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S 000	Initial Comments Annual Health Statement of Licensure Violations	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 Violations 300.610a) 300.1210b) 300.1210d)6) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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well-being of the resident, in accordance with each resident's comprehensive resident care plan. 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.

Section 300.1210 General Requirements for Nursing and Personal Care

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Based on observation, interview, and record review the facility failed to supervise a resident with a history of falls; failed to ensure a safe environment for a resident with a history of falls; failed to safely transfer a resident; and failed to supervise a resident with difficulty swallowing for four of six residents (R9, R6, R207, R66) in the sample of 20. This failure resulted in R9 sustaining a right distal femur fracture.

The findings include:

1. On 10/01/19 at 02:40 PM, V25 (R26's spouse) reported that someone was on the floor down the hall. V27 (Licensed Practical Nurse - LPN) and

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V29 (Registered Nurse/MDS) went down the hall to R9's room. R9 was lying her right side, on the floor in her room. R9 was positioned in front of her wheelchair and a recliner. R9 smelled of urine. R9 was saying, "Ow, ow, ow," (holding right mid thigh area). At 2:48 PM V27 (LPN) asked R9 if she had pain. R9 pointed to the outside of her right leg, just above her knee. At 2:50 PM, V2 (Director of Nursing) took R9's vital signs. At 3:00 PM, R9 was transported to the local emergency room by the ambulance crew.

R9's Facesheet printed 10/03/19 showed diagnoses to include: dementia, delusional disorders, anxiety disorder, difficulty walking, generalized muscle weakness, unsteadiness on feet, lack of coordination and repeated falls.

R9's Physician Order Report dated 10/01/19 - 10/31/19 showed 12/13/18 - 12/16/18 and 3/13/19 "Fall: Monitor status for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to fall; and Fall: With Suspected head trauma - Neuro checks Q (every) 15 minutes x 4, then Q (every) hour x 2, then Q2 hours x2, then Q4 hours x 2, then Q shift x 3."

R9's Fall Risk Assessment dated 06/27/19 showed she was at "High Risk" for falls.

R9's facility assessment dated 06/27/19 showed R9 had severe cognitive impairment; required extensive assistance of one staff member for bed mobility, transfers, and toilet use; required limited assistance of one staff member to walk in room; and was always incontinent of urine.

R9's Progress Note showed she fell in her room on 12/12/18, 3/13/19, 5/27/19, and 10/1/19. The 10/1/19 2:40 PM Progress Note showed, "Patient

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found half sitting/lying on her right hip in her room by a resident's family member. Patient was yelling with movement of the right leg. Patient's head and upper shoulder were against her recliner chair in her room. Two nurses assisted patient to a supine position on the floor to better evaluate patient's injuries. Patient unable to be placed fully on her back as she stated her right leg hurts. Patient was yelling out and stating the right legs hurts her. She pointed to her right knee. However when this writer touched her right hip area to reposition, she yelled out in pain. Patient states, "she tried to hang up a hanger that was hers into her closet." Another nurse called 911 and let the family member know of the fall and transfer to the hospital for further evaluation. [Nurse Practitioner] was also notified of fall and transfer to hospital..."

The undated Fall Log provided to us by the V1 (Administrator) on 10/02/19 showed R9 had falls on 12/12/18, 03/13/19, 05/27/19, and 10/01/19.

R9's Fall Care Plan edited 10/2/19 showed, "Resident at risk for falling related to anxiety, paranoia, and dementia." One of R9s interventions was, "Observe frequently and place in a supervised area when out of bed and Assist of 1 for transfers."

R9's emergency room record dated 10/1/19 showed, "Reports to the emergency department via ambulance from [the facility] for evaluation of right leg pain after an un-witnessed fall..."

R9's Right Femur 2-View X-ray dated 10/1/19 showed, "Fracture of the distal femur in obliques projections with complete displacement with overriding of the proximal fragment foreshortening. Minimal angulation. Right arthroplasty (hip replacement) and knee

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arthroplasty (knee replacement) with hardware intact."

R9's Orthopedic Surgery Consult dated 10/02/19 showed, "...The patient had a fall and sustained a displaced right inner-prosthetic femur fracture..."

On 10/02/19 at 03:30 PM, V29 (R26's spouse) said she was leaving on Tuesday (10/1/19) and happened to glance in a room. V29 stated, "I saw her on the floor in front of her recliner, so I went directly to the nurse and told her."

On 10/03/19 at 08:50 AM, V1 (Administrator) said R9 is not back from the hospital yet, she suffered a femur fracture from her fall on Tuesday (10/1/19).

On 10/03/19 at 09:32 AM, V2 (DON) said her investigation into R9's fall is still in progress. V2 stated, "[R9] likes her room tidy and in order; if she sees something out of place, then she will try to fix it." V2 said at this time it sounds like there was a plastic hanger in a place R9 didn't want it. V2 said R9 did sustain a right femur fracture from the fall on 10/1/19 and is still in the hospital.

On 10/03/19 at 11:15 AM, V30 (R9's POA) said my aunt fell at the nursing home and now she is at Swedish American Hospital. V30 stated, "I think they said she broke her hip on the right side." V30 said R9 had falls in the bathroom and in her room in the past, but it wasn't very serious. V30 said R9 tried to get up all the time by herself, but she needs help. V30 stated, "They (the facility) put an alarm on her for a while and that seemed to help." V30 stated, "After the last fall they said they would watch her very closely." V30 said they are supposed to keep her under supervision. V30 stated, "I'm not sure what

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happened this time."

On 10/03/19 at 12:26 PM, V31 (LPN) said a resident's family member told me that R9 had fallen. V31 said she immediately went to R9's room with V33 (Registered Nurse/MDS). V31 said R9 was half sitting/half lying on her right side with her back, upper torso up against her recliner. V31 said R9 was facing away from the door and toward the window. V31 said R9 had a hanger lying on her when she was lying on the floor. V31 stated, "[R9] was telling me she was trying to get the hanger put up and she couldn't do it." V31 said R9 was crying and saying her right leg hurt. V31 said she knew R9 had fallen in the past, but wasn't aware if she had any fall precautions in place. V31 said R9 is supposed to have help with standing up and doing things.

On 10/03/19 at 12:35 PM, V32 (CNA) said I had already left for the day before R9 fell. V32 stated, "She was acting normal the whole day, I had toileted her throughout the day with no problems." V32 said R9 is a one assist with a gait belt. V32 said R9 is usually only in her room when she needs to go to the bathroom, but there are times when she is in her room that she fiddles with the drawers.

On 10/03/19 at 12:45 PM, V33 (RN/MDS) said she was at the nurse's station on Tuesday (10/1/19) afternoon, when a visitor walking up the hall said,"There's someone on the floor in 210."V33 said she went to the room with V31 (LPN) immediately. V33 said R9 was lying on the floor on her right side, in front of her wheelchair, in front of the window/closet area. V33 said R9 was crying and probably saying, "it hurts."

On 10/03/19 at 01:16 PM, a message was left for

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V34 (Orthopedic Surgeon). The call was not returned.

The facility's Fall Reduction Program (rev 04/19) showed "1. It is the policy of this facility to have a Fall Reduction Program that promotes the safety of residents in the facility. The program's intent is to assist clinical staff in determining the needs of each resident through the use of standard assessments, the identification of each resident's individual risks, and the implementation of appropriate interventions, supervision, and/or assistive devices deemed appropriate. Standards: 4. Assigned nursing personnel are responsible for ensuring that the ongoing precaution(s) are put in place and consistently maintained per the individual's plan of care.

2. On 10/01/19 at 12:40 PM, R6 was self-propelling her wheelchair down the hall from the dining room. R6 stated, "My knees get tired, you think you can get someone to push me to my room."

On 10/02/19 at 08:24 AM, R6 was self-propelling her wheelchair in her room. At 10/02/19 at 08:33 AM, R6 self-transferred into her high back chair. R6 turned her wheelchair so it was facing forward and placed her feet on the seat of the unlocked wheelchair. R6 covered her lap and legs with a blanket and closed her eyes.

On 10/02/19 at 03:25 PM, R6 was sitting in her high back chair in her room with her feet propped up on the seat of her unlocked wheelchair.

On 10/03/19 at 07:59 AM, R6 was sitting up in her high back chair with her feet resting on the seat of her unlocked wheelchair. R6 stated, "I like to sit like this, this is my comfortable position; I

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don't have a recliner so this works." This surveyor asked R6 if she thought a recliner would be better. R6 replied, "A recliner would be nice, but that's not what I have. I just make use of what I have."

R6's Facesheet printed 10/3/19 showed diagnoses to include: Stroke with left sided weakness, chronic obstructive pulmonary disease (COPD), memory deficit, aphasia, generalized arthritis, and hyperparathyroidism.

R6's facility assessment dated 9/18/19 showed had severe cognitive impairment and required extensive assistance of one staff member for bed mobility, transfers,and toilet use.

The facility's Fall Log provided by V1 (Administrator) on 10/02/19 showed falls on 12/25/18, 01/15/19, 02/18/19, 04/09/19, 05/30/19 (5 falls in last 10 months).

R6's Care Plan created 7/30/19 showed, "The resident presents with a functional deficit in ambulation, which appears to be related to the diagnosis of hemiplegia & hemiparesis following cerebral infarction, affecting left non-dominant side." R6's Fall Care Plan edited 6/21/19 showed, "Resident has history of falling related to impaired mobility, weakness, left sided hemiplegia, and osteoarthritis." The interventions include: "Assist of 1 for transfers and ambulation; Give resident verbal reminders not to ambulate/transfer without assistance; and provide resident an environment free of clutter."

On 10/03/19 at 09:16 AM, V9 (LPN) said R6 always sits like that, she likes to keep her legs up. R6 was sleeping in her high back chair with her feet resting on the seat of her unlocked

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wheelchair. V9 stated, "R6 needs assistance, but she is sometimes non-compliant with that."

On 10/03/19 at 09:53 AM this surveyor demonstrated to V2 (DON) how R6 sits with her feet on the seat of the unlocked wheelchair. V2 stated, "I don't think that's a good idea. She could slide right out of that chair and fall." V2 continued to state, "And the wheelchair could move on her if she's putting it there herself and it's not locked." V2 said R6 probably needs a recliner. V2 stated, "Resident self-transferring is another problem we have here."

3. R207's computerized face sheet showed diagnoses including dementia, osteoporosis and repeated falls. R207's facility assessment dated 9/20/19 showed R207 is moderately cognitively impaired and requires staff assistance with transfers, toileting, bed mobility, dressing and hygiene. R207's Fall Risk Assessment dated 9/30/19 showed a high risk for falls.

R207's care plan showed a problem area start dated 9/29/19 stating: "resident has a surgical wound to right hip R/T (related to) falling. R207's care plan showed a problem area start dated 9/10/19 stating: resident at risk for falling R/T weakness."

On 10/1/19 at 1:24 PM, V16 (CNA-Certified Nurse Aide) wheeled R207 to the bathroom and transferred him from his wheelchair to the toilet. R207 stood up to transfer and was unsteady and wobbling on this feet. R207 had difficulty balancing and pivoting around to sit down on the toilet. V16 held onto to R207's arms to assist him. R207 pulled his pants down and a large adhesive bandage was visible on his right outer hip. V16

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stated R207 had recent hip surgery and was still weak on that side. R207 used the toilet and was assisted back into the wheelchair, again unsteady on his feet. V16 did not use a gait belt to transfer R207 on or off of the toilet.

On 10/2/19 at 1:36 PM, V17 (CNA) stated R207 is unsteady on his feet and needs a gait belt on during all transfers. V17 said the gait belt is necessary to safely hold onto R207 around the waist rather than pulling on his arms which could cause pain or damage.

On 10/3/19 at 10:08 AM, V2 (interim Director of Nurses) stated gait belts are needed at all transfers for residents that are weak or unsteady on their feet. V2 said gait belts are necessary to stabilize residents and prevent falls. V2 said falls can occur during transfers if staff do not have a gait belt on residents' waists to hold on to. V2 said all residents with a high fall risk or history of falls should be transferred with a gait belt. V2 said R207 had recent hip surgery and most likely is still not strong on that side.

The facility's Transfer-Using a Gait Belt policy dated 5/17 states under the objective section: "1. To relocate from a chair(to) bed, chair (to) toilet, chair (to) chair with gait belt." The policy states under the responsibility section: "1. Nursing assistants will routinely have a gait belt immediately available to them during resident transfer."

4. On 10/1/19 at 12:45 PM, R66 was sitting in his wheelchair at a dining room table for lunch. V13 (Occupational Therapist - OT) was standing by R66 and said to V14 (Certified Nursing Assistant - CNA) that she was good to go and was only

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looking in for a minute. V14 walked away. R66 was sitting at the table by himself, picked up an entire piece of chicken, tilted his head down to meet his hand and was trying to chew a piece off. At 12:54 PM, R66 received some assistance with eating.

On 10/2/19 at 9:00 AM, R66 was served his breakfast. R66 was trying to lift a bowl of hot cereal to his mouth to feed himself and was unable. At 9:08 AM, V11 (CNA) went to R66's table and opened straws and put them in his drinks.

On 10/03/19 at 8:26 AM, V3 (Registered Nurse - RN/Clinical Support Supervisor/Assistant Director of Nursing) stated, "R66 has to be fed. He does not have the use of his hands. Someone has to be with him at all times at meals because he has to be fed; if he tries to do it himself he could give himself too big of a bite and choke. R66's care plan should show dining room interventions."

R66's Care Plan dated 9/18/19 did not have a plan in place for feeding or dining assistance.

On 10/03/19 at 9:49 AM, R66 stated, "Today I had pancakes and sausage and I can't cut them. They left them in front of me. They came back asked if I needed the pancakes and sausage cut. Someone cut it and left again. I wasn't able to pick it up and eat it. I couldn't hook the fork into the meat or pancake and get it to my mouth. They know I can't. Someone saw that I couldn't do it myself so he sat down and put the stuff on the fork and laid it on the plate for me to pick it up. When he saw that I couldn't feed myself he started to help me. The food was cold. I get regular liquids. I get served food and no one is at table and I have to wait for help; they are feeding

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other people that need help. I try to feed myself what I can until they can help me. They think I can do more than I can. I won't eat cold food. I eat 1/3 of what I used to eat; since this disability I don't eat as much as I used to."

On 10/03/19 at 11:37 AM, V26 (Speech Therapist - ST) stated, "R66 as of this week he has made some good gains with his left arm range of motion. If I place certain things positioning wise he can reach and grab. He tends to have difficulty grabbing. It depends on his pincher grasp at that moment. He can bring the fork to his mouth if we stab it ahead of time for him. R66 can't bring his arm to his mouth; he leans forward. A spoon doesn't work to well for him he dumps it. I tell him that's a good thing because he tends to be impulsive. Its pacing him; smaller portions. When I initially did his evaluation he needed one to one for pocketing to the left side and needed a liquid wash and he needed cueing. R66 wanted to be fed fast. R66 still needs the supervision. I wouldn't feel 100 percent about leaving him alone, he needs supervision. My biggest concern is his impulsiveness when eating. He loves talking with food in his mouth. He likes to drink big sips. I don't like the straws because fluid comes up to quickly and if you suck real hard it can go down the wrong pipe. Yesterday was the first day I saw them using a sippy cup. Sometimes they have him a little to reclined at the table and I tell the CNA's that he needs to be upright. I am just concerned with choking."

The Dietary Note dated 9/13/19 for R66 showed, "Registered Dietician consult. 79 year old male presents upon admission with potential for altered nutrition status related to a past medical history of dysphagia, type 2 diabetes mellitus and hypertension. Diet recently upgraded. General

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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
S9999	Continued From page 12	S9999		

diet, regular texture, thin consistency appropriate to meet estimated nutrient needs.... Special instructions: regular diet with 1:1 supervision, small bites and small sips. After 1-2 bites give liquids to wash clear."

The Speech Therapist notes for R66 showed: On 9/16/19 he presented with reduced chewing and difficulty with the consistency of the food that day that resulted in a choking episode. On 9/17/19 R66 required pacing to reduce the risk of coughing/choking and overall risk of aspiration. On 9/20/19 R66 had a choking episode on thin liquids. On 9/22/19 there were some safety issues with the CNA who was providing feeding assist to R66 who was in a slightly reclined position. Speech therapy educated on the best position for feeding is as upright as possible; 90 degrees. On 9/27/19 R66 stated he didn't think it was necessary to take smaller bites. On 9/30/19 R66 had incomplete clearance of foods; he is on regular foods and given small bites. On 10/1/19 R66 requests larger bites and if not careful he will take large sips from straw of liquids leading to increased coughing. On 10/2/19 R66 was given feedback on increasing the use of his left arm/hand to use for feeding while pacing as he attempts to eat faster than he should increasing the risk of choking/coughing.

The Speech Therapist note dated 10/4/19 for R66 showed, "Long term goals: The patient will safely consume regular consistency while facilitating 1:1 feeding assist to decrease signs and symptoms of aspiration or penetration risk to independent. Patient continues to require skilled speech therapy services to focus on treatment of swallowing dysfunction and/or oral function for feeding. Prognosis for further progress: good due to significant decrease in aspiration. Swallow

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	IL6006514	A. BUILDING: _____ B. WING _____	10/04/2019

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S9999	Continued From page 13	S9999		

response time improving; however, R66 tends to be impulsive if not verbally and physically cued to take smaller bites and slow down."

(B)

Section 300.7050a) Staffing

a) The unit shall have a full-time unit director.

This regulation was not met as evidenced by:

Based on interview and record review the facility failed to have a director for the dementia unit for all 17 residents residing on the dementia unit (R2, R7, R20, R31, R34, R36, R43, R47, R53, R62, R68, R74, R81, R83, R88, R95 and R207).

The findings include:

On 10/03/19 at 02:40 PM, V1 (Administrator) stated she was not sure how long the dementia unit was without a unit coordinator. V1 stated there was no one in the facility with the "proper credentials" to be the director of the unit. V1 stated, "we may need to look into decertifying the unit." V1 was asked to provide the date when the last director of the unit left. At 2:45 PM, V1 provided a piece of paper showing the last day there was a director of the dementia unit. The paper showed V15's name and a date of 3/28/18.

The facility's undated Special Care Unit policy and procedure for the Alzheimer's/Dementia Care, shows the staff on the unit will consist of a unit coordinator, licensed nurses, certified nursing aides, activity assistant and social service

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S9999	Continued From page 14 designee. The unit coordinator leads the interdisciplinary team insuring each resident is "appropriately assessed, planned for and care delivered as planned." The facility's marketing brochure (undated), shows the facility has a certified Alzheimer and dementia unit. (C)	S9999		