual duty to report any abusive and neglectful situations to the administrator. In the administrator's absence, the employee will report to the previously designated supervisory employee who will then report to the proper authority; and
  - D. Disciplinary or precautionary action to be taken against employees suspected of abuse or neglect, or any employee who was aware of any abusive or neglectful situation but failed to report it.
- III. The facility will take the following actions to prevent reoccurrence of abuse or neglect.
  - A. Staff will have the above inservice repeated on a regular basis;

- B. All new employees will have this information presented to them during their orientation;
  - C. The administrator will take immediate action, in accordance with the established policies and procedures, against any employee who is suspected of abusing or neglecting a resident;
  - D. Appropriate disciplinary action will be taken against any employee who witnesses to properly and immediately report an abusive or neglectful incident; and
  - E. Any employee suspected of abuse or neglect will be suspended pending full investigation by the facility and/or local law authorities (if warranted).
- IV. The administrator shall be responsible for implementing facility policies and procedures regarding abuse and neglect, and for ensuring this plan of correction is followed.

COMPLETION DATE: Within fourteen (10) days of receipt of this notice.  
LJK 08/26/2014