Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004881	A. BUILDING: ______ B. WING ______	C 02/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK REHABILITATION & HCC	**1700 WHITE STREET MOUNT VERNON, IL 62864**

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S9999	Final Observations	S9999		

Statement of Licensure Violations:

300.610a)
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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.

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

Attachment A
Statement of Licensure Violations

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well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Regulations were not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide the level of supervision needed during an identified period of agitation and restlessness, failed to implement fall prevention interventions and failed to ensure that fall prevention interventions such as alarming

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devices were functioning, for 4 residents (R2, R5, R6 and R7) reviewed for fall risk.

These failures resulted in R2 falling and sustaining a fracture at the C5 - C6 level of the cervical spine as noted on a hospital Cervical Spine Computed Tomography (CT) report dated 1/19/2015 and which resulted in R2's death on 1/20/2015, 2 days after the fall, as noted on the Certification of Death record with an issue date of 1/28/2015.

On 2/5/2015 the facility identified 11 current residents (R5, R6, R7, R8, R10, R11, R12, R13, R14, R15, R16) at risk for falls who were using some type of fall intervention device.

Findings include:

1. R2 was admitted to the facility on 8/21/14 with a history of falls as noted on the Admission Minimum Data Set (MDS) dated 8/28/2014. R2's diagnoses included Alzheimer's Dementia, Seizure Disorder, Peri Orbital Hematoma and History of Falls as noted on an undated Cumulative Diagnosis form. The 8/28/2014 MDS indicates a history of a fracture related to a fall within the 6 months prior to this admission.

The 11/20/14 MDS indicated that R2 had fallen twice with no injury since the date of the previous MDS (of 8/28/14).

A physician's order for a bed alarm was noted on the November Physician Order Sheet POS) with a date of 9/14/14.

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A Fall Risk Assessment dated 11/19/2014 had assessed R2 as high risk for falls.

R2's Care Plan with a start date of 8/29/14 includes problem areas of falls and risk of self injury,disruptive/socially inappropriate behaviors, history of aggression, hallucinations and/or delusions and pain issues. Interventions included intervene as needed as soon as behaviors are noted, take to a quiet location and divert from distracting stimuli, observe for non verbal signs of restlessness that may precipitate movement and attempts to stand/walk unattended, and bring to nurses station when out of bed for observation.

R2's Nurses Notes indicated the following falls occurring after the 11/20/2014 MDS was completed:

A) 11/22/2014 at 8:15 pm, fall from bed with no injury. Nurses notes indicated that the bed alarm was in place but was not sounding. An approach was added to use a raised edge bed mattress on 11/24/14. The bed alarm was discontinued on 11/26/14.
B) 12/9/2014 - 8:30 pm, fall from bed with no injury. The raised edge bed mattress was discontinued on 12/10/14 and a bed alarm was restarted.
C) 12/24/2014 - 8:00 pm, fall from wheel chair and received a "small bump" to head. Facility determined on 11/29/2014 that R2's pin chair alarm was not in place.
D) 12/25/2014 - 9:30 pm, fall from wheel chair and no injury. New intervention was for Occupational Therapy (OT) to screen and placement of a lap cushion positioning device while up in wheel chair was added. OT screen was completed on 1/7/15 with no new recommendations.

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S9999	Continued From page 4 E) 01/17/2015 - 8:45 pm, Nurses Note indicates that Z1, Medical Doctor, was notified of an incident but it does not state that it was a fall. E2, Director of Nurses verified on 2/1/15 at 11:00 pm that R2 did have a fall from her wheel chair with no injury on 1/17/2015. E2 stated that the investigation found that R2 was screaming and hollering in the hall, as was normal for R2, and E11 Registered Nurse (RN) took R2 into her room, in her wheel chair and instructed E10 to sit at R2's door and keep an eye on R2 until R2 had calmed down. E2 stated the investigation indicated that R2 was very agitated, attempting to self transfer and did not have R2's intervention of a lap cushion device in place and that the pin chair alarm did not sound at the time of the fall. E2 further stated that the investigation indicated that R2's door had gotten partially closed and E10 did not maintain direct visual observations of R2 as instructed. E2 stated that a new intervention of starting 15 minute checks for R2 was added and staff were inserviced to remember to check resident Care Plans for determining which assistive devices are used for each resident. E10, CNA, stated on 2/3/15 at 2:00 pm that when she had worked on R2's hall on 1/17/2015, she was not able to use the chair alarm for R2 because the clip was missing from the alarm cord. E10 further stated that she was not aware that R2 was to have a lap cushion positioning device when up in the wheel chair. E10 verified that R2 had a fall from her wheel chair on the evening of 1/17/2015. E10 stated that for approximately 2 weeks, every time she had worked with R2, she had not been able to find the clip for the chair alarm and stated that "we" had reported it. E2 Director of Nurses (DON) stated on 2/3/2015 at 10:45 am that she was not notified and had no knowledge of the missing clip to the	S9999		

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chair alarm.

E8 (CNA) stated on 2/3/2015 at 10:40 am that R2 was always yelling "let me out of here and other stuff." E8 stated two days prior to the fall on Sunday 1/18/15, R2 was really upset at start of the shift around 2:15 pm and E8 stayed with R2 in her room, holding her hand until she had calmed down.

F) 1/18/15 fall at 8:40 pm, from the bed, with a change in condition that required transfer to the emergency room.

The Nurses Notes for 1/18/2015 indicate that at 8:40 pm, R2 was found on the right side of R2's bed, face down, incontinent of urine and denied pain or discomfort. R2 was repositioned and lifted back to bed with the use of a mechanical lift device and 2 staff. The notes indicate that R2's grasp was weak and that R2's pupils were "sluggish with light". The documentation does not include whether there was an alarm device sounding at the time of the fall. R2's neuro checks indicated weak grasps, pupils slow to react and muscle tone flaccid. R2 was noted to have a 1 centimeter by 1 centimeter sheared area to R2's left forehead "X 2" with a raised area. Orders were received from Z1 to send to the emergency room.

R2 was transferred to a local hospital emergency room shortly after the fall, and several hours later (on 2/19/2015) was transferred by ambulance to an out of state hospital where she died on 1/20/2015, as documented in the Hospital Nurses Notes of 2/18/2015 thru 2/21/2015.

The local hospital's Emergency Department notes indicate that as a result of a fall at the nursing

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home, a "CT (computed tomography) Cervical Spine Non Contrast" was done on 1/19/2015 at 3:30 am and R2's diagnosis was Fracture - to C5 osteophyte with flaccidity. Notes indicated that R2 needed resources not available at the local hospital and that R2 was being transferred to an out of state hospital.

A Cervical Spine Computed Tomography (CT) dated 1/19/2015 from the out of state hospital indicates the following: Hperextension injury at the C5-C6 level with C5 avulsion fracture and C5-C6 disc distraction injury. It further indicated that R2 had severe canal stenosis at the involved level with a suspicion of a hematoma within the canal. It further stated "When compared to the outside study performed 1/19/2015, there has been no significant change in the above findings."

The Certification Of Death record states the following: "Underlying Cause: Manner: Accident, Complications of Cervicospinal Blunt Trauma." Date of Death-1/20/2015. Z4- Chief Investigator, Medical Examiners Office, stated on 2/17/2015 at 3:30 pm that R2's death was attributed to the 1-18-15 fall, which R2 sustained at the facility, where she resided.

E10 stated that she did not work on R2's hall on 1/18/2015 but she recalled seeing R2 up in her wheel chair sometime during the evening, upset and agitated, which was normal stuff for R2, but could not recall an exact time.

E8 stated on 2/3/15 at 10 :40 am, that on the evening of 1/18/15, E8 wasn't working on R2's hall but that she had come onto the hall to help with a resident around 8:00 pm and R2 was sitting in her wheel chair in the hall at that time. E8 stated that when she was finished helping with

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the other resident she came back up the hall past R2's room and noticed she was in bed at that point, maybe 5 minutes later.

E4 Certified Nurse Aide (CNA) stated at 10:15 pm on 2/1/15, that R2 fell between 8 and 9 pm on 1/18/15. E4 stated that after putting R2 to bed for the evening, R2 kept trying to get up from the bed and E4 and E3- (CNA'S) had gotten R2 back up into R2's wheelchair and sat R2 in the hallway where E3 and E4 had R2 in visual (site) while they worked on the books. E4 stated that she went on break and while she was on break, E3 came and got her and told her that R2 had fallen.

E3, Certified Nurse Aide (CNA) stated on 2/1/15 at 10:30 pm that E3 and E4 had put R2 to bed for the night on 1/18/2015 but R2 kept trying to get up out of bed. E3 stated that R2's bed alarm was working at that time because it kept sounding when R2 would try to get up. E3 stated that she and E4 got R2 back up and placed R2 in a wheel chair and placed her out in the hallway so staff could keep an eye on R2. E3 stated that she left the hall to go help another CNA with a transfer and that she told the nurse (E6- Licensed Practical Nurse LPN) to watch R2 who was still in her wheel chair in the hall near her room. E3 stated that she thought the other CNA- E4 had gone into another resident's room. E3 stated that when she returned from assisting with the transfer on a different wing, as she neared R2's doorway, she could see R2's head in the floor and that R2 was face down near the doorway inside R2's room. E3 stated that E6 was still in the hall a couple feet from R2's doorway with her back to the door and was not aware of R2 falling. During a second interview on 2/3/2015, at 2:30 pm, E3 stated that she was "pretty sure" R2 had the chair alarm in place but not a lap cushion

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when she left R2 but that there was no alarm sounding when she returned to the hall a few minutes later. E3 stated that R2's bed was turned down and her wheel chair was on the room mates side of the room (window side) with wheels locked. E3 stated that she recalled having made R2's bed up when they had gotten R2 up from it earlier. E3 stated that as they were assisting R2 into bed using the mechanical lift, she noted R2 was limp like a wet noodle and had been incontinent of a large amount of urine. E3 stated that no one else working stated that they had put R2 to bed but E3 felt that R2 could not have walked from the wheel chair to the bed on her own.

E6, Licensed Practical Nurse (LPN) stated on 2/3/15 at 3:00 pm, that E6 had instructed E3 and E4 around 7:45 - 8:00 pm to to put R2 to bed because she was yelling out in the hall way. E6 stated that at about 8:30 pm she went into R2's room to give the room mate her medications and that R2 was in bed with the head of the bed up and her two half rails in the up position. E6 stated that she could not recall seeing R2 back up in the wheel chair prior to the fall but that at about 8:45 pm, E3 had stuck her head out of R2's room and stated that R2 was in the floor. E6 stated that there was no alarm sounding and indicated that she recalled that R2's wheelchair was out in the hallway but did not think R2 would have been able to get from her wheelchair to her bed or push herself into her room, lock the wheel chair and then get into her bed on her own. E6 stated that she observed R2 laying in the floor with one arm to the side and the other in front of her with her legs straight and face forward partly in the door way. E6 stated she assessed R2 and did not find any injury but did note that after R2 was placed in bed with the mechanical lift and 2 staff,

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she did a neuro check and noted R2's pupils were sluggish but then became brisker. E6 stated that she also noted that R2 was a little flaccid but that "she would do that, kinda go limp then turn around and try and hit you." E6 stated she notified Z1 of her findings and received an order to send R2 to the emergency room. E6 stated that when the ambulance crew arrived, R2 kept swinging at them when they were trying to put a soft collar on R2.

E1, Administrator and E2 stated during the daily status meeting on 2//5/2015 at 4:15 pm that R2 had a history of a previous C5 injury. An 8/13/2014 CT of Chest report was provided by E2 which documented Impression: ... 4. Moderate compression deformities at T5 and C5, The exact age of these is uncertain.

On 2/5/2015 at 10:45 am, E2 was asked if after R2's fall on 1/18/2015, when the investigation revealed that R2's alarms did not sound and staff had not been consistently using the lap cushion device, if there was a facility wide check for the proper functioning and placement of the alarms and lap cushion devices for all residents with alarm devices and lap cushions. E2 stated that E6 had verbally told E2 that E6 had checked other resident devices after R2's fall on 1/18/2015. E2 stated that there was no protocol for checking them after a fall and there was no hard copy record of a check being done after R2's 1/18/2015 fall, specifically related to assessing other residents for any potential alarm or lap cushion device concerns. E2 stated that staff are to check for the presence of fall prevention alarms each shift and document daily on the monthly Treatment Administration Record (TAR).

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R2's January 2015 TAR was noted to contain several blanks where nurses did not initial that the bed alarm had been checked. The January 18th, 2015 date is not signed off as checked during the 6 am to 6 pm shift nor for the 6 pm - 6 am shift. There is no area on this TAR for nurses to initial that a chair alarm was in place and working. As noted above, R2's fall and serious injury occurred on 1/18/2015 at 8:40 pm.

2. R5's Care Plan for Falls was updated on 5/22/14 for a Bed Alarm. R5's Fall Risk Assessment completed on 7/15/14, 10/21/14, 12/7/14 and 1/22/15 all document that R5 is scored as a High Risk.

On 2/5/15 at 11:35AM, R5 was lying in his bed sleeping. At this same time, R5's bed alarm was in place but the battery box to the bed alarm was turned off. On 2/5/15 at 11:45AM, E14, Certified Nurse Aide (CNA), looked at the batteries in R5's battery box and stated that the batteries were in backwards. At this same time, E14, CNA, put the batteries in correctly but R5's bed alarm still did not work. E14, CNA, went on to say, "I guess the batteries are dead".

On 2/5/15 at 10:45AM, E2, Director of Nursing (DON), stated the CNAs check the bed alarms every shift and when they put the residents to bed. E2, DON, went on to say that bed alarm maintenance is done by changing out the batteries around the 15th of every month and that all of this informaton is recorded on the resident's Treatment Record. R5's December, 2014,

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January, 2015, and February, 2015 Treatment Records do not have any documentation regarding a Bed Alarm.

3. R6's Care Plan for Falls was updated on 2/1/15 for a Bed Alarm. R6's Fall Risk Assessment completed on 1/21/15 documents that R6 was scored as a High Risk.

On 2/5/15 at 11:50AM, R6 was lying in her bed. On 2/5/15 at 11:55AM, E15, Certified Nurse Aide (CNA), came into R6's room and assisted R6 out of bed but R6's bed alarm did not sound. At this time, E15, CNA, checked R6's bed alarm pad and noted that the pad had slipped down to the foot of R6's bed. On 2/5/15 at 11:58AM, E15, CNA, stated that R6's bed alarm pad, which is long and narrow, has to be positioned directly under the resident's body weight, preferably resident's hips, otherwise the alarm will not work. E15, CNA, went on to say that some bed alarm pads tend to slip down to the foot of the bed and that some CNAs do not know how to position the bed alarm pads correctly on resident's beds.

R6's February, 2015 Treatment Record does not have any documentation regarding a Bed Alarm.

4. R7's Nurses Notes document that on 12/21/14 at 1900PM (7PM), R7 was found on the floor with no injury noted. R7's Nurses Notes document that on 12/22/14 at 9:30AM, the Interdisciplinary Team met and determined the root cause of R7's fall on 12/21/14 was because R7 continues to attempt to self transfer from bed to wheelchair without assist or using a call light. R7's Care Plan for Falls was updated on 12/22/14 for a Bed Alarm while in bed. R7's Fall Risk Assessment completed on 12/21/14 documents that R7 was scored as a High Risk.

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(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	Continued From page 12	S9999		

On 2/5/15 at 11:20AM, R7 was lying in her bed. At this same time, the battery box for R7's bed alarm was fastened to the right front leg of R7's bed and the alarm was turned off. On 2/5/15 at 11:25AM, E14, Certified Nurse Aide, stated that R7 turns her bed alarm off.

R7's January, 2015 Treatment Record documents that R7 is to have a bed alarm while in bed related to decreased cognition and increase in falls. The Treatment Record documentation for R7's bed alarm, is to be completed twice a day. There are 14 times during the month of January, 2015 where the bed alarm documemtation was not completed.

pads tend to slip down to the foot of the bed and that some CNAs do not know how to position the bed alarm pads correctly on resident's beds.

R6's February, 2015 Treatment Record does not have any documentation regarding a Bed Alarm.

4. R7's Nurses Notes document that on 12/21/14 at 1900PM (7PM), R7 was found on the floor with no injury noted. R7's Nurses Notes document that on 12/22/14 at 9:30AM, the Interdisciplinary Team met and determined the root cause of R7's fall on 12/21/14 was because R7 continues to attempt to self transfer from bed to wheelchair without assist or using a call light. R7's Care Plan for Falls was updated on 12/22/14 for a Bed Alarm while in bed. R7's Fall Risk Assessment completed on 12/21/14 documents that R7 was scored as a High Risk.

On 2/5/15 at 11:20AM, R7 was lying in her bed. At this same time, the battery box for R7's bed alarm was fastened to the right front leg of R7's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004881	A. BUILDING: ______ B. WING ______	C 02/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK REHABILITATION & HCC	**1700 WHITE STREET MOUNT VERNON, IL 62864**

(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	Continued From page 13 bed and the alarm was turned off. On 2/5/15 at 11:25AM, E14, Certified Nurse Aide, stated that R7 turns her bed alarm off. R7's January, 2015 Treatment Record documents that R7 is to have a bed alarm while in bed related to decreased cognition and increase in falls. The Treatment Record documentation for R7's bed alarm, is to be completed twice a day. There are 14 times during the month of January, 2015 where the bed alarm documemtation was not completed. (A)	S9999		

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White Oaks Rehabilitation & HCC
Complaint 1550526/IL74649
Survey Date: February 18, 2015

Imposed Plan of Correction

300.610a)
300.1210b)
300.1220d)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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a) *An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.* (Section 2-107 of the Act)

Compliance with the above Regulations will be accomplished by:

A. Resident assessments are to be reviewed to ensure that those residents who are at risk for falls have appropriate interventions on their care plans.

B. Daily audits are to be conducted by the DON to determine which residents were at risk for falls, to continue for a period of four weeks, and then three times weekly until the facility has sustained compliance.

C. Nursing staff is to be educated, as needed, on where safety equipment was located, process on when equipment is not available, process on how to maintain resident safety until correct safety equipment is available, and on the facility's Fall Policy, including preventative measures, implementing interventions after a fall, and identifying the root cause of the fall. Staff is not permitted to work until after receiving this re-education.

D. The facility is to review residents who sustain a fall at the morning IDT meeting to determine if appropriate interventions had been implemented as well as the weekly At Risk meeting. Findings will be presented to the Quality Assurance Committee monthly for three months for review and recommendations. Update Plan of Care as needed.

E. The Maintenance Director will performed audit of available safety devices, chair and bed alarms, and checked for operational ability, as needed.

F. CNA and all care givers are to aware of the patient's plan of care and any interventions needed for prevention of injury or accidents.

Completion date: 20 Days from Receipt of Notice

Attachment B
Imposed Plan of Correction