STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005292	A. BUILDING: _____ B. WING _____	C 09/19/2014

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LENA LIVING CENTER	1010 SOUTH LOGAN STREET LENA, IL 61048

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S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1010i) 300.1210b) 300.1210d)3) 300.1210d)6) 300.3240a) 300.3240b) 300.3240c) 300.3240d) Section 300.610 Resident Care Policies a)The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician	S9999		

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S9999	Continued From page 1 of any accident, injury, or significant 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. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid procedures. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.	S9999		

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S9999	Continued From page 2 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) These Requirements are not met as evidenced by: A. Based on interview and record review, the facility neglected to follow their policy and procedure for Accident/Incident Occurrence and their policy on Resident Change in Condition for a resident after a fall. This neglect contributed to a 4 day delay in the identification and treatment of R1's femur fracture which caused excruciating pain and required surgical intervention.	S9999		

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S9999	Continued From page 3 This applies to 1 of 6 residents, (R1), reviewed for falls in the sample of 34. The findings include: The facility's policy for Change in Condition, dated 3/5/12, states the licensed nursing staff will: "assess any changes noted through direct observation or through assigned staff...Chart in the nurses notes, assessment data, observations...physician should be updated at least daily, (for a minimum of 48 hours), of the resident's status, including any deterioration or improvement. The facility's policy Accident/Incident Occurrence, (Undated), shows "all accidents or incidents where there is injury or the potential to result in injury," should have interventions initiated. The policy shows all residents that having sustained an injury, or were involved in a fall, should be observed "closely for any change from normal habits that could be an indication that there is an injury not noticed or diagnosed during the initial assessment." R1's Minimum Data Set (MDS) dated 7/21/14 identified R1 as being able to transfer and/or ambulate with one person limited physical assist. The MDS showed R1's balance as not steady but was able to stabilize without assist. An incident investigation dated 8/8/14 at 6:15 PM, shows R1 was "observed (on the floor), laying on her left side...with complaints of left knee pain." The nursing note of 8/8/14 at 6:30 PM, shows R1 was non-weight bearing which was not "her usual." The 8/9/14 nursing notes shows R1 was complaining of pain in her left hip when moved and exhibited a decrease in appetite by only eating "a few bites of meal." No nursing entries were made again until 8/11/14 at 12:00 PM which	S9999		

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S9999	Continued From page 4	S9999		

reads, "resident (R1) grabs at left leg when moved. The nursing note dated 8/11/14 at 4:00 PM, shows an order was obtained for an X-Ray of R1's left hip. The nursing note written on 8/11/14 at 5:50 PM documents an order was received to send R1 to the local hospital emergency department for evaluation and treatment. The nursing notes show R1 left the facility at 6:45 PM and was admitted to the local hospital with a diagnosis of a left hip fracture. The defination of a hip fracture is a "break in the upper quarter of the femur (thigh) bone.

The Radiology report dated 8/11/14 at 5:26 PM, show R1 with an "acute left intertrochanteric fracture with a near 90 degree angualtion of the fracture fragments."
R1 required surgical intervention on 8/12/14.

On 9/5/14 between 10:35 AM and 2:20 PM, E3, E7, E9, and E11 Certified Nursing Assistant's (CNA's), stated they were aware of R1's fall. All stated they worked with R1 during the 4 days following the fall and noticed her decreased ability to bear weight and an onset of complaints of pain to her left hip area. All stated they reported these findings to the on duty nurses on a daily and every shift basis.

On 9/11/14, E16 (RN) stated R1 "stayed in bed" and "complained of her (R1's) left leg hurting" on 8/9/14. E16 said, "E11 kept telling us, (nurses), (R1) was hurting badly." E16 said "E11 kept insisting R1 was complaining of left hip pain." E16 said, "we, (nurses), need to listen to the CNA's." E16 stated she did not document an assessment/re-assessment on R1 on 8/9/14 when E11 reported the complaints to her. E16 said she really didn't notice anything different because R1 has behaviors and sometimes just

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S9999	Continued From page 5	S9999		

stays in bed. E16 stated assessments are to be completed and documented in the nursing notes every shift for 3 days following a fall. E16 said "I don't know why, I just didn't document it." E16 stated no new interventions were implemented for R1. E16 said R1 "gets anxious" and "refuses cares," so "I use the topical Ativan ordered to decrease her (R1's) behaviors. It makes her more cooperative."

The nursing notes between 8/8/14 and 8/11/14 show no treatment or interventions were implemented for R1. There was no additional pain medication ordered or given. There was no documentation of re-assessment of R1 despite her noted changes in condition (inability to bear weight, deformity of left leg, decreased in appetite and continual complaints of left hip/leg pain.)

On 9/5/14 between 9:45 AM and 2:45 PM, E5, E7, E8, E9, and E11, (CNA's) were interviewed. All stated they do not feel the nursing staff takes their observations and concerns seriously when presented. All stated they feel there are many times when there are significant, (several days), delays in getting residents sent out for evaluations.

On 9/11/14 at 11:50 AM, E19 (LPN) stated she was the nurse on duty when R1 fell on 8/8/14. R1 was found on the floor on her left side. E19 stated she helped staff "roll R1 to her back and R1 complained of "pain to her left knee and began grabbing at it." E19 stated she didn't notice any shortening or rotation. E19 said R1 was uncooperative with a (mechanical lift) transfer which is the standard for lifting people following a fall. For this reason, E19 stated the staff used a 3 person assist to get her up into her wheelchair because she would not bear weight.

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S9999	Continued From page 6	S9999		

E19 said she had the CNA's take R1 to her room and transfer her to the bed so "I could re-assess her." E19 said "She (R1) kept rubbing her left leg" but "I didn't see anything different, (besides not bearing weight)." E19 said she was off for the next 3 days but when she returned on Monday, 8/11/14, R1 was still "acting like something was hurting." E19 said because R1 was still hurting, "I called the doctor to get an order for an X-Ray."

B. Based on observation, interview and record review, the facility neglected to follow their policy and procedure for Accident/Incident Occurrences after an allegation of theft was reported. This neglect resulted in a cash loss of greater than $200.00 for R3, and the loss of personal property for R8, R9 and R25.

This applies to 4 of 14 residents (R3, R8, R9 and R25) reviewed for neglect/theft in the sample of 25.

The findings include:

The facility's policy Accident/Incident Occurrence, (undated), states, interventions are to be initiated for "Allegations of mistreatment, neglect, or misappropriation of resident property registered by residents, visitors, or others." Incidents that "involve mistreatment, neglect, or abuse, injuries including injuries of unknown origin and misappropriation of resident funds . . . b) the facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the Investigation is in progress, c) the facility must ensure that any incident, related investigations, and corrective actions taken are reported

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S9999	Continued From page 7	S9999		

immediately to the Administrator of the facility; and to other State Survey/licensing/certification officials in accordance with State Law, within 5 working days of the incident, utilizing established procedures."

On 9/5/14 at 8:25 AM, R3 stated he has had money stolen from him on several occasions. R3 likes to have about $200.00 cash on hand to take family and/or friends out on the weekends. R3 said the facility provides the use of a locked dresser drawer in his room. R3 used to put his cash in his billfold and place it in the locked drawer in his room until he had the money stolen from his drawer. R3 stated he placed his billfold in his locked drawer and placed the drawer key in his trouser pocket. At bedtime, R3's trousers were hung in his closet with the key in the pocket. The next morning, the key was gone and so was the billfold and cash. R3 said he reported the theft of the theft of over $200.00 to the administrative personnel. R3 was not aware of any investigation or any efforts made to locate the missing money. R3 was told that he could place his money in the front office to be locked up. R3 expressed concerns that if he were to use the front office lock up, he would not be able to have access to his money from Friday evening until Monday. R3 added, "the missing key" to his locked drawer "mysteriously returned" to his room several days later. R3 said, with no other options, he began placing his cash in a "waterproof" envelope and taping it to his abdomen. R3 said this method seemed to be working until recently, (7/18/14). R3 shared that while he was in the shower, (on 7/18/14), "the envelope had at least $200.00" and it "disappeared" from the seat of his walker. R3 stated when he undressed, he placed the envelope on the seat of his walker and covered the envelope with paper napkins. R3

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S9999	Continued From page 8	S9999		

was able to give details of the events that occurred during the shower and verbalized his belief that it was taken by E4 (CNA). R3 reported the money missing. R3 said "this time they must have called the local sheriff's department because they showed up." On 9/12/14 at 10:25 AM, R3 stated he has money stolen at 3-4 month intervals. R3 said, "I keep telling them and reporting it but it keeps happening. Will you be able to keep this from happening to others here?"

On 9/5/14 at 12:35 PM, E8 (CNA) stated, on 7/18/14, after lunch, R3 was to be given a shower. E8 asked E4 to sit with R3 while she obtained some clean clothes from his room. Upon returning to the shower room, E8 said E4 had already showered R3 and was drying him off. E8 said E4 "left the shower room when I returned." E8 said 30-45 minutes later, R3 returned to the shower room stating his money/envelope was missing.

R3 lost more than $200.00 with the event of 7/18/14. Grievance logs for the past 3 months showed R8, R9 and R25 all reported personal items missing with no investigation initiated/completed and no alternatives for protection of personal property provided.

The investigation file for the allegation of theft dated 7/18/14 showed no resident interviews were conducted. No report was submitted to the Public Health Department and no further interventions were implemented/offered to ensure the safety of R3's money in the future. On 9/5/14 at 1:30 PM, E1 (Administrator) stated a summary of the investigation for 7/18/14 was not completed until today, (9/5/14), by E12 (Human Resources). This report was written 7 weeks after the allegation was initially reported.

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S9999	Continued From page 9 All investigations completed and submitted to the Department of Public Health from February 2014 to the present, (7 months) were reviewed. There were no allegations of theft investigated by the facility or reported to the Public Health Department. Between 9/5/14 and 9/12/14, interviews were conducted with E1, E2 (Acting Director of Nursing), E3, E6, E7, E8, E9, E11 (CNA's), and E27 Licensed Practical Nurse (LPN). All stated they were aware R3 had issues with money stolen/missing over the course of his stay. All stated there had been allegations of theft in the past. All were aware that R3 was taping the money to his abdomen in an effort to prevent future loss/theft. (B)	S9999		