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	IL6014260	A. BUILDING: _____ B. WING _____	C 08/21/2014

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THOMAS HERBSTRITT HOUSE	4003 N RTES 1 & 17, P.O. BOX 260 MOMENCE, IL 60954

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Z9999	FINDINGS LICENSURE VIOLATIONS: 350.620a) 350.1210 350.1220j) 350.1230d) 350.3240a) 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. (B) Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.1220 Physician Services j) The facility shall 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, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. Section 350.1230 Nursing Services 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. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or	Z9999		

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Z9999	Continued From page 1 agent of a facility shall not abuse or neglect a resident These Requirements are not met as evidenced by: Based on record review and interview, the facility failed to provide nursing services for 1 of 1 individuals (R1) in the sample. This failure resulted in R1 being hospitalized, when: a. Nursing Staff failed to provide effective and timely nursing services for R1 who had a deterioration in his medical condition and mental status. b. Nursing Staff failed to assess/recognize signs and symptom of Lithium Toxicity which resulted in delay in treatment for 6 days. c. Nursing Staff failed to notify the physician of deterioration in medical condition and mental status which resulted in delay in treatment for 6 days. d. Nursing Staff failed to document in the Nurses Notes changes in medical condition and mental status. e. Nursing Staff failed to communicate deterioration in medical condition and mental status at change of shift report. f. Nursing Staff failed to monitor significant injuries from multiple fall from 7/28/2014 to 8/2/2014 R1 was admitted to the hospital on 8/2/2014 with a diagnosis of Lithium Toxicity (1.5 Mmol/L), Frequent Falls and Dehydration. The hospital emergency room, client record, dated 8/2/2014 at 4:00 p.m. documented that R1 had the following 19 measurable injuries. R1 also had 78 areas of injuries in varying stage of healing captured in	Z9999		

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Z9999	Continued From page 2 photographs copied to a CD titled Elder Abuse Exam. The measurable injuries documented are: 1. 2cm x 1cm yellow/purple discoloration right lateral chest 2. 2cm circular yellow discoloration to upper sternum 3. 4cm x 1cm purple/red/yellow discoloration to right upper abdomen 4. 4cm irregular shaped yellow discoloration to right lateral abdomen/ribcage 5. 3cm purple/yellow discoloration to right lateral ribcage 6. 2cm yellow/purple discoloration with pencil eraser size abrasion to right lateral abdomen 7. 7cm x 1 cm purple/yellow discoloration with 2 pencil eraser size abrasions to right lower lateral abdomen 8. 4 - 0.5cm circular purple discolorations to right upper inner arm 9. 6cm x 4cm purple discoloration to lateral chest at posterior auxiliary line 10. 10cm x 5cm red/yellow/purple discoloration to right flank 11. 6cm x 4cm purple/yellow discoloration to right hip 12. 6cm x 2.5cm purple discoloration to right buttock 13. 37cm x 10cm reddish/purple/yellow discoloration to right lateral and posterior upper leg 14. 2.5cm x 1cm red area that appears to be healing to upper lumbar area 15. 2cm x 1cm deep abrasion surrounded by 4.5cm x 3 cm redness to right knee 16. 1cm scab and 2 abrasions 2cm x 3cm to left lateral knee 17. 0.5cm (scab) and 2cm x 1cm abrasion with 2.5cm x 4.5cm surrounding redness to left medial knee. 18. 1cm scab and 2 abrasions 2cm x 3cm to left	Z9999		

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Z9999	Continued From page 3 lateral knee 19. 3.5cm x 2.4 cm yellow/green discoloration & 1.5cm x 1cm purple/yellow discoloration to left upper anterior arm. Review of the Facility Policy Section 243 - Abuse, Neglect, and Death Investigation Policies dated 6/7/2013 states the following: ... 3. Neglect a. ..."A failure in a facility to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a resident or in the deterioration of a resident's physical or mental condition. This shall include any allegation where: The alleged failure causing injury or deterioration is ongoing or repetitious; or a resident required medical treatment as a result of the alleged failure, or the failure is alleged to have caused a noticeable negative impact on a resident's health, behavior or activities for more than 24 hours. Review of the Facility Policy Section 350 - Incident/Accident Policies dated 2/28/2005 states the following: ... 5. The nurse on duty shall notify the physician of any serious accidents, injury or unusual change in a resident's condition. If the attending physician or designee cannot be reached, the nurse shall contact the emergency room of either local hospital and follow the orders given by the physician on -call at the hospital. 6. The staff person who witness or discovers an unusual incident, occurrence, or injury shall complete the Unusual Occurrence/Injury Reports prior to the end of the shift.	Z9999		

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Z9999	Continued From page 4 Review of the Facility Policy Section 370 - Resident Records dated 12/14/2012 1. An active record is maintained on each resident. This record is kept current, dated, signed, complete, legible, and available at all times to the personnel of this facility... 4. c. An ongoing record of notations describing significant observations or developments regarding each resident's condition and response to treatments and programs. Incident Reports for R1 were reviewed from 6/30/2014 to 8/2/2014 and documented the following: 7/28/2014 (E9, nurse, completed nursing assessment) - 12:48 p.m. - Resident threw himself to the floor 3x "buttocks." No injury noted at this time. In the section of the report which states "if not witnessed, was client able to communicate what happened? YES is checked. What did the client report? He fell." E9 documented under Nursing Assessment "(no) new injurys (injuries) at this time." Also checked on the form was "Injury resulted from maladaptive behavior." No documentation of R1's mental status or change in medical condition. 7/29/2014 - (E9, completed nursing assessment) - 3:15 p.m. - (R1) was mad that no chairs were available to sit in he walked outside ...looked around then dropped to his knees then started yelling he did not have a chair. Nursing Assessment: Scab to (Right) knee, no redness, no bruising, (no) swelling to hands. No apparent injury to hands. No documentation of R1's mental status or change in medical condition.	Z9999		

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Z9999	Continued From page 5 7/30/2014 - (E12, nurse, completed nursing assessment) - 8:20 a.m. - (R1) fell while on his way to get on the bus in the morning. Nursing assessment: Upon examination resident has open areas that were bleeding approximate 1 (inch) x 1(inch) to knees, appears to be old sores that opened up when he fell... No documentation of R1's mental status or change in medical condition. 7/31/2014 - (E9, nurse, completed nursing assessment) - right knee was bleeding. Nursing assessment: Resident right knee scab removed, no bleeding, bruising, swelling noted. No documentation of R1's mental status or change in medical condition. 8/1/2014 -(E12, completed nursing assessment) (he) throw him self to the floor and as I was picking him up noticed he had a bruise on his back. E14 (interviewed E6, E10 and E11) and they stated that (R1) became wobbley on his feet and eased his way down to the ground. Nursing assessment: upon evaluation there were several bruises to upper leg and back. No documentation of R1's mental status or change in medical condition. 8/2/2014 - E12, nurse who transferred R1 to hospital). When getting (R1) ready for his trip to the hospital noticed he had a bruise on his left upper arm and on his back. E7, Supervisor, documented that "based on the interview and E8 (direct care), the unknown bruises are due (to) increased weakness and falls. He was sent to the ER (emergency room) for evaluation due to weakness and falls. Also documented that he was sent to ER for evaluation of his weakness and multiple falls. No documentation of R1's mental status.	Z9999		

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During interview with R1 and interviews with facility staff, the following was stated:

R1, was interviewed on 8/12/2014 at approximately 10:25 a.m. R1 said, I was in the hospital, I was sick. I throw up. R1 said that I been falling down., R1 said I don't get upset and fall to the floor, I don't know why I fall. I get dizzy and weak before I fall. My legs get weak. R1 said that he does not mean to fall on the floor. Sometimes I fall forward and hit my head but I always have my helmet on.

E7, supervisor, was interviewed on 8/12/2014 at approximately 2:15 p.m. E7 said she was the supervisor on duty on 8/2/2014 and recommended that R1 go to the hospital. E7 said that (R1), all week, was lethargic and weak, and he had changed. E7 said she use to work with him in the home and knows him well. She went to the home at about noon and R1 was lethargic, weak, not talking not eating, cheeks sunken and sitting in a wheelchair. E7 said she saw him earlier in the week, when she was walking in the hallway, she heard a commotion and R1 had fell. R1 was very weak and (staff) had to get another staff (E13) to help us (get him up off the floor). R1 was not helping us get him up.

E6, direct care, was interviewed on 8/12/2014 at approximately 2:45 p.m. E6, said that on 8/1/2014, I saw him throw himself on the floor. I was told it was a behavior but we got concerned because he was looking pale, shaking and touching his right arm. On Wednesday at DT (day training) R1 fell 4 times and we picked him up. As the day progressed, he was not able to help us get him up and we had to call (E13) from another home to help us pick him up. We put

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him in a recliner. We used a wheelchair to get him to the bus. When we got to the house, E13 and I got him off the bus (with me on one side and E13 on the other side) and walked him into the home and put him to bed. If he was having a behavior, he would have got up on his own. E6 said that E9, nurse, said it was a behavior. E6 said she saw R1 briefly on Thursday (7/31/2014) and he fell on this date. On Friday (8/1/2014) at about 10:00 a.m. he (R1) fell and we called E14. E6 stated that E14 said he did not look good. Nursing was called (E12) and she did vital signs and they were okay. We had to use a wheelchair for him to get home that day.

E12, nurse, was interviewed on 8/13/2014 at approximately 10:00 a.m. E12 said she sent R1 to the hospital. E12 said the supervisor (E7) and staff stated he (R1) looked bad, pale, drawn, and could not walk. I was hearing about a lot of falls and heard about reports of falls.

E8 was interviewed on 8/12/2014 at approximately 2:00 p.m. E8 said he (R1) was at home on 8/2/2014 in a wheelchair at 8:00 a.m. and the night shift said he was not walking again. E8 stated we kept him in the wheelchair. He was not looking right at around 12:00 p.m. E7, came to the house and E12 was called to see R1. We (E7 and E8) asked if he could be sent out (to the hospital). E8 stated he had been falling previously but did not fall on her shift.

E10, direct care classroom 6, was interviewed on 8/12/2014 at approximately 11:09 a.m. E10 said that on 8/1/2014, she observed R1 was shaky, unsteady and wobbly. A injury report was completed and I wrote the Medical Concern Report (E4, Director of Nursing was unable to present this document to surveyor as of

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Z9999	Continued From page 8 8/14/2014.) E10 said on this particular day, there was something wrong with him (R1). E9 was interviewed on 8/12/2014 at approximately 1:30 p.m. E9 said on 7/28/2014, R1 threw himself on the floor 3 times in the Senior's restroom. No injuries noted on examination by her. E9 said on 7/29/2014 she help staff get R1 up from the ground. E9 said she assessed his knee and is was a old scab present, no injury to his hands. E3, Qualified Intellectual Disability Professional (QIDP), was interview on 8/7/2014 at approximately 2:30 p.m. E3 said that R1 has a behavior of falling down. He (R1) will drop to the ground. When he is at home, he is sitting in chair then he gets up and dropped to floor. No way staff can anticipate he will do it. He will not say why he drops to the floor. He been doing this a few weeks. We are not baseline (the behavior) to determine how often he does it (fall to the floor). We are not tracking any pattern or trends regarding him dropping to the floor. He was not upset about anything prior to him dropping to the floor. There has been no changes in his (R1) supervision level due to this behavior (falling to the floor). E3 said that (R1) has not had a physical therapy evaluation (as of 8/7/2014) but is scheduled for one. R1 has a history of seizures but has not had any seizures. E3 also was interviewed on 8/14/2014 at approximately 9:10 a.m. E3 states the facility does not have a policy regarding resident "falls". E3 said the QIDP's do a Risk Assessment annually for the Integrated Individual Habilitation Plan and nursing completes the "fall" assessment. E3's QIDP Summary/Progress Note (monthly review) dated 8/5/2014 was reviewed and there was no documentation of R1's falls or	Z9999		

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deterioration in medical condition. It states under the area titled Medical: (R1) had no appointment this month. It states under the area titled Behavior: (R1) had 7 instances of verbal aggression and 2 instances of pounding on objects...

E13, direct care, was interviewed on 8/14/2014 at approximately 9:27 a.m. E13 said that (R1) fell a couple of times in the classroom (on 7/28/2014). I did not witness the fall, they called the home I was working in, to come help lift him off the floor. I came over (to the workshop) and helped pick him up. I went back to the home I was working, staff called me again to come and assist them to get him off the floor because he fell again. Also on that day he needed a wheelchair to transport him (R1) and we used someone else wheelchair to take him into the house. He was not walking. He was falling, disoriented and (had) altered mental state. On 7/30/2014, I was in the drivers seat and he (R1) was standing at the door (of the bus) and he (R1) fell backwards. ...these recent falls may have been something else, I was thinking. I don't know if falls are behaviors or something else.

E11, Day Training Instructor Senior 6, was interviewed on 8/12/2014 at approximately 10:52 a.m. E11 said that on 7/30/2014, R1 returned from the bathroom and as he was pivoting to sit in the chair he missed the chair and fell to the floor. Three people assisted to get him up and he pivoted away from the chair and fall to the floor again. R1 was pushing away from us so we had to call E13 to help us. The next day he also fell. E11 stated that you know when he is going to display this behavior (of falling) because he start shuffling with his walker and he will giggle.

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E5, Day Training Director, was interviewed on 8/13/2014 at approximately 9:25 a.m. E5 said that he did not observe R1 falls but was told about them. I did go into the bathroom and saw him (R1) on the floor on 7/28/2014. (I) never known him to throw himself on the floor, this is a new behavior. When he was on the bathroom floor, I asked him to get up and he could not. I seen him getting progressively weaker and has been some decline but I am not a (medical) doctor. After the 28th (7/28/2014) he was not himself. He was in a wheelchair for his safety. R1 falling to the floor 4 times on any give day was not brought to my attention. Don't know why he drop to floor, don't know if it's frustration or he is weak. Don't know if (R1) is having a behavior or is he getting weak.

E4, was interviewed on 8/13/2014 at approximately 1:30 p.m. E4 stated when staff have a medical concern about a client's medical status, they are to complete a Medical Concern Form. When the form is received the nurse will follow-up on the issue. Surveyor requested all Medical Concern Forms for R1. E4 was unable to present any Medical Concern Forms to surveyor as of 8/14/2014. Surveyor asked E4 if nursing staff have been re-trained in recognizing signs and symptom of Lithium toxicity. E4 said no, staff have not been retrained. E4 stated that all staff have been trained in the medication Lithium and side effects. E4 present a form titled New/Changed Medication Training Form for (R1). Surveyor noted the form documented the following side effects: weight gain, dry rough skin and irregular heart beat. E4 validated that this is the information that staff are trained on (for Lithium) when there is a change/new medication for R1. These side effects do not correlate with the side effects printed on the medication

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administration record or the written informed consent signed by the guardian on 5/25/2014 which are: tremors, dizziness, blurred vision, double vision, runny nose, sore throat, loss of coordination, dry mouth, mild nausea, stomach pain, upset stomach, back pain, sleep problems. Serious side effect:.. loss of appetite, pale skin, feeling light headed... E4 also validated that the physician was not notified of changes in R1 condition until 8/2/2014 (before being sent to the hospital).

Surveyor request a copy of R1's current Fall Risk Assessment. On 8/13/2014, E4 present a document titled Fall Risk Assessment. Surveyor noted that the last Fall Risk Assessment was completed on 5/15/2014. E4 validated that a new/revised Fall Risk Assessment has not been completed for R1 for his increased potential for fall as of 8/13/2014.

Nurse's Notes from 1/1/2014 to 8/11/2014 were reviewed and documented the following:

7/28/2014 - No nursing documentation regarding resident threw himself to the floor 3x "buttocks."

7/29/2014 - Resident angry threw himself to knees, scab to right knee, no apparent injury to hands. No documentation of R1's mental status or change in medical condition.

7/30/2014 - Staff brought resident to infirmary for a fall, both knees have an open area approximate. 1" x 1", appears to be an old wound that open up on falling... walked back to class with walker. No documentation of R1's mental status or change in medical condition.

7/31/2014 - No nursing documentation regarding

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Z9999	Continued From page 12 right knee was bleeding. 8/1/2014 - No nursing documentation regarding R1 falling. 8/2/2014 - was called to ... house for resident, he has frequent falls, weakness, confusion and antique...(physician) called, (R1) sent to (hospital). (R1) admitted to (hospital) with Dx (diagnosis) Toxic Lithium Level and possible dehydration. Computerized (change of) Shift Reports from 6/1/2014 to 8/12/2014 were reviewed and documented the following: 7/28/2014 - 6 am to 2 pm and 1 pm to 9 pm - No shift change communication regarding R1 falling on the floor, mental status or change in medical condition. 7/29/2014 - 6 am to 2 pm and 1 pm to 9 pm - No shift change communication regarding R1 falling, mental status or change in medical condition. 7/30/2014 - 6 am to 2 pm - Staff brought (R1) to infirmary for a fall, both knees have an open area approximate. 1 inch by 1 inches, appears to be an old wound that opened upon falling... No documentation of R1's mental status or change in medical condition. 7/31/2014 - 1 pm to 9 pm - (R1) is sitting himself on the floor - has done it several times this afternoon. No documentation of R1's mental status or change in medical condition. 8/1/2014 - 6 am to 2 pm and 1 pm to 9 pm - No shift change communication regarding R1 falling on the floor, mental status or change in medical	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014260	A. BUILDING: _____ B. WING _____	C 08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Z9999	Continued From page 13 condition. 8/2/2014 - 6 am to 2 pm - Was called to ...House for (R1), resident has frequent falls, weakness, confusion, and fatigue...(physician notified...to (hospital) for evaluation at 12:30 p.m. Nursing failed to assess R1 for changes in medical condition, mental status and notify the physician of these changes. (A)	Z9999		

Imposed Plan of Correction

W331 483.460(c) Nursing Services

Surveyor's Allegation: This STANDARD is not met as evidenced by: The facility failed to provide nursing services for 1 of 1 individual (R1) in the sample. The failure resulted in R1 being hospitalized when:

a. Nursing Staff failed to provide effective and timely nursing services for R1 who had a deterioration in his medical condition and mental status.
b. Nursing Staff failed to assess/recognize signs and symptom of Lithium Toxicity which resulted in delay in treatment for 6 days.
c. Nursing Staff failed to notify the physician of deterioration in medical condition and mental status which resulted in delay in treatment for 6 days.
d. Nursing Staff failed to document in the Nurses Notes changes in medical condition and mental status.
e. Nursing Staff failed to communicate deterioration in medical condition and mental status at change of shift report.
f. Nursing Staff failed to monitor significant injuries from multiple fall from 7/28/2014 to 8/2/2014.

Plan of Correction: Thomas Herbstritt House ensures all residents receive appropriate nursing services.

1. **Corrective Actions for those residents found to have been affected by the deficient practice:**

- 8/5/14, obtained order for PT/OT evaluation of R1
- 8/7/14, lithium 300mg PO twice daily started for R1 per psychiatrist telephone order, repeat lithium level on 8/11/14
- 8/10/14, R1 seen by podiatrist for palliative foot care
- 8/11/14, R1's lithium level 0.33mEq/L, within normal limits
- 8/11/14, R1 PT evaluation completed, recommends PT 2-3 times per week for 6-8 weeks
- 8/11/14, R1 refused OT screening
- 8/12/14, OT screening for R1 completed, more cooperative
- 8/14/14: R1 seen by primary care physician - Ultrasound of the gall bladder was ordered due to weight loss; diet was changed from low concentrated sweets to heart healthy high fiber diet with prune juice 3 x per week; labs were ordered
- R1 assessed by nursing on 8/5, 8/6, 8/7, 8/8, 8/9, 8/11, 8/14, and 8/16. Bruises are fading, denies pain. Walking with walker and wearing helmet and knee pads, gait steady. R1 is alert and oriented, belligerent on 8/5, cooperative and happy on other days. 8/11 R1 presented to the nurse with a superficial 0.5cm round scrape to lower anterior left leg, no bruise or swelling present, first aid administered, denies pain. 8/16 R1 fell at group home while trying to sit in his chair, 6" x 4" scrape to the middle of his back was noted, first aid administered, left message for primary care physician. 8/18 client sent to emergency department due to falling a second time in 3 days, IDPH notified on 8/18.

- A memo dated 8/11/14 regarding the reporting of incidents and accidents was distributed to staff beginning 8/12/14
- All medication training sheets will identify where staff can look in order to obtain more information regarding side effects of medications.

2. **Identification of other residents having the potential to be affected by the same deficient practice:**

   Nursing shall complete a chart audit of 100% of the clients to identify significant changes of condition which would warrant physician notification; and to identify and review any client who is prescribed lithium or any high risk medication.

   The DON shall monitor compliance with this action.

3. **Measures the facility will take to ensure that the problem will not reoccur:**

   All House and Day Program staff shall attend an in-service conducted and monitored by the Day Program Director and Residential Director to review:
   - How to recognize and communicate changes in client condition
   - How to fully and accurately complete a medical concern form
   - How to fully and accurately complete an unusual occurrence form
   - How to report changes in condition of clients
   - How to accurately describe an event/incident/concern

   The Residential and Day Program Director shall monitor compliance with this action.

   Supervisors shall attend an in-service conducted and monitored by the Residential Services Director to review:
   - How to respond to a medical concern
   - How to review and investigate an unusual occurrence

   The Residential Director shall monitor compliance with this action.

   Nursing shall attend an in-service training conducted and monitored by the DON to review:
   - How to respond to a medical concern form
   - How to respond to an unusual occurrence report
   - How to assess and document clients with reported medical concerns and unusual occurrences
   - When to notify physicians of: falls, changes in client condition, need for assistive devices, changes in mentation, changes in appetite
   - How to identify high risk medications and look up medication side effects
   - How to identify when a fall risk assessment should be completed

The Residential and Day Program Director shall monitor compliance with this action.

Supervisors shall attend an in-service conducted and monitored by the Residential Services Director to review:

- How to respond to a medical concern
- How to review and investigate an unusual occurrence

The Residential Director shall monitor compliance with this action.

Nursing shall attend an in-service training conducted and monitored by the DON to review:

- How to respond to a medical concern form
- How to respond to an unusual occurrence report
- How to assess and document clients with reported medical concerns and unusual occurrences
- When to notify physicians of: falls, changes in client condition, need for assistive devices, changes in mentation, changes in appetite
- How to identify high risk medications and look up medication side effects
- How to identify when a fall risk assessment should be completed

The DON shall monitor compliance with this action.

4. **Quality assurance plan to monitor facility performance:**

The DON will conduct a random audit of 2 resident charts per week for the next 6 weeks to ensure any signs of a change in condition have been reported properly to staff and to the resident's family/physician as required. The results of these audits will be reported to the QA committee for follow-up as necessary.

The DON will conduct a review of all resident charts for those residents on lithium over the next 6 weeks to ensure no residents on lithium are showing signs of lithium toxicity. The results of these audits will be reported to the QA committee for follow-up as necessary.

The DON shall monitor compliance with this action.

Completion date: 8/28/14

OK 9/22/14