

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6014948</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/11/2018</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ILLINOIS VETERANS HOME AT MANTENO</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>ONE VETERAN'S DRIVE</b> <b>MANTENO, IL 60950</b>
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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
S 000	Initial Comments  Annual Licensure  Facility Reported Incident (FRI) of 10/4/2018 IL106342  340.1505 a) c) 340.1800 c), d) 1) 3), e) 1) 340.1810 b) 3) 4) 340.1590 a) 1) 2) 3) 4) i)	S 000		
S9999	Final Observations  Statement of Licensure Violations:  340.1505 a) c) 340.1800 c), d) 1) 3), e) 1) 340.1810 b) 3) 4) 340.1590 a) 1) 2) 3) 4) i)  Section 340.1505 a), b) and c)  340.1505 Medical, Nursing and Restorative Services  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	S9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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S9999	<p>Continued From page 1</p> <p>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 the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)</p> <p>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care shall be provided to each resident to meet the total nursing care needs of the resident.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>These requirements were not met, as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to ensure that residents care plan are being followed. The facility also failed to monitor weight loss and update the care plan.</p> <p>This applies to 3 of 12 residents (R1, R2 and R8) reviewed for care plans in the sample of 12.</p> <p>The findings include:</p> <p>1. R1 was admitted to the facility on 9/12/18 with multiple diagnoses which included Alzheimer's</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>disease, dementia with behavior disturbance, atherosclerotic heart disease of native coronary artery without angina pectoris, hypertension, presence of aortocoronary bypass graft, A-fib (atrial fibrillation), DM (diabetes mellitus), dorsalgia, stage 4 pressure ulcer of the sacral region and history of TIA (transient ischemic attack) and cerebral infarction without residual.</p> <p>R1's admission MDS (minimum data set) dated 9/18/18 showed a BIMS (Brief Interview for Mental Status) score of "07" which meant that the resident is severely impaired with cognition. The MDS showed that the resident required extensive to total assistance with regards to his ADL's (activities of daily living). Further review of the same MDS also showed that R1 required extensive assistance with two (2) person physical assist for bed mobility and that R1 was totally dependent from the staff and required two (2) person physical assist for transfers.</p> <p>R1's initial incident report submitted via fax by the facility to the State Agency on 10/4/18 at 8:22 AM, showed, "On 10/4/18 at approximately 0520 (5:20 AM), (R1) was noted to be partially off his bed. His head was on the bed near the side rail and his legs off the bed in almost a praying position. Staff upon seeing this assisted the member back in bed and noted (R1) to be not breathing. A sternal rub was done to the member's chest with no response. Member is a DNR (Do Not Resuscitate) and resuscitation efforts were not initiated. A linear red/blue mark was noted to the member's neck. Shift coordinator was immediately notified of member's death. Due to the circumstances the shift coordinator contacted the MD (Medical Doctor), DON (Director of Nursing), Administrator, (State</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>Police) and Coroner. Family was notified of the death." Further review of the same incident report showed, "Coroner stated initial observation did not indicate strangulation, as there is no petechia or discoloration above the linear mark."</p> <p>The facility submitted an updated initial incident report to the State Agency on 10/4/18 at 1:20 PM which showed that on 10/4/18 at 1:15 PM, the State Police and the deputy coroner contacted the DON of the facility for the preliminary autopsy result stating, "The resident died of a "heart attack" and not from the linear mark to the neck. The deputy coroner stated the coronary event most likely caused the deceased to move and that was his final position at death."</p> <p>R1's side rail evaluation dated 9/28/18 showed, "Member (resident) will benefit from bilateral side rails for pressure relief technique and repositioning."</p> <p>R1's bed side rail consent signed and dated 9/12/18 showed, "Side rail- means a 1/4 length rail mounted on the upper portion on each side of a member's bed. A side rail on a member's bed can be used for transfers, turning and repositioning." The same consent showed that the reason for the use of the side rails is for repositioning.</p> <p>R1's POS (physician order sheet) dated 10/2/18 showed an order for, "(R1) will benefit from bilateral side rails for pressure relief techniques and repositioning per PT (physical therapy) on 9/28/18."</p> <p>R1's care plan initiated on 9/12/18 showed that the resident has ADL self-care performance</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>deficit. The same care plan showed in-part, under interventions/tasks, "Side rails: Half rails up as per Dr's (doctor's) order for safety during care provision, to assist with bed mobility per PT 9/28/18. Observe for injury or entrapment related to side rail use. Reposition as necessary to avoid injury."</p> <p>On 10/5/18 at 11:38 AM, V4 (Physical Therapist) stated that he was the therapist who evaluated R1 on 9/28/18 for the need to use side rails while in bed. According to V4, he recommended the use of the bilateral quarter side rails (shoulder to head portion) only during provision of care, such as during turning &amp; repositioning, cleaning &amp; changing the resident and during wound treatment. V4 stated that if R1 was just sleeping in bed and no care is being provided, his bilateral quarter side rails should not be used.</p> <p>On 10/9/18 at 12:40 PM, V3 (CNA/Certified Nursing Assistant) stated that she worked on 10/3/18 during the 11PM through 7AM shift. Per V3, she was not the assigned CNA for R1. According to V3, on 10/4/18 at around 5:15 AM, she went inside R1's room to help get up residents. Per V3, when she turned on the light inside R1's room, she noticed that R1's head was on the bed, while the rest of his body was on the floor mat. V3 described R1's position as follows: R1's head was on the bed, his face was facing the door and the right side of R1's neck was touching the side rail, which was raised up. According to V3, R1's neck was not wedged between the side rail and the mattress. Per V3, she immediately called V5 (nurse). V3 stated that V5 and V6 (CNA) came in the room to assist in getting R1 off the floor to the bed. According to V3, when R1 was transferred to bed, V5</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>started assessing and calling R1's name but the resident did not respond. Per V3, it was during this time that she left R1's bedside to attend to R1's roommates, so she can help them dress up and go out of the room.</p> <p>On 10/9/18 at 2:30 PM, V5 stated that she worked on 10/3/18, during the 11PM through 7AM shift. Per V5, she was the nurse in-charge of R1. V5 stated that on 10/4/18 at 2:00 AM, R1 was sleeping in bed with bilateral quarter side rails up (shoulder to head portion). According to V5, R1 is supposed to have both quarter side rails up, while in bed even when the resident is sleeping. Per V5, on 10/4/18 at around 5:20 AM, she was called by V3 to come and see R1 in his room. Per V5 she immediately went inside R1's room and saw R1's head resting on the bed, up against the side rail. R1's face was facing the door, while the right side of R1's head and neck was resting on the side rail. V5 stated that R1's head and/or neck was not wedged between the side rail and the mattress. According to V5, R1's bed was at the lowest position and the resident's right shoulder, trunk and lower extremities were touching the floor mat. V5 stated that R1's side rails were raised up, "The rail probably prevented resident's head from being on the floor mat." Per V5, when she initially assessed R1, the resident was still warm, she yelled out R1's name but no response. According to V5, they (V5, V3 and V6) placed R1 in bed. While R1 was in bed, she continued to call out R1's name and performed sternal rub on R1's chest area, but still without response. According to V5, R1 still felt warm but his lips were gray, his face was pale, his eyes were closed and no vital signs were appreciated. According to V5, CPR (cardiopulmonary resuscitation) was not performed on R1 because</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>the resident was on DNR (Do Not Resuscitate) status.</p> <p>On 10/10/18 at 12:49 PM, V6 stated that she was the assigned CNA for R1 on 10/3/18 from 11PM through 7AM. Per V6, on 10/4/18 at around 3:30 AM, she checked R1 to see if the resident needed changing. According to V6, during that time R1 was clean and did not need changing, so she repositioned the resident in the middle of the bed, facing towards the window. Per V6, during repositioning of R1, the resident's bilateral side rails were raised and after she repositioned R1 in bed she left the bilateral side rails up. V6 stated that the next time she saw R1 was on 10/4/18 between 5:10 AM and 5:20 AM when V3 and V5 called for her assistance to transfer R1 from the floor to the bed.</p> <p>2. R2 was admitted to the facility on 9/18/18 with multiple diagnoses which included Alzheimer's disease, dementia with behavior disturbance, history of falling, aortocoronary bypass graft, coronary angioplasty implants and graft, atherosclerotic heart disease without angina pectoris and stage 2 pressure ulcer of the sacrum based on the face sheet.</p> <p>R2's admission MDS dated 9/24/18 showed that the resident is moderately impaired with cognition and would require extensive assistance X two (2) person physical assist for bed mobility and transfers.</p> <p>R2's side rail evaluation dated 10/1/18 showed, "Side rails in-placed at the time of evaluation. Side rails recommended."</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>R2's bed side rail consent signed and dated 9/18/18 showed, "Side rail- means a 1/4 length rail mounted on the upper portion on each side of a member's bed. A side rail on a member's bed can be used for transfers, turning and repositioning." The same consent showed that the reason for the use of the side rails is for repositioning.</p> <p>R2's POS (physician order sheet) dated 10/4/18 showed an order for, "Side rails bilaterally recommended for bed mobility per PT (physical therapy) on 10/1/18."</p> <p>R2's care plan initiated on 9/18/18 showed that the resident has ADL self-care deficit. The same care plan showed in-part, under interventions/tasks, "Side rails: Half rails up as per Dr's (doctor's) order for safety during care provision, to assist with bed mobility per PT (physical therapist) 10/1/18."</p> <p>On 10/5/18 at 1:55 PM, R2 was observed sleeping in bed. R2 was noted to be using an air mattress with perimeter (concave wings on both the lower and upper portion of the bed) and with open sides in the middle of the bed. R2's bed was also noted with bilateral 1/4 length side rails on the top portion (from shoulder to head area). No care was being provided to R2 at the time of this observation.</p> <p>On 10/11/18 at 2:03 PM, V14 (Physician) stated that he is the doctor of R1 and R2. V14 stated that with regards to the use of the side rails, the staff should follow the care plan in place to ensure the safety of the resident. V14 read the care plan of R1 with regards to the side rails use</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>and stated that based on R1's care plan his side rails should only be used during provision of care of the resident's safety. According to V14, if the resident is sleeping and no care is being provided. The side rails should not be raised. Stated that he was informed by the staff of the coroner's preliminary report for the cause of death of R1 and it was heart attack. Per V14, he is waiting for the final report from the coroner's office.</p> <p>3. R8 was admitted on 10/21/13 with multiple diagnoses which includes venous insufficiency, intestinal obstruction, presence of urogenital implants, disorder of kidney and ureter, major depression recurrent and anemia.</p> <p>On 10/9/18 at 11:55 AM, R8 was in bed with eyes closed but responded immediately to greetings. R8 was alert and oriented x 4. R8 was asked if he was going to the dining room to eat lunch since lunch was already being served. R8 stated sometimes he eats lunch and sometimes he does not. R8 pointed at the beverages on top of his overbed table and stated he saved them to drink intermittently. There were several containers of cranberry juice with dates from 10/5 - 10/9, two 4 fluid ounce (oz) cartons of vanilla shakes (one carton thawed on 9/25 and the other was undated), and a container of nutritional ice cream (container was warm and had no date) and two cartons of 2% milk. R8 stated he intermittently drinks the beverages. R8 was encouraged to eat lunch. R8 got out of bed by himself, hung his indwelling catheter bag on the walker and ambulated to the dining room and ate his lunch. On 10/9/18 in the afternoon, V2 (Director of Nursing/DON) and a supervisor were</p>	S9999		
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S9999	<p>Continued From page 9</p> <p>informed of the observation.</p> <p>On 10/10/18 at 12:35 PM, R8 was in bed asleep but woke up when greeted. R8 was asked if he was notified when lunch was served. R8 stated he was not (R8 eats lunch during the first seating at approximately 11:45 AM). There were 6 containers of cranberry juice on top of his overbed table with dates from 10/5/18 - 10/9/18, an uncovered bowl of fruit cocktail, a carton of 2% milk, two 4 fluid oz containers of vanilla shake (one thawed on 9/25 and one without a date). A 4 fluid oz of disposal cup contained a tan colored liquid. R8 was asked what was contained in the cup. The cup was surrounded by a big ant and smaller ants. R8 stated the drink was given to him along with his medications. R8 was told not to drink the liquid but was unable to hear the instruction right away and grabbed the cup and drank all of the liquid. R8 stated sometimes there are gnats in his room.</p> <p>On 10/10/18 at 12:50 PM, V9 (Nurse) stated the liquid in the cup was hi-cal with protein powder. V9 stated R8 has a routine and sometimes he eats lunch and sometimes he does not. Informed V9 of R8's continued weight loss and inconsistent weights. V9 stated the certified nursing assistants do not know how to calibrate the scale which was old. V9 stated if there are significant inconsistencies with weights, reweigh should be done.</p> <p>The nurse progress notes dated 9/16/18 showed R8 had a significant weight loss from the time he was re-admitted from the hospital on 9/7/18. Weight on 9/7/18 was 125 pound (Lbs.). Current weight was 118 Lbs. The power of attorney (POA), physician and dietitian were notified.</p>	S9999		
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S9999	<p>Continued From page 10</p> <p>The Weights and Vitals Summary showed R8's weight on 10/1/18 was 115 Lbs, an 8% change from 9/7/18.</p> <p>No physician documentation was found in the medical records addressing the weight loss.</p> <p>The only nutritional assessment by the dietitian in the electronic medical records were on 9/10/18 and 9/17/18.</p> <p>On 9/10/18 dietitian (V13) progress notes showed R8 had a BMI (Body Mass Index) of 18.2 (underweight). Recent weight gain was attributed to fluids given during recent hospitalization. Staff was to continue encouragement at meal times. Further weight gain was desired. Follow-up as needed.</p> <p>On 9/17/18, the dietitian (V13) progress notes showed R8 had a significant weigh loss of 5.6 % from 9/7/18 - 9/17/18. No additional recommendation was given.</p> <p>On 10/11/18 at 1:40 PM on a telephone interview with V13 (RD/Registered Dietitian) stated she did not review the lab results on 9/17/18 and has not seen R8 yet in October. V13 stated probable cause of weight fluctuation was the fluid received while R8 was in the hospital from 9/4/18- 9/7/18.</p> <p>On 10/11/18 at 12:00 PM, V8 (Nurse/Supervisor) was informed that no document was found to show the physician had addressed R8's weight changes.</p> <p>The weight care plan initiated on 3/25/14 showed the last weight intervention was initiated on</p>	S9999		
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NAME OF PROVIDER OR SUPPLIER  <b>ILLINOIS VETERANS HOME AT MANTENO</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>ONE VETERAN'S DRIVE</b> <b>MANTENO, IL 60950</b>
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S9999	<p>Continued From page 11</p> <p>12/25/16 for staff to encourage him to consume more of his meals.</p> <p style="text-align: center;">( AW )</p> <p>Section 340.1800 c), d) 1), 3) and e) 1)</p> <p>340.1800 Resident Record Requirements</p> <p>c) The facility shall keep an active medical record for each resident. This resident record shall be kept current, complete, legible, and available at all times to those personnel authorized by the facility's policies and to the Department's representatives.</p> <p>d) Record entries shall meet the following requirements:</p> <p>1) Record entries shall be made by the person providing or supervising the service or observing the occurrence that is being recorded.</p> <p>3) Medical record entries shall include all notes, orders or observations made by direct resident care providers and any other individuals authorized to make such entries in the medical record, and written interpretive reports of diagnostic tests or specific treatments including, but not limited to, radiologic or laboratory reports and other similar reports.</p> <p>e) An ongoing resident record, including</p>	S9999		

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S9999	<p>Continued From page 12</p> <p>progression toward and regression from established resident goals, shall be maintained.</p> <p>1) The progress record shall indicate significant changes in the resident's condition. Any significant change shall be recorded upon occurrence by the staff person observing the change.</p> <p style="text-align: center;">(AW)</p> <p>Section 340.1810 b) 3) and 4)</p> <p>340.1810 Content of Medical Records</p> <p>b) In addition to the information that is specified above, each resident's medical record shall contain the following:</p> <p>3) Nurse's notes that describe the nursing care provided, observations and assessment of symptoms, reactions to treatments and medications, progression toward or regression from each resident's established goals, and changes in the resident's physical or emotional condition.</p> <p>4) An ongoing record of notations describing significant observations or developments regarding each resident's condition and response to treatments and programs.</p> <p>These requirements were not met, as evidenced</p>	S9999		

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S9999	<p>Continued From page 13</p> <p>by:</p> <p>Based on record review and interview the facility failed to ensure that a resident's change in condition and death was documented on the medical records.</p> <p>This applies to 1 of 3 residents (R1) reviewed for the use of side rails in the sample of 12.</p> <p>The findings include:</p> <p>R1 was admitted to the facility on 9/12/18 with multiple diagnoses which included Alzheimer's disease, dementia with behavior disturbance, atherosclerotic heart disease of native coronary artery without angina pectoris, hypertension, presence of aortocoronary bypass graft, A-fib (atrial fibrillation), DM (diabetes mellitus), dorsalgia, stage 4 pressure ulcer of the sacral region and history of TIA (transient ischemic attack) and cerebral infarction without residual.</p> <p>R1's admission MDS (minimum data set) dated 9/18/18 showed a BIMS (Brief Interview for Mental Status) score of "07" which meant that the resident is severely impaired with cognition. The MDS showed that the resident required extensive to total assistance with regards to his ADL's (activities of daily living). Further review of the same MDS also showed that R1 required extensive assistance with two (2) person physical assist for bed mobility and that R1 was totally dependent from the staff and required two (2) person physical assist for transfers.</p> <p>R1's initial incident report submitted via fax by the facility to the State Agency on 10/4/18 at 8:22 AM, showed, "On 10/4/18 at approximately 0520</p>	S9999		

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S9999	<p>Continued From page 14</p> <p>(5:20 AM), (R1) was noted to be partially off his bed. His head was on the bed near the side rail and his legs off the bed in almost a praying position. Staff upon seeing this assisted the member back in bed and noted (R1) to be not breathing. A sternal rub was done to the member's chest with no response. Member is a DNR (Do Not Resuscitate) and resuscitation efforts were not initiated. A linear red/blue mark was noted to the member's neck. Shift coordinator was immediately notified of member's death. Due to the circumstances the shift coordinator contacted the MD (Medical Doctor), DON (Director of Nursing), Administrator, (State Police) and Coroner. Family was notified of the death." Further review of the same incident report showed, "Coroner stated initial observation did not indicate strangulation, as there is no petechia or discoloration above the linear mark."</p> <p>The facility submitted an updated initial incident report to the State Agency on 10/4/18 at 1:20 PM which showed that on 10/4/18 at 1:15 PM, the State Police and the deputy coroner contacted the DON of the facility for the preliminary autopsy result stating, "The resident died of a "heart attack" and not from the linear mark to the neck. The deputy coroner stated the coronary event most likely caused the deceased to move and that was his final position at death."</p> <p>On 10/5/18, R1's medical records was reviewed. R1's medical records did not show any documentation of the above incident that occurred on 10/4/18. There was no documentation to indicate that R1 had expired at the facility and that the physician and the family were notified of the incident.</p>	S9999		
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S9999	<p>Continued From page 15</p> <p>On 10/9/18 at 12:40 PM, V3 (CNA/Certified Nursing Assistant) stated that she worked on 10/3/18 during the 11PM through 7AM shift. Per V3, she was not the assigned CNA for R1. According to V3, on 10/4/18 at around 5:15 AM, she went inside R1's room to help get up residents. Per V3, when she turned on the light inside R1's room, she noticed that R1's head was on the bed, while the rest of his body was on the floor mat. V3 described R1's position as follows: R1's head was on the bed, his face was facing the door and the right side of R1's neck was touching the side rail, which was raised up. According to V3, R1's neck was not wedged between the side rail and the mattress. Per V3, she immediately called V5 (nurse). V3 stated that V5 came right away and another CNA (V6) also came in the room to assist in getting R1 off the floor to the bed. According to V3, when R1 was transferred to bed, V5 started assessing and calling R1's name but the resident did not respond. Per V3, it was during this time that she left R1's bedside to attend to R1's roommates, so she can help them dress up and go out of the room.</p> <p>On 10/9/18 at 2:30 PM, V5 stated that she worked on 10/3/18, during the 11PM through 7AM shift. Per V5, she was the nurse in-charge of R1. According to V5 on 10/4/18 at around 5:20 AM, she was called by V3 to come and see R1 in his room. Per V5 she immediately went inside R1's room and saw R1's head resting on the bed, up against the side rail. R1's face was facing the door, while the right side of R1's head and neck was resting on the side rail. V5 stated that R1's head and/or neck was not wedged between the side rail and the mattress. According to V5, R1's bed was at the lowest</p>	S9999		

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S9999	<p>Continued From page 16</p> <p>position and the resident's right shoulder, trunk and lower extremities were touching the floor mat. V5 stated that R1's side rails were raised up, "The rail probably prevented resident's head from being on the floor mat." V5 stated that when she initially assessed R1, the resident was still warm, she yelled out R1's name but no response. Per V5, they (V5, V3 and V6) placed R1 in bed. While R1 was in bed, she continued to call out R1's name and performed sternal rub on R1's chest area, but still without response. According to V5, R1 still felt warm but his lips were gray, his face was pale, his eyes were closed and no vital signs were appreciated. According to V5, CPR (cardiopulmonary resuscitation) was not performed on R1 because the resident was on DNR (Do Not Resuscitate) status. Per V5, she called the physician and the shift coordinator/off shift supervisor to report the incident. The shift coordinator came over the unit. Per V5, it was the shift coordinator who called the management team and the Director of Nursing called the family.</p> <p>On 10/10/18 at 3:32 PM, V5 stated that she did not document the incident that occurred on 10/4/18 in R1's medical records. V5 further stated that she also did not document on R1's medical records that the resident expired at the facility on 10/4/18, including the notification of the physician and family. V5 stated that R1 expired at the facility on 10/4/18 at 5:20 AM.</p> <p>( AW )</p> <p>Section 340.1590 a) 1), 2), 3), 4) and i)</p>	S9999		
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S9999	<p>Continued From page 17</p> <p>340.1590 Non Emergency Use of Physical Restraints</p> <p>a) Physical restraints shall only be used when required to treat the residents' medical symptoms or as a therapeutic intervention, as ordered by a physician, and based on:</p> <ol style="list-style-type: none"> <li>1) the assessment of the resident's capabilities and an evaluation and trial of less restrictive alternatives that could prove effective (Section 2-106(c) of the Act);</li> <li>2) the assessment of a specific physical condition or medical treatment, that requires the use of physical restraints, and how the use of physical restraints will assist the resident in reaching his or her highest practicable physical, mental or psychosocial well being (Section 2-106(c) of the Act);</li> <li>3) consultation with appropriate health professionals, such as rehabilitative nurses and occupational or physical therapists, which indicates that the use of less restrictive measures or therapeutic interventions has proven ineffective; and</li> <li>4) demonstration by the care planning process that using a restraint as a therapeutic intervention will promote the care and services necessary for the resident to attain or maintain the highest practicable physical, mental or psychosocial well being. (Section 2-106(c) of the Act, see P.A. 88-413, effective August 20, 1993)</li> </ol> <p>i) A resident wearing a physical restraint shall have it released for a few minutes at least once every two hours, or more often if necessary. During these times, residents shall be assisted with ambulation, as their condition permits, and provided a change in position, skin care and</p>	S9999		

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S9999	<p>Continued From page 18</p> <p>nursing care, as appropriate.</p> <p>These requirements were not met, as evidenced by:</p> <p>Based on observations, interview and record review, the facility failed to assess the need for usage of flip buckle seatbelt and failed to follow care plan interventions for release of the same by the resident.</p> <p>This applies to 1 of 1 resident (R12) reviewed for restraint in the sample of 12.</p> <p>The findings include:</p> <p>R12's EHR (electronic health records) included diagnoses of non-traumatic intracranial hemorrhage, unspecified hearing loss, anxiety disorder. POS (physician order sheet) initiated 10/2/18 (15:02) included "Self release seat belt while up in w/c (wheel chair)." R12's quarterly MDS (minimum data set) dated 9/7/18 showed that R12 was severely impaired in cognition with a BIMS (brief interview of mental status) score of 00. Restorative evaluation for communication in the same MDS for R12 included the following: "Difficulty following directions and making needs known, expressive aphasia due to brain hemorrhage. Periods of restlessness and agitation. AROM (active range of motion) for activities of daily living progress notes dated 9/9/18 included "unable to follow cueing."</p> <p>On 10/9/18 at 1:55 PM, R12 was observed sitting on a high back wheel chair in the day room. R12 had a seat belt (flip buckle belt) fastened over his lap as he sat in the wheel chair. R12 appeared to be confused and was laughing every now and</p>	S9999		

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S9999	<p>Continued From page 19</p> <p>then. When R12 was asked multiple times if he can release the belt, R12 laughed and babbled about unrelated topics. V10 (Certified Nursing Assistant/CNA) who was in the vicinity stated that the seat belt was for R12's safety and was not aware of its protocols.</p> <p>On 10/9/18 at 2:05 PM, V11 (Nurse) stated that the seat belt was added by V12 (Restorative Nurse) about two weeks ago after R12's family had requested for the same with R12's history of falling.</p> <p>On 10/9/18 at 2:18 PM, V12 stated that R12 was able to release the belt when she asked him twice before intervention for the same. V12 stated that the staff had reported that R12 was able to release it the next day. V12 stated that R12's release of seat belt is supposed to be looked at as a task by the CNA's every shift. V12 stated that the CNA's should ask R12 whether he can release the seat belt and are supposed to document the same. V12 stated that if R12 cannot release the seat belt, we (nursing staff) will have to take it off, for it is considered a restraint. V12 stated that R12 has some cognitive deficits.</p> <p>On 10/9/18 at 2:20 PM, R12 was not able to release the seat belt when V12 cued him to do so. R12 continued to laugh and embark on unrelated topics.</p> <p>On 10/10/18 at 3:30 PM, V12 stated that she did not do an assessment for use of seat belt as the least restrictive intervention for safety from falls.</p> <p>V12's progress notes dated 10/2/18 included the following: Daughter here on 10/1/18 requesting a</p>	S9999		

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S9999	<p>Continued From page 20</p> <p>seat belt for member. This writer informed daughter that a seat belt is a restraint unless he could release it himself on demand. Member unable to release push button seatbelt on demand. Able to release a flip buckle seatbelt on demand. Will be reassess 10/9/18.</p> <p>Nursing care plan for R12 included the following: R12 is high risk for falls r/t (related to) poor safety awareness, difficulty making needs known and following directions. Self-releasing seat belt while up in manual w/c. Ensure R12 can release his seat belt on demand every shift.</p> <p>Nursing documentation (via computer) under "task" for self-releasing seat belt included the following: Ensure R12 can release seatbelt on demand.</p> <table border="0" data-bbox="170 1092 771 1764"> <thead> <tr> <th></th> <th>Applied</th> <th>Removed</th> <th>Not applicable</th> </tr> </thead> <tbody> <tr> <td>10/3/2018 06:35</td> <td>x</td> <td></td> <td></td> </tr> <tr> <td>20:08</td> <td>x</td> <td></td> <td></td> </tr> <tr> <td>10/4/2018 05:50</td> <td>x</td> <td></td> <td></td> </tr> <tr> <td>22:49</td> <td></td> <td></td> <td>x</td> </tr> <tr> <td>10/5/2018 06:57</td> <td>x</td> <td></td> <td></td> </tr> <tr> <td>15:24</td> <td>x</td> <td></td> <td></td> </tr> <tr> <td>10/6/2018 01:59</td> <td>x</td> <td></td> <td></td> </tr> <tr> <td>10:34</td> <td>x</td> <td></td> <td></td> </tr> <tr> <td>10/7/2018 06:16</td> <td>x</td> <td></td> <td></td> </tr> <tr> <td>16:06</td> <td></td> <td></td> <td>x</td> </tr> <tr> <td>23:21</td> <td>x</td> <td></td> <td></td> </tr> <tr> <td>10/8/2018 14:59</td> <td>x</td> <td></td> <td></td> </tr> <tr> <td>20:36</td> <td></td> <td></td> <td>x</td> </tr> </tbody> </table>		Applied	Removed	Not applicable	10/3/2018 06:35	x			20:08	x			10/4/2018 05:50	x			22:49			x	10/5/2018 06:57	x			15:24	x			10/6/2018 01:59	x			10:34	x			10/7/2018 06:16	x			16:06			x	23:21	x			10/8/2018 14:59	x			20:36			x	S9999		
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S9999	<p>Continued From page 21</p> <p>10/9/2018 02:14 x</p> <p>Policy and procedure titled "Physical/Therapeutic Device Evaluation" included the following: A Physical Devise is any manual, physical, or mechanical equipment attached to or adjacent to the member's body. The member may or may not be able to remove it. If the device restricts the freedom of movement or normal access to one's body it is considered a restraint. If the member is able to remove the device and move freely it is not a restraint. The member must be able to understand and demonstrate the removal of the device.</p> <p>The Physician will, if indicated by assessment: Specify the type, reason, goal ( i.e. sit straight for meals) frequency of use (mealtimes, etc.) and release frequency every two (2) hours for ten (10 minutes of the service.</p> <p>( AW )</p>	S9999		
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