STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000517	A. BUILDING: _____ B. WING _____	10/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARTHUR HOME, THE	423 EBERHARDT DRIVE ARTHUR, IL 61911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)6) 300.3240a) 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 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with	S9999		

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the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)
b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

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 are not met as evidenced by:

A. Based on observation, record review and interview, the facility failed to ensure safety/supervision to prevent falls by failure to supervise in the bathroom, failure to have a functional alarm, failure to use a gait belt when indicated, and failure use two staff as directed to prevent tube dislodgment. These failures affect three of 12 residents (R1, R4, R14) reviewed for safety on the sample of 12. These failures resulted in falls with rib fractures for R1 and R4.

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Findings include:

1. The Incident Report dated March 2014 documents on 3/8/14 that R4 was "found on floor" at 6:35 pm resulting in fractured ribs. The Fall Assessment dated 2/19/14 documents that R4 is at high risk for falls. Care Plan dated 2/26/14 documents "(R4) often requests to be in the bathroom for extended periods of time. Due to needing supervision with transfers and ambulation when in room and hallway, CNA staff should continue to assist him to the bathroom; if he requests to be in the bathroom for 5 min (minutes) or longer offer verbal reminder as needed to pull call light...offer Visual check q (every) 5 min until finished in the BR (Bathroom)."

The Nurses Notes on 3/8/14 document "I (E6) walked resident to room from DR (Dining Room). Put resident on toilet. Asked him to pull call light when finished. This occurred at 6:16 pm. Checked on resident at 6:30 pm et (and) found on toilet. CNA (Certified Nursing Assistant, E5) found resident on BR (Bathroom floor) at 6:35 pm....c/o (complained) of pain in RLQ (Right Lower Quadrant) of back. Red spot, possible bruise starting."

On 10/9/14 at 10:30 am E6, Licensed Practical Nurse (LPN) stated that she told E5, Certified Nursing Assistant (CNA) that R4 was on the toilet. E6 stated that she and E5 were going back and forth from the dining room bringing residents back to the area. E6 states "I know that when he (R4) puts on his call light you have about five minutes or less to respond and he is impatient and will get up to care for himself." E6 stated she did not see R4's light go on. E6 stated, "I probably turned the corner and was down another hall or in the

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S9999	Continued From page 3 medication room or in another resident's room. . . .I should not have left him." On 10/8/14 at 4:20 pm E5 stated, "Anyone with an alarm on the chair can't be left alone on the toilet. But (R4). He is the only exception." E5 confirmed that while R4 is on the toilet he is to be visibly checked every five minutes. E5 stated that on 3/8/14 after dinner she was assisting residents from the dining room to the resident area when she noticed R4's call light was on. E5 stated, "I went in his (R4) bathroom and he was sitting on the floor. His britches were already pulled up." On 10/9/14 at 9:25 am E2 Director of Nursing stated, "(R4) is quick. He will pull the call light then hop right up." E2 stated that staff should have been readily available to assist R4 in the bathroom when he turned his call light on. E2 states that she would not have recommended staff to leave the area when R4 was placed on the toilet. E2 stated that staff need to be "readily available and visible to his (R4's) call light." R4's X-ray Report on 3/12/14 documents "Fractures of the right anterior 8th, 9th, and 10 ribs." 2. The Incident Report dated June 2014 documents that R1 fell on 6/5/14 resulting in fracture of the eight and ninth ribs on left side. The root cause documents "Resident attempting to get from recliner to wheelchair independently." The Fall Assessment on 4/23/14 documents that R1 is at high risk for falls. X-ray Report of 6/5/14 documents "There are acute fractures involving the left eight and ninth ribs laterally as well as the left ninth rib posterior laterally. The ninth rib has two fractures."	S9999		

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The Nurse's Notes on 6/5/14 at 11:45 am document that E17, Registered Nurse (RN) "heard res (R1) call 'help' and found R1 lying on the floor on her right side. . . (R1) was trying to get into w/c (wheelchair) from recliner. Alarm sensor pad on. Not alarming."

On 10/7/14 at 10:30 am E2, Director of Nursing confirmed regarding the 6/5/14 fall that R1's alarm was "not sounding" and that R1 sustained fractures of the eight and ninth ribs. E2 stated that R1's sensor alarm is to be checked every shift per Physician Orders. E2 confirmed that there was no documentation that R1's alarm was checked 6/4/14 on the 10-6 shift, prior to her fall. E2 states that R1's alarm should have been checked on 6/4/14 on the third shift. E2 stated "the floor nurses are responsible for checking the alarms and sign off."

Care Plan dated 5/9/14 documents that R1's pressure pad alarm is to be checked "every shift for proper functioning and replace PRN (as needed) if defect noted."

R1's Treatment Record for June 2014 does not document that staff checked the sensor alarm on 6/4/14, the third shift.

3. On 10/7/14 at 10:15 am E14, Licensed Practical Nurse (LPN) and E16, RN transferred R1 from a seated position in her wheelchair to a standing position at her walker. E14 cued R1 to grab hold of her walker and stand up. R1 made unsuccessful attempts to stand. E14 then reached under R1's left arm and attempted to pull R1 up. At that time R16 grabbed the back of R1's pants and pulled R1 to a standing position.

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On 10/7/14 at 10:20 am E14 stated "We don't usually use a gait belt for her (R1)." E16 stated, "I don't believe she is designated for a gait belt."

On 10/7/14 On 10/8/14 at 10:05 am E15, Physical Therapy Assistant, stated that R1 is to be transferred with a gait belt.

On 10/7/14 at 10:25 am E13, Minimum Data Set and Care Plan Coordinator, confirmed that R1 is to be transferred with a gait belt.

According to the facility's "Resident Transfers/Use of Gait Belts" policy dated 6-8-14, states "Never pull a resident up by their arm or under the armpit. Always use a gait belt."

4. The Physician Order Sheet (POS) for May 2014 documents that R14's diagnoses include Cerebral Vascular Accident, Left Side Stroke, and Dysphasia. This (POS) states that R14 receives feeding per Gastrostomy Tube. The Care Plan dated 3/11/14 documents that R14 requires total staff assist for hygiene/grooming/bathing. Minimum Data Set dated 3/11/14 documents that R1 requires extensive assistance for Activities of Daily Living, toileting and hygiene/bathing.

The Incident Report dated May 2014 documents that R14's feeding tube was "pulled out" on 5/31/14. Nurse's Notes dated 5/31/14 documents that "Peg (percutaneous endoscopic gastrostomy) tube got pulled out while CNA (Certified Nurse Assistant) was giving bed bath. Pressure drsg (dressing) applied to the peg tube site D/T (due to) bleeding."

On 10/8/14 at 10:48 am E2, Director of Nursing,

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S9999	Continued From page 6 stated regarding the Investigation Report of 5/31/14 that "The CNA (E18) was giving him (R14) a bed bath and the G-Tube was caught under his left arm as she rolled him to his right. When she tried to release the tube it pulled out. The stoma was bleeding." E2 stated that E18 was educated on R14's need for two staff assistance for care. On On 10/8/14 at 11:15 am E13, Minimum Data Set and Care Plan Coordinator, stated that R14 requires assist of two staff for bed mobility, bathing, transfers and dressing. E13 stated that R14 should have had two staff assisting with his care and he only had one staff person at the time of the incident. (A)	S9999		

Plan of Correction
The Arthur Home
423 Eberhardt Drive, Arthur Illinois 61911
Provider Number 146023/0005462
Survey Type: Annual Health Survey
Cycle Date 10/9/2014
Survey Date 10/9/2014

F323: The facility will continue to ensure that the resident environment remains as free from accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

Regarding R4:
R4 has been comprehensively reassessed regarding risk for falls. R4's care plan has been reviewed and modified including but not limited to when resident expresses need to remain on toilet for an extended period, staff are to remain in room per alarm policy. Involved unit staff have been inserviced regarding R4's care plan interventions and modifications.

Regarding R1:
R1 has been comprehensively reassessed regarding risk for falls. R1's care plan has been reviewed to ensure that interventions address current risks, conditions and care needs. R1's alarm has been checked as is functional.

Regarding R14:
R14 has been comprehensively reassessed regarding transfer status. R14's care plan has been reviewed to ensure that interventions address current risks, conditions and care needs including but not limited to transfer with assist x 2. Involved unit staff have been reinserviced regarding R14's transfer status.

Regarding other potentially affected residents:
Residents assessed as at risk for falls have been reviewed to ensure that care plan interventions address current risks, conditions and care needs, including but not limited to supervision during toileting, transfer status, use of alarms, etc. All alarms have been inspected to ensure proper functioning.

Corrective Measures:
The facility has reviewed its Fall Prevention & Management policies and procedures.
All staff have been reinserviced including but not limited to:

- Supervision of residents who are at risk for falls during toileting.
- Monitoring placement and functioning of alarms.

- Alarm battery replacement schedule.
- Compliance with resident transfer status.

The Director of Nursing/designee, supervisory staff, unit nurses, etc. will ensure compliance with facility policies/procedures and resident-specific care plan interventions through daily unit rounds, resident-specific observations, random inspection of alarms, and observation of staff performance.

QA plans and monitoring:

Audits will be conducted including:

- Observational audits of resident supervision during toileting.
- Observational audits/inspections of alarms in use.
- Observational audits of staff transfer performance.

The aforementioned audits will be conducted weekly x 4 weeks then monthly x 3 months. Audit results will be reviewed by the QA Committee with evaluation of trends/patterns and corrective actions implemented if/as indicated. Ongoing audit frequency will be based upon goal attainment.

Completion Date: 10/20/2014 accepted