

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009120	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/26/2015
NAME OF PROVIDER OR SUPPLIER ST PAUL'S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1021 WEST E STREET BELLEVILLE, IL 62220		
(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) 300.1210b) 300.1210d)3 300.3240a) 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 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. 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	S9999		

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	Continued From page 1 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. Based on interviews and record review, the facility failed to adequately assess and monitor for injury following a fall and failed to identify, assess, monitor and treat pain for 1 of 4 residents (R8) reviewed for a condition change in a sample of 8. This failure resulted in delay in treatment of R8's fractured hip with the facility providing no pain management following her fall on the morning of 8/11/15 until she was transferred to the hospital for treatment at 5:18 PM on 8/12/15. Findings include: 1. R8's Minimum Data Set (MDS), dated 8/2/15, documents R8 as being totally dependent on staff for all aspects of Activities of Daily Living (ADLs) and has severely cognitively impaired. R8's Nurse's Notes, written by E14, Licensed Practical Nurse (LPN), dated 8/11/15 at 6:45 AM, documents R8 was found on the floor of her room yelling. The note documents she was complaining of left side and hip pain. At 7:00 AM, E14 documented Z2, the Physician, was called	S9999			

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S9999	Continued From page 2 with a message left and at 7:05 AM, Z3, R8's daughter, was notified and requested R8 not be sent to the hospital. At 7:10 AM, E14 documented that the physician on call for Z2 returned the call and was notified of the family wishes to not send to hospital. Vitals were documented (no time). At 3:00 PM, E14 documented Z2's office was called due to R8's complaints of left side and hip pain but did not document the severity of R8's pain or monitoring for injury. At 4:45 PM, R8's Nurse's Notes documented a returned call from the physician's office with new orders received to obtain an X-ray of left hip and ribs, apply moist heat and aspercreme twice daily (BID) times (x) 1 week to noted areas. On 8/11/2015, R8's Nurse's notes, written by E14 and at 8:30 PM documents, an X-ray was ordered from mobile X-ray at 7:05 PM and the X-rays were completed. There were no further entries into the Nurse's Notes regarding assessments and/or evaluation of pain and/or injury until 3:00 AM on 8/12/2015. On 8/12/2015, at 3:00 AM, the Nurse's Notes written by E10 LPN documents R8 "yelling out in pain most of noc (night), c/o (complained of) L (left) hip pain, resting quietly at this time." The Note continued "No results from (mobile X-ray) at this time." There is no documentation of any followup to R8's pain complaints, no documentation the nurse assessed R8 for injury from the fall, and no documentation pain medication was administered. There was no further documentation in R8's Nurse's notes until 8/12/15 at 1:25 PM, over 10 hours after the last documentation. On 8/12/2015, at 1:25 PM, R8's Nurse's Note,	S9999			

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S9999	Continued From page 3 written by E7, LPN documents, "Resident alert c (with) confusion, HOH (hard of hearing), yelling out in pain periodically throughout shift. Resident remains in bed, appetite has been poor, bruising noted to L (left) hip." Again, there is no documentation of any assessment done for pain or injury from fall evident in the clinical record and none provided by the facility. On 8/12/2015, at 4:45 PM, R8's Nurse's Notes document Z3 was at the facility and wanted R8 to be sent out. The Nurse's Notes document Z2 was notified and R8 was transferred to the hospital at 5:18 PM for treatment of fractured hip. R8's August 2015 Physician's Order Sheets (POS) and telephone orders had no documentation an pain medications were ordered for this time. On 8/21/15 at 11:00 AM, an X-ray report of R8's hip done on 8/11/15 was requested. The facility did not have a copy of the X-ray report. At 12:17 PM a copy of the report was faxed to the facility by the mobile X-ray service and provided to the surveyor. The Findings identified a comminuted intertrochanteric fracture, mild superior medial displacement of the distal fracture fragment is identified. On 8/21/15 at 12:20 pm, Z4, mobile X-ray service agent, stated the results of R8's X-ray was sent to the facility at 10:40 PM 8/11/15. On 8/21/15 at 2:25 PM, E14 stated R8's leg was not rotated out and she had been yelling out for a couple days prior to the fall so she didn't think anything of it. E14 stated she left the evening of 8/11/15 around 11-11:30 PM and had not received any call or X-ray result from the mobile	S9999			

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S9999	Continued From page 4 service at that time. E14 stated she understood that Z3 did not want any treatment. E14 stated she did not give R8 any pain medication at all on the day of 8/11/15 and that she was sleeping on and off throughout the day. On 8/21/15 at 2:45 PM , E14 LPN stated the the X-ray results had been gotten right before she came on shift at 3:00 PM on 8/12/15. E14 stated R8 had been yelling out in pain but she did not have any pain medication ordered and she did not call for any. E14 stated she had been told by E7 that R8's family did not want any treatment or her to be sent out. E14 stated the only fax machine to the facility was located in the assisted living area and that the "analog" was out so they wouldn't have gotten the results if the mobile X-ray had sent it anyway. E14 stated Z3 came in and wanted her sent out after she found out her hip was fractures and she talked with the physician. On 8/21/15 at 1:20 PM, Z3, R8's daughter and Power of Attorney (POA) stated she initially did not want her mother sent to the hospital unless it was something "serious" and that her mother had a tendency to be "dramatic" when it was nothing so she wanted to wait and see her in person before making the decision to send her to the hospital. Z3 stated R8 was in pain especially when they moved her and that she thought they were giving her pain medication. Z3 stated she called the Physician's office the afternoon of 8/12/15 with the X-ray results and after discussing the risks/benefits with the physician, decided to send her in for treatment of the fractured hip. Z3 stated had she known R8's hip was broken the day/night before, she would have had the conversation with the physician then and sent her at that time.	S9999			

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S9999	Continued From page 5 On 8/25/15 at 3:00 PM, Z2, R8's Physicians, stated the facility initially called the doctor on call to report the fall timely. Z2 stated she understood that R8's daughter did not want her to go to the hospital and that the facility discussed the options with the daughter after the X-ray results came in. Z2 stated she did not get the X-ray report until late afternoon on 8/12/15 and did not realize the results came in the night before. Z2 stated pain management is difficult for residents with severe dementia which R8 has but didn't know the nurse documented R8 yelling out in pain in the nurses notes. Z2 stated she assumed they assessed her to be in pain if they documented her yelling out. On 8/25/15 3:15 PM, E8, Executive Director and E1 Administrator provided a time line and stated mobile services told them that they called and gave the results of the X-rays to E14, LPN along with faxing the results the evening of 8/11/15. Both E8 and E1 stated E14 denied receiving the information. E1 and E8 confirmed that the facility did not call for the results until the afternoon of 8/12/15 and could not state why. Both agreed R8 did not receive any pain medication because she had none ordered. E1 stated R8 only exhibited pain when she was moved and that the night nurse would have staff check for incontinence before moving her. Both stated that R8's daughter decided to have R8 treated once she found out her hip was fractured. The facility's policy and procedure (undated) entitled "Pain Management Plan" documents that "As advocates for the elderly, we are committed to assure that the resident's do not suffer needlessly from pain. We believe our residents "have the right to have their pain assessed and	S9999			

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S9999	Continued From page 6 continuously and appropriately managed within the framework of psychological and physical adaptations." The policy documents "The elements of pain include frequency, intensity, location, duration and aggravating/alleviating factors. The assessment is to be done on admission, with change of condition, PRN (As needed) on set of new pain, semi annually." The policy continues "A screening for pain will be completed each shift and as indicated using the Medication Administration Record or a monthly screen/documentation form designated for this purpose." The policy documents "Goal of pain management is to provide relieve to the resident so that pain intensity is no greater than 3, or a level acceptable to the individual resident." (C)	S9999			