

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/20/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145364</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/07/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHAMPAIGN COUNTY NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 SOUTH ART BARTELL DRIVE</b> <b>URBANA, IL 61802</b>		
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F 000	INITIAL COMMENTS	F 000			
F 324 SS=D	<p>Complaint Investigation #0760432/IL27024</p> <p>No extended survey was conducted.</p> <p>483.25(h)(2) ACCIDENTS</p> <p>The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide adequate supervision for 1 of 4 sampled residents by failing to implement new and appropriate interventions following multiple falls while ambulating, from the bed and from the chair (R3).</p> <p>Findings include:</p> <p>According to admission records and the current Physician's Order Sheet for 1/16/07 to 2/15/07, R3 has multiple diagnoses including Alzheimer's, Agitation, Parkinson's, Psychotic Mood Disorder, Osteoarthritis and Osteoporosis. R3 has orders for psychoactive medications Seroquel, Lexapro and Razadyne, with Risperdal being discontinued on 1/18/07. The most recent Minimum Data Set (MDS) of 12/7/06 assesses R3 with memory problems, moderate cognitive impairment, and requiring supervision only for ambulation. This MDS also states that R3 has behaviors of wandering, an unsteady gait, a history of falls, and uses no devices or restraints.</p> <p>According to nurses notes reviewed from</p>	F 324		2/19/07	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 324	<p>Continued From page 1</p> <p>10/26/06 to present and incident reports from 12/05/06 to present, R3 had falls and comments as follows:</p> <p>11/7/06 - 7:05pm - "Resident found sitting on buttocks in the doorway of room . . . "</p> <p>11/10/06 - 7:00pm - "Res. got up from w/c (wheelchair) in lounge et fell on the floor onto L' (left) side. Hipsters and bilateral elbow pads in place. . . "</p> <p>11/16/06 - 1:30PM - "Res. up amb. (ambulatory) ad lib. Weak on feet at times and gait shuffling and unsteady. Spoke with staff. . . .Informed that res. does amb. at will and should amb. with hipsters and elbow protectors. . . "</p> <p>11/24/06 - 7:40pm - "Found res. in sitting position on floor next to chair she had been sitting in (lounge). . . res. helped to get up and back to chair."</p> <p>11/27/06 - 6:30pm - "Resident noted trying to sit in chair in {unit} dining area slide off edge and sat herself on the floor..."</p> <p>11/29/07 - 3:00pm - "Res. up wandering. Elbow pads and hipsters on. . . "</p> <p>12/5/06 - 5:05pm - "Found on floor sitting up." The Accident/Incident Report of this date stated that R3 was found "sitting on the floor near her bed" and that bedrails were up at the time. The report had "no" for "Was personal alarm sounding?" There was nothing for "What measures were implemented to prevent this incident from recurring?", or any Summary/Outcome of investigation with administrator's signature.</p> <p>12/11/06 - 6:00pm - "Resident at dinner table in w/c with wheels locked. She was able to stand and fell to floor on right side unwitnessed. She said she hit her head. . . " The incident report had "N/A" (not applicable) regarding the personal alarm. For measures to prevent recurrence was</p>	F 324			

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F 324	<p>Continued From page 2</p> <p>written "We put resident to bed." Again, there was no summary or administrative review.</p> <p>12/26/06 - 12:10pm - "Res. found on DR (dining room) floor {unit} per nurses. Nurses charting at nurses station. No sound heard, res. quiet. Res. awake and alert but confused. . . Up {without} difficulty with 2 assist into w/c. . ." The report for this incident stated ". . . Bystander stated '{R3} is on the floor' She did not see incident. . ." The Investigation Report portion was blank, with no summary/outcome and administrative review.</p> <p>1/17/07 - 3:30pm - "Res. found sitting on floor in front of table in lobby at 12 {noon}. . ." The incident report for this incident stated that R3 "fell again at {7:00pm}." The front of this report was signed by the unit manager. The Investigation Report on the back answered "no" to all the questions, and under the measures to prevent wrote, "Res. is a wanderer. Re-directed often." The summary/outcome was "Same as above."</p> <p>1/18/07 - 3:30pm - "At 8:00am res. got out of w/c and tripped up in front of TV, landed on bottom. . . At 11:30am res was found lying on left side {with} a w/c on top of her. . . N.O. (new order) for lap (restraint)." The incident report for the 11:30am incident stated R3 was "in the hallway." The implemented measure for these incidents was the order for the lap (restraint).</p> <p>1/18/07 - 7:00pm - "Res in lobby - took w/c lap (restraint) off - attempted to stand unassisted - lost balance and fell. . . hematoma noted left side of head - 2 assist to w/c then bed. . ." The Investigation Report for this incident stated as preventive measures that "Res is in PT for gait and strength training." The summary/outcome was "Res. took off lap (restraint) - tried to stand</p>	F 324			

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F 324	<p>Continued From page 3 lost balance and fell."</p> <p>The physician's order regarding Physical Therapy (PT) was dated 1/16/07 and was for a 2 week trial. The physician's order dated 1/18/07 was for "Lap (restraint) when up in w/c release every 2 hours and ambulate patient. . " On 2/1/07 the order was to discontinue the skilled PT and put res. in a restorative walking program.</p> <p>The careplan for falls most recently reviewed on 12/7/06 had multiple approaches for "Standard Interventions" for the Gold Star program, including observation and monitoring, fall alert poster, informing family, and falls reviewed by falls committee. The most recent intervention of 12/7/06 was for the hipsters and elbow protectors, and an undated hand-written entry stated, "Add - 1 or 2 {side rails up} for mobility." There were no entries regarding personal or pressure alarms, physical therapy, restorative programs, ambulation or use of lap (restraint). No assessment or consent was in the record for the lap (restraint).</p> <p>On 2/7/07, after requesting assessment information regarding the lap (restraint) from E3 (Assistant Director of Nursing), E4 (nurse) was observed at 11:30am completing the assessment form. The assessment was dated 1/18/07, but E4 confirmed at that time that she just completed it, as well as placing a late-entry nurses note regarding verbal consent. The assessment lists measures used prior to the lap (restraint) as hipsters, elbow protectors and side rails. It also states that R3 does not attempt to remove the lap (restraint), and there are not plans to reduce the use of the restraint. When asked regarding if a body alarm had been tried or other less restrictive</p>	F 324			

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F 324	<p>Continued From page 4</p> <p>device than the lap (restraint), E4 stated, "There was really nothing to alarm, she would sit in a chair and then get up and walk and sit somewhere else."</p> <p>R3 was observed at random intervals on 1/31/07 and 2/7/07 in the TV/lounge area on the unit and in her room in bed. While in the common areas, R3 was in the w/c with a lap (restraint) that was very tight and close fitting next to the body. While an activity was going on, R3 appeared to be engaged. But when there was no activity, R3 was restless, handling chair cushions and other items. There were periods of times when no staff were at the nurses station or in the area. R3 was not observed attempting to remove the lap (restraint). When R3 was in bed, on 1/31/07 approximately 2:00pm to 3:30pm and on 2/7/07 from 10:00am to 11:40am, R3's bed was set at regular height, not low, with both full side rails up, and no alarms. R3 was observed to be restless and "fidgety," handling stuffed animals and not sleeping. Attempts to interview R3 noted R3 to be confused. R3 was not observed to be ambulated by staff. On 2/7/07 approximately 10:30am, E8 (Certified Nurse Aide/CNA) was asked if staff ever ambulate R3. E8 stated "sometimes - depends on her mood if she will or not." At 11:40am, R3's transfer from the bed to the wheelchair was observed, upon surveyor request. E7 (CNA) and E8 transferred R3 without difficulty from the bed to the chair, pulling the wheelchair up very close to the bed, so that R3 only had to pivot, and not take any steps. When asked again regarding ambulation, E7 offered to ambulate her. R3 ambulated from her room down the hall to the nurses station with 1 assist and gait belt, using short, shuffling steps but fairly steady. E7 stated that they ambulate R3 "couple</p>	F 324			

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F 324	Continued From page 5 of times a day." At the nurses station, R3 was told to sit down in the wheelchair, where the lap (restraint) was placed and she was taken to the unit dining area for lunch.	F 324			