

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146154	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER Concordia Village Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4101 West Iles Avenue Springfield, IL 62711	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45947</p> <p>Based on interview and record review, the facility failed to provide timely assessment and treatment of humeral fracture in 1 of 3 residents (R2) reviewed for abuse in the sample of 3.</p> <p>This failure resulted in a delay of care for R2's humeral fracture from, at a minimum, 5:30 PM on 6/12/24 to 12:34 PM on 6/13/24.</p> <p>Findings include:</p> <p>R2's Face Sheet documents, R2 was admitted to the facility on [DATE], with diagnoses including dementia, depression, muscle weakness, osteoporosis, and history of falling.</p> <p>R2's, undated, Minimum Data Set/MDS documented R2 was severely cognitively impaired with inattention, disorganized thinking, and altered level of consciousness. The MDS documented R2 ambulated via wheelchair, required substantial assistance with rolling, and was dependent with transfer.</p> <p>R2's Care Plan, starting 3/29/24, documents R2 is at risk for falls, injury, and pain.</p> <p>On 6/25/24 at 1:43 PM, V7, Certified Nursing Assistant (CNA), stated, (R2) complained of right arm pain before getting up on the morning of 6/12/24 and was not using her right arm at lunch time, which she usually uses to feed herself.</p> <p>On 6/25/24 at 2:58 PM, V8, Registered Nurse, (RN) stated several people commented to her that R2 was not her usual perky self on 6/12/24. She stated V7, CNA, mentioned to her in the afternoon that R2 had complained of right arm pain earlier in the day, but when V8 checked in on R2, she was sleeping peacefully in her bed.</p> <p>On 6/25/24 at 3:15 PM, V9, CNA, stated he cared for R2 on the evening of 6/12/24, and noticed R2 was not using her right arm during dinner. He stated, (R2's) right arm was hanging in an unusual way, then I noticed bruising while getting her ready for bed. V9 stated he informed V20, Licensed Practical Nurse, (LPN), and she stated she would let the other nurses know.</p> <p>On 6/26/24 at 8:35 AM, V20, Licensed Practical Nurse, (LPN), stated she was walking out the door to leave work, around 5:30 PM on 6/12/24 when V9, CNA, came and asked her if she knew anything about a bruise on R2. She stated she was unaware of any bruising, but told V9 he should check with the other nurses and see if there was any documentation in the Shift Change Report Notes.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/26/24 at 9:06 AM, V15, LPN, stated she cared for R2 on 6/13/24, and V9, CNA, did not report any bruising to her. She stated if she had been informed, she would have evaluated R2's arm and notified management.</p> <p>On 6/25/24 at 11:25 AM, V4, CNA, stated she was getting R2 dressed on the morning of 6/13/24, and R2 acted like she was in pain. V4 then noticed the bruising all over R2's right upper arm, her right armpit, and her right eye. She stated she immediately told V5, LPN. X-Rays were ordered and R2's arm was found to be broken.</p> <p>On 6/25/24, at 10:12 AM, V5, LPN, stated on the morning of 6/13/24, V4, CNA, alerted her that R2 had bruising from her shoulder to her mid arm. V5 stated she immediately notified V3, Assistant Director of Nursing (ADON), who notified V19, Physician, and R2's Family. She stated V19 ordered an X-Ray that showed R2 had a broken arm.</p> <p>The Facility's Shift Change Report Notes for Day Shift on 6/12/24 document R2 was less talkative and complained of arm pain.</p> <p>The Facility's Shift Change Report Notes for Evening Shift on 6/12/24 document, Ok next to R2's name.</p> <p>R2's Clinical Note by V5, LPN, on 6/13/24 at 12:34 PM, documents, CNA was getting resident up and dressed when she noticed bruising to her right arm and right side of her head just above her eyebrow. Writer called management to let them know. Writer noticed she was grimacing, not moving arm, and complaining of pain. She would not let writer move her arm. Family and (V19, Physician) aware. (V19) ordered X-Rays of shoulder, elbow, and ribs.</p> <p>R2's X-Ray of right shoulder on 6/13/24 documents, Acute comminuted, (broken in at least two places) fracture proximal right humerus, (upper arm bone), with deformity and inferior, (lower), subluxation, (partial dislocation), of the proximal right humerus.</p> <p>R2's Clinical Note by V3, Assistant Director of Nursing (ADON), on 6/13/24 at 12:37 PM documents X-ray results were received and R2 was transported to the emergency room (ER) at 12:34 PM for further evaluation.</p> <p>R2's Clinical Note by V15, LPN, on 6/13/24 at 10:20 PM, documents R2 returned to the Facility at 8:30 PM with arm in a sling due to a comminuted fracture of the right humerus.</p> <p>On 6/25/24 at 2:20 PM, V1, Administrator, stated the Facility completed an investigation and determined the injury likely happened between 6/10/24 and 6/12/24.</p> <p>On 6/26/24 at 11:23 AM, V19, Physician, stated she ordered R2's X-rays on 6/13/24 as soon as she was notified of the bruising and pain. She stated she would expect the Facility to contact her as soon as the bruising and pain were discovered, and if they were present the day before they contacted her, that would be a delay. She stated the treatment would not have changed, but pain is always something they consider, and if they had told her the day before about R2's bruising and pain, she would have automatically ordered the X-Ray, especially since R2 has dementia and is unable to communicate her needs.</p> <p>(continued on next page)</p>		

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