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	145234	A. BUILDING _____ B. WING _____	C 01/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL PAVILION	**900 SOUTH KIWANIS DRIVE FREEPORT, IL 61032**

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F 000	INITIAL COMMENTS Incident Report Investigation to Incident of January 23, 2017/IL 91348.	F 000		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to superivise a resident at risk for falls, failed to apply an alarm device correctly, and failed to evaluate the effectivenes of fall prevention interventions. These failures	F 323		

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

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contributed to R1 having repeated falls and sustaining a fractured neck on January 23, 2017. R1 expired the same day.
This applies to 1 of 3 residents (R1) reviewed for falls in the sample of 3.
The findings include:
On January 26, 2017 at 8:35 AM, E3 CNA (Certified Nursing Assistant) demonstrated how on January 23, 2017 she placed the tab alarm on R1. E3 said R1 was seated in a stuffed "pleather" recliner in front of the nurse's station on the second floor. E3 said the recliner did not have any way to attach the alarm box to the chair so she tucked it into the recliner next to (to the left) R1 in the seat. E3 said she then attached the clip to the back of R1's shirt. The recliner E3 said she used had a handle to the right to recline the chair but the handle was flush to the chair. There was another similar recliner next to this that had a long wooden arm used to recline the chair. E3 identified the recliner with the flush handle as the one R1 was seated in and that was why the alarm was tucked into the chair. E3 said R1 was able to remove the clip on his alarms.
On January 27, 2017, all resident ' s (whose names were on the alarm list) alarms were checked for proper placement and function.
R1 ' s cognition care plan revised on January 23, 2017 shows R1 was forgetful, confused and had impaired short and long term memory loss.
R1 ' s fall care plan dated January 23, 2017, showed a fall history with falls incidents on:
July 12, 2016 and 25, 2016
August 5, 25, and 30, 2016
November 17, 21, 26 and 30, 2016
December 24, 2016
January 17 and 23, 2017
R1's Physician Order Sheet of December , 2016 documents R1's diagnoses include Progressive

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Supranuclear Palsy. According to Mayoclinic. org website this disease includes symptoms of falling, loss of balance, and impulsive behavior.
R1 ' s fall care plan revised on January 23, 2017 documents a history of Dementia. the same care plan does not document R1's progressive disease. No interventions specific to the level of supervision R1 requires, or any alarm devices, or other modifications used to prevent falls are documented.
R1 ' s Progress notes showed multiple entries of R1 self-transferring and attempting to ambulate unassisted:
August 14, 2016 at 4:00 PM documents R1 stands up and tries to walk around and is noncompliant with his alarms.
August 30, 2016 at 5:30 AM entry shows staff (witnessed fall) but was unable to reach R1 before he fell.
September 1, 2016 at 7:14 PM entry shows R1 was in and out of bed several times attempting to self transfer.
November 1, 2016 at 3:29 AM shows R1was transferred to a recliner in front of the nurse ' s station because he was constantly attempting to get up unassisted.
November 17, 2016 at 11:38 PM the progress note shows R1 was on the floor after being in the wheelchair. R1 ' s chair alarm was not sounding.
November 20, 2016 at 3:56 AM documents R1 attempts to transfer self at times and tries to ambulate independently.
November 20, 2016 at 1:44 PM shows R1 was near the nurse ' s station for high visual contact to ensure resident safety from falls.
November 21, 2016 at 10:30 AM documents R1was on both knees with arms resting on the wheelchair. The pad alarm was not sounding.
November 22, 2016 at 4:46 AM shows R1 was

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redirected often to not transfer self or ambulate by self due to unsteady gait.
November 26, 2016 at 7:14 AM the progress note shows R1 was in the TV room near the nurses station and was found laying on the floor.
November 28, 2016 at 12:27 AM , shows R1 was up walking around in room. The patient alarm was not sounding.
January 17, 2017 at 7:00 AM documents R1 had a fall from the recliner at 3:00 AM.
January 18, 2017 at 6:10 PM shows R1 attempting to stand up.
January 19, 2017 at 1:13 AM shows R1 attempts to self transfer and stand. He (R1) is unable to make most of his needs known due to significant cognitive impairment, both short and long term memory impairments.
January 19, 2017 at 10:07 AM the progress note shows R1 continues to attempt to self transfer and stand.
January 21, 2017 at 10:56 its documented R1 needs frequent reminders to stay in the chair.
January 21, 2017 at 4:15 PM the electronic Medication Administration Record (MAR) shows R1 was restless and repeatedly attempting to independently transfer self.
An Incident note dated January 23, 2017 at 9:50 AM, shows R1 attempted to self transfer from the recliner and fell before staff could reach him. R1 ' s alarm was not sounding and it (the alarm) was observed shoved in the bend of the recliner. R1 suffered three lacerations to his forehead.
The Social Service Progress note dated September 4, 2016 at 6:56 AM shows R1 ' s Cognitive Summary score was 4. (4 = severe cognitive impairment).
The Psychiatric Progress note dated October 4, 2016 at 7:35 PM; shows R1 had impaired judgment, insight, immediate memory and

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attention.
The Fall Risk Assessment dated December 25, 2016 assessed R1 at high risk for falls.
R1 ' s MDS (Minimum Data Set) dated January 5, 2017 shows he required extensive assistance to transfer, toilet and move about the facility. The same MDS shows R1 is not steady and is only able to stabilize with staff assistance.
The Progress note dated January 19, 2017 at 1:13 AM documents R1 has significant cognitive impairment.
The facility ' s Fall Investigation form and interviews dated January 17, 2017 at 3:10 AM show R1 fell from a recliner in the sitting area in front of the nurse ' s station. Three staff members (E14-16) were at the nurses station at the time, and the fall was not witnessed.
On January 27, 2017 at 12:00 PM, E14, CNA (Certified Nursing Assistant) said she was seated at the nurse ' s station with two other staff on January 17, 2017 (E15 and E16) when R1 fell. E14 said none of the three staff present witnessed R1 ' s fall. E14 said R1 was placed by the nurse ' s station so staff could keep an eye on him as he kept attempting to get up without assistance. E14 said R1 tried to get up from the recliner five times before falling. We just kept readjusting him in the chair and the alarm. E14 said by the time we all looked up R1 was on the floor.
On January 27, 2017 at 1:20 PM, E16 CNA said R1 kept trying to get up so he was placed in the sitting area (by the nurse ' s station) so more eyes would be on him. E16 said she was sitting at the nurse ' s station but did not see R1 fall. E16 said " By the time I saw him (R1) he was already on the floor. " E16 said R1 was positioned with his back to the nurse's station facing the TV. Staff had to go around the desk and around R1 ' s chair to get

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to him on the floor.
According to the facility ' s interviews, E14 CNA (Certified Nursing Assistant) said she was charting when R1 fell. E15 RN (Registered Nurse) said she was charting, looking up information and texting E2 DON (Director of Nursing) when R1 fell. E16 CNA said R1 was trying to get out of bed all night so he was placed in a recliner in front of the nurse ' s desk. E16 said she was sitting at the nurse's station when she looked up R1 was on the floor and she did not witness the fall.
The facility's fall investigation and interviews regarding R1's January 23, 2017 fall shows R1 was sliding out his chair at 9:47 AM and 9:53 AM. The timeline provided by the facility shows R1 attempted to independently transfer out of the recliner and fell on January 23, 2017 at 9:54 AM. The same document shows the alarm did not sound and it was found shoved into the bend of the recliner. On January 23, 2017, R1 left the facility by ambulance at 10:13 AM to a local hospital, later that day he transferred to a larger hospital due to a neck fracture . Later the same day R1 expired at 10:53 PM.
On January 26, 2017 at 11:15 AM, E7 LPN (Licensed Practical Nurse) said R1 slid down in the recliner twice on January 23, 2017 before he fell. E7 said the alarm did not sound when R1 fell. The alarm was shoved in the bend of the recliner. E7 said R1 would remove the clip alarm once in a while. E7 said she was at nurse's station and saw R1 attempt to stand up from the recliner and he fell straight onto his forehead. E7 said they could not get to R1 fast enough to prevent his fall.
On January 26, 2017 at 8:35 AM, E3 CNA said on January 23, 2017 R1 was in his wheelchair in front of the nurse's station. R1 stood up and said he wanted to get in the recliner so I assisted him

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to transfer. R1 slid down in the recliner twice before he fell. E3 said she attached the clip from the alarm onto the back of R1's shirt and tucked the alarm into the recliner next to R1. E3 said the alarm box was not attached to any fixed part of the recliner. E3 said R1 knew how to remove the alarm from his clothing. E3 said she was standing at the nurse's station and could not get to R1 before he fell.

On January 26, 2017 at 11:30 AM, E8 CNA said R1 would take his clip alarms off.

On January 26, 2017 at 9:40 AM, E2 DON (Director of Nursing) said if alarms are not used properly a fall may occur and staff response would be delayed. E2 said E10 MDS coordinator (Minimum Data Set) evaluates fall interventions randomly.

On January 26, 2017 at 10:55 AM, E6 CNA said on January 23, 2017 R1 kept trying to get up out of his chair. R1 had a clip alarm on and kept taking it off his shirt, he always did that. The alarm did not go off when he fell. E6 said she was seated behind the desk when R1 fell. E6 said if we had been 1:1 with R1, distracting him or pushing him around in his chair maybe he would not have fallen.

On January 26, 2017 at 2:10 PM, E5 CNA said an alarm can prevent a fall and would consider an alarm an intervention to prevent a fall.

On January 26, 2017 at 2:35 PM, E2 said when R1 fell on January 23, 2017 it was verified by viewing the video recording that there was no alarm on R1. E2 said the cause of R1's fall was that R1 was restless and wanted to stand up. E2 said it was not uncommon for R1 to try to stand up from a chair unassisted.

On January 27, 2017 at 1:40 PM, E10 measured the distance from behind the middle of the nurse ' s station desk to the area of R1 ' s fall on January

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F 323	Continued From page 7 27th as approximately 28 feet. The manufacturer ' s recommendations for the alarm device used for R1 on January 23, 2017 shows failure to comply with all directions may result in injury and death. It shows that alarms are not intended to be used as a substitute for visual monitoring. The recommendation shows they are to be used on wheelchairs, standard upright chairs and beds. The directions for use show to attach the alligator clip to the resident's clothing and attach the device to a wheelchair, chair or bed using the strap, bedrail clip or wheelchair clip. On January 27, 2017 at 10:05 AM, E13 (Maintenance) said straps were added to the sides of the recliners by the nurse's station on January 26, 2017 so there would be a place to securely hold the magnet alarms like we ' re supposed to. On January 27, 2017 at 9:45 AM, E1 Administrator said if R1's alarms were working or not the staff members (E3, E5 and E6) would not be able to get to him in time to prevent the fall. E1 said this was based on the video surveillance of the incident. R1 was positioned approximately 20 feet away with his back to the nurse's station with other resident's in chairs on both sides of him. On January 27, 2016 at 8:50 AM, E10 said R1 took his clip alarms off frequently and the alarm intervention was not in R1's care plan. E10 said after each fall the IDT (Interdisciplinary Team) meets to ensure interventions were in place and implement new interventions if appropriate. A meeting of this type is how it was determined that alarms were deemed appropriate for R1. E10 said it is not appropriate to set an alarm next to a resident because the box could move and not trigger the alarm. If alarms are not working properly staff may not be alerted to a resident ' s movement, which is the purpose of an alarm.	F 323		

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F 323	Continued From page 8 The facility ' s policy on Fall Prevention Alarm Devices dated June 2014 shows the purpose of alarms is to alert staff members of a resident ' s attempt to stand and to prevent resident falls. The policy shows all alarms will be applied as per manufacturer recommendations. R1 ' s medical records from the hospital showed R1 was pronounced dead at 10:53 PM on January 23, 2017. On January 26, 2017 at 1:50 PM, Z1 Trauma Surgeon said R1's fall of January 23, 2017 and subsequent injuries directly contributed to his death. The swelling around his spinal cord eventually impaired his ability to breathe.	F 323		