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S9999	Final Observations	S9999		

Statement of Licensure Violation:
1 of 1 Violation

300.610a)
300.1210b)
300.1210d)6)
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, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing

Attachment A
Statement of Licensure Violations

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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 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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

These Requirements are not met as evidenced by:

Based on observation, interview and record reviews, the facility failed to implement interventions in preventing accidents and falls for one (R1) of three residents reviewed for accidents. This failure resulted in R1 sustaining multiple facial lacerations which caused bleeding and subsequent emergent transfer to the

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emergency room where R1 required life-saving intubation. R1 also acquired an oblique oriented fracture of right side nasal bones.

Findings include:

R1 is a 42 year old, male, admitted in the facility on 08/13/18 with diagnoses of Paraplegia, Unspecified; Iron Deficiency Anemia Secondary to Blood Loss (Chronic), Anemia, Unspecified; Other Lack of Coordination and Abnormal Posture.

MDS (Minimum Data Set) dated 04/02/19 documented the following:
Section C - BIMS (Brief Interview for Mental Status) score of 15 which means cognitively intact cognition.
Section G - needs extensive assistance from one person physical assist during bed mobility, transfer, dressing and toileting; has impairment on both sides in lower extremities
Section J - no fall incidents since admission

R1's POS (Physician Order Sheet) documented:
06/03/19 - may use bilateral upper side rails while in bed for safety purposes.

R1's Care Plan for falls documented the following interventions:
08/20/18: Be sure (R1) call light is within reach and encourage (R1) to use it for assistance as needed. (R1) needs prompt response to all requests for assistance.
08/20/18: Follow facility fall protocol.
10/10/18: (R1) re-educated on his primary mode of transfers and that safety wise he isn't allowed to self transfer himself. He agreed to comply with care regimen.
04/15/19: Re-educated (R1) on utilizing the

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reacher when trying to get items from a distance and to utilize the call light when he needs staff.
04/16/19: Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT (interdisciplinary team) as to causes.

R1's Care Plan for ADL (activities of daily living) documented the following interventions:
08/20/18: Transfer - (R1) requires mechanical lift with two staff assistance for transfers
08/20/18: Encourage (R1) to use bell for call for assistance.

R1's care plan for anemia documented the following interventions:
12/13/18: Monitor/document/report PRN (when necessary) following signs and symptoms of anemia: Pallor, fatigue, dizziness, syncope, headache, palpitations, weakness, feeling of cold, low hemoglobin/hematocrit, shortness of breath on exertion, sore tongue, chest pain tinnitus, headache, changes in condition.

R1's Fall Risk Assessments documented the following:
08/13/18 - score of 55 which means high risk for falling
10/10/18 - score of 55 which means high risk for falling
04/02/19 - score of 40 which means moderate risk for falling
04/13/19 - score of 35 which means moderate risk for falling
05/01/19 - score of 80 which means high risk for falling

R1's Incident Reports documented the following:

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10/10/18 - observed in a sitting position on the floor in his room resting against his motorized wheelchair. R1 stated that he was transferring to his chair and lost his grip and could not do it. No injuries or trauma noted.
04/13/19 - observed sitting on some bags and garbage can between his bed and window. No injuries noted.
04/16/19 - found on the floor in his room between his bed and window side. R1 stated that he reached out for something and fell. No open wound, no redness but has slit at tip of penis and was in pain. R1 was sent to the hospital.
05/27/19 - observed in room sitting in his motorized wheelchair with his upper body leaning over the left arm of his power chair. R1's left side of his head was laying on his small dresser. Upon assessment, R1 was noted with changes in level of consciousness and with lacerations on his face. Lacerations were actively bleeding. R1 was sent to the hospital.

Hospital records dated 05/27/19 under Clinician History of Present Illness, R1 presented to the emergency room after a reported fall from the wheelchair and subsequent mental status. Lacerations to forehead were noted on R1 and has shallow labored respirations. R1's Vital Signs at 6:15 PM indicated that blood pressure was 83/54; pulse rate of 93/min (per minute); respiratory rate of 21/minute; Pulse Oximetry was 99% on room air. R1's Glasgow coma score was 5 which means can vocalize no words; abnormal extension posturing and no eye opening. R1 was on profound obtundation. Endotracheal intubation was performed on R1. Further review of R1's hospital records also revealed the following nursing assessment: Pulmonary - slow respirations: 8; shallow respirations noted. Poor respiratory effort. No

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stridor. On room air, O2 sat greater than 92%, no cough.
Circulatory/Cardiac - regular heart rate and rhythm noted. Hypotensive.
Neurologic - Confused; poorly responsive; disoriented. History of head injury/trauma. Gag reflex present. Pupils equal. Slowly reactive to light, nonverbal.
Skin/Soft Tissue - skin feels cool to touch. Moist sweaty skin. There are a total of 3 separate lacerations with a total length of 1 cm noted over the right side of forehead.
Nursing Consultation notes orders: Patient on respirator, cardiac monitor, awaiting ICU (Intensive Care Unit) bed placement. R1's CT (Computerized Tomography) of head and brain revealed an oblique oriented fracture of right side nasal bones. R1's laboratory tests also indicated the following results:
1. CBC (Complete Blood Count): a. WBC (white blood cells) - 17.2 which was high; b. HGB (hemoglobin) - 8.9 which was low.
2. Nasal Culture resulted to light growth staphylococcus aureus
3. Urine culture result: 50,000 to <100,000 col/ml (colony per milliliter) proteus mirabilis

R1's Patient Discharge Transition Record 05/27/19 documented the following primary diagnoses: Altered mental status; Acute Respiratory Failure; Injury of head; Forehead lacerations; Fournier's gangrene
On 06/04/19 at 11:21 AM, R1 was asked regarding the incident happened on 05/27/19. Dried lacerations on the bridge of nose, middle of forehead and on above right eye were observed on R1's face. R1's lower extremities are paralyzed and uses upper extremities for movement. R1 stated, "I got dizzy because of the infection in my genital area and hit my head in the

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drawer of the television stand. I passed out. I was in the wheelchair that time and I was getting something from the drawer, I got dizzy and hit my head. Staff saw me, I was bleeding, I tried to talk but I was too dizzy." V4 (Licensed Practical Nurse, LPN) was also observed in his room who had just finished providing wound care and was asked about R1. V4 stated, "I am helping with the wound care since last week. He's pretty much independent and he tells you what he needs. Don't know about any falls." R1 was asked if he is able to transfer himself into the wheelchair, stated, "I can transfer myself from bed to this wheelchair, done it for already 8 years and I don't need any assistance from staff."

On 06/04/19 at 11:50 AM, V5 (LPN) was interviewed regarding R1 incident on 05/27/19. V5 stated that she was the nurse at the time. V5 stated, "He (R1) was in his room, his room was near nurses' station. I was at the nurses' station and just got off the phone. I stood up and took my medication cart when I saw him in his wheelchair with his body leaning on the left side of the wheelchair and he was in front of the television stand. So I called out, he did not respond so I went around to his room and saw blood on his face and on the floor. I shook him and tried to wake him up. He responded to verbal but not conscious enough to talk. He had laceration over the bridge of his nose, around right eye and forehead hairline. He was going in and out of consciousness. I applied ice pack and cold wet rag on his face and bleeding stopped. 911 was called and V9 (Primary Physician) was notified. I called hospital emergency room and gave report of what happened to R1. And I also did the incident report. He (R1) was alert, oriented, no unusual signs prior to this incident."

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On 06/05/19 at 2:46 PM, V2 (Director of Nurses, DON) was asked regarding accident and fall preventions. V2 stated, "I have been here for three weeks. But I have nursing experience for 35 years, as a DON which is close to 15 years. I am now the fall coordinator. This is the role I have taken on. Responsibilities: proper documentation of the incident in the computer; appropriate follow-ups and investigation of the root cause whether its preventable or not is done, check appropriate referrals. I am responsible making sure that care plans are updated regularly upon admission, quarterly and any significant change in condition. For injuries happened to R1, there is a need to update the care plan but I have not done it yet because I don't know how to access the care plan portion in the computer. So for him (R1), we did a safety sweep into his room; close monitoring for 72 hours post readmission; he does not want re-arranging his room furnitures, again I don't know or think any more interventions for him (R1). There is also a need to update care plan post fall incident." V2 was also asked on how to ensure that interventions in preventing fall and accidents are implemented. V2 further stated, "Personally, I go the residents' room and check for implementation of interventions like re-arranging the room to have better access as permitted by resident, make sure call light is within reach; situate the room across the nurses' station for close monitoring and observation by keeping his door open except during provision of care. Again, I haven't read his (R1) care plan and don't know if I need to initiate a new care plan or update an existing care plan."

On 06/06/19 at 2:45 PM, V9 was interviewed regarding R1. V9 stated, "He's (R1) been under my care since last year or about 2017. His sacral lesion got infected and hard for him to move

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around. His wound was severely infected requiring surgical debridement. He'd been in and out of the hospital due to wound infections. He has issues with sepsis, wound graft was in place. General surgery is seeing him for antibiotics and Infectious Diseases for management and prevention. I was informed by staff on 05/27/19 that he had fallen from bed and landed on the wheelchair and was sent to the hospital due to sustained lacerations. This is my understanding of the situation that he fell. He was found to have an infection when he came there in the facility. He has a wound and not healing and tends to bleed and he becomes anemic. His hemoglobin is low. He is very independent when he is not septic. Then, his infection suddenly will take over. He has episodes that he is fine, he is independent and then will change all of a sudden due to infection. His anemia predisposes him to get dizzy and its hard to predict on when that is going to happen. He (R1) tries to be independent all the time but when these changes happen, staff need to be more on precautions for falls. The facility needs to follow fall protocol. Close monitoring on him (R1) like frequent blood checks, side rails for him (R1) for he is a stubborn resident thinking he is independent, maybe bed alarms. Staff knows that he (R1) has chronic wound infections and that's becoming unpredictable so they can develop interventions to address this condition. I could meet with them to help them."

On 06/10/19 at 10:00 AM, V5 was asked regarding interventions in preventing accidents and falls on R1. V5 stated, "He is usually independent, just monitoring and needs encouragement to ask for help before transfer now that he had this fainting spell. I didn't know anything about it. I didn't realize that he has this fainting spells until I witnessed it last time. I didn't

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know his reaction if he is sick. I have been taking care of him since December 2018. That time, he said he was trying to call my name be he can't. When I found him, half of his body was laying on the table like falling. Now I know that he has fainting spells, he need to have side rails and I called V9 and she ordered side rails. I believe he does the transfer of himself but actually he needs assistance. He had incidents of falling before, he has a reacher to use. He actually did not have any unusual signs and symptoms before that incident, the 05/27/19.

On 06/10/19 at 10:15 AM, V10 (Certified Nurse Aide, CNA) was also asked regarding R1. V10 stated, "He (R1) is okay. He does transfer himself to wheelchair. If he needs assistance, he will push the call light or get into his chair and come out of his room. He is not at risk for falls. I was not aware if he went to the hospital. For him (R1), he really does things for himself. So I check on him first thing in the morning and make sure he has everything he needs. During the day, I monitor him for safety and for anything he needs."

On 06/10/19 at 10:32 AM, V11 (LPN, Restorative Director) was asked regarding accidents and fall interventions. V11 stated, "I do care plans for falls as long as there is no injury. The DON is the one responsible for injury/fall care plans. For him (R1), I re-educated him on using the reacher stick and the use of call light for assistance. I didn't know the incident last time happened to him. Any type of injury during fall, that is the DON's job. I am more on the preventative care plan. Once fall occurs, I update the care plan, we do meet about wounds, falls, behavior and we discuss the interventions. There is a cardex in the computer that actually shows the interventions to be implemented, I was the one who put it and floor

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nurses should be able to check it every day. In preventing future falls or accidents, we do re-education on safety awareness; call lights within reach, appropriate lighting and footwear. We review past falls and see how resident actually had fallen."

Facility's policy titled "Falls - Clinical Protocol, revised October 2010 stated in part but not limited to the following:
Assessment and Recognition: 1. As part of the initial assessment, the physician will help identify individuals with a history of falls and risk factors to subsequent falling. c. While many falls are isolated individual incidents, a significant proportion occur among a few residents/patients. Those individuals may have a treatable medical disorder or functional disturbance as the underlying cause.

Treatment/Management: 1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of serious consequences of falling. a. Examples of such interventions may include calcium and vitamin D supplementation to address osteoporosis, use of hip protectors, addressing medical issues such as hypotension and dizziness, and tapering, discontinuing, or changing problematic medications (for example, those that could make the resident dizzy or cause blood pressure to drop significantly on standing). 2. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation (for example, if the individual continues to try to get up and walk without waiting

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S9999	Continued From page 11 for assistance). Monitoring and Follow-Up: 3. If the individual continues to fall, the staff and physician will re-evaluate the situation and consider other possible reasons for the resident's falling (besides those that have already been identified) and will re-evaluate the continued relevance of current interventions. (B)	S9999		