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	IL6009393	A. BUILDING: _____ B. WING _____	12/17/2014

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S9999	Final Observations Statement of Licensure Violations 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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,	S9999		

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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

These requirements were not met as evidenced by:

A. Based on observation, record review and interview, the facility failed to implement safety measures and progressive interventions to prevent falls, and provide safe transfer techniques for 5 of seven residents (R1, R3, R4, R5, R10) reviewed for falls in the sample of 15. This resulted in staff failing to transfer R3 safely and R3 sustained a fractured femur.

Findings include:

1. The Physician's Order Sheet for R4 documents, diagnoses, in part, as "Altered Mental Status, Post Radiation Dementia and Neuropathy." The Minimum Data Set (MDS) dated 11/04/2014, documents R4 is moderately impaired with cognition, has unsteady sitting and standing balance, with limited range of motion to the lower extremities, and requires extensive assistance for transfers.

On 12/09/2014, at 10:01 AM, R4 was in bed on her right side. A fall mat was on the floor next to

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R4's bed and the bed was in low position. A soft foam lap top cushion was next to the bed. At that time, E2, Director of Nursing (DON) stated, "(R4) leans really bad."

On 12/09/2014 at 12:05 PM, R4 was in the wheelchair with a soft foam lap cushion attached to the wheelchair, and a personal body alarm (PBA) with a long string attached by a clip to R4's shirt. On 12/09/2014 at 12:13 PM, E10 and E18, Certified Nurses Aides (CNA) applied a gait belt to R4 after removing the soft foam lap cushion. Without locking R4's wheelchair, E10 and E18 attempted to transfer R4 to the bed. R4 was holding onto the arms of the wheelchair to steady herself and the wheelchair began to roll backward. R4 immediately began to sit back down, nearly missing the seat of the wheelchair. Both E10 and E18 left R4 in the wheelchair, left the room without placing the soft foam lap cushion back onto R4's wheelchair. R4 began to propel herself into the hall, leaning over forward. R4 was out in the hall for several minutes, when E10 noticed and reapplied the lap cushion.

On 12/09/2014, at 3:35 PM, E11 and E12 toileted R4 and placed her in bed. E12, CNA attached the clip of the personal body alarm to R4's blouse and placed the base of the alarm next to the pillow, with no attachment to anything. E12 washed her hands and left R4's room.

On 12/10/2014 at 9:20 AM and 10:05 AM, R4 was laying in bed with the base of the personal body alarm not attached to anything, enabling the alarm to sound if R4 begins to leave the bed.

On 12/10/2014 at 12:45 PM, R4 was in the wheelchair by the nurses station leaning forward, with her head resting on the lap cushion. R4 was

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asleep. The string attached to the PBA and blouse was 22 and 1/2 inches long.

The Incident Detail Report, dated 8/10/2014, at 5:40 AM documents, in part, "(R4) rolled out of bed onto floor. No injury noted at this time, but later on noted bruise to right thumb. Bed was in low position. Comments: Position resident in center of bed to prevent rolling out of bed."

The Nurse's Note, dated 8/10/2014 at 5:30 AM, documents R4 was "found lying on the floor on the right side on mat beside bed, alarm not sounding."

The Safety Risk Data Collection for R4, dated 5/11/2014, documents, in part, "Is at risk for falls due to confusion, poor balance, poor safety awareness, leans forward in wheelchair, unsteady gait, leans back. Pressure alarm in bed, PBA (personal body alarm) in wheelchair, lap (cushion) when in wheelchair." Quarterly Review for R4 dated, 11/04/2014, documents in part, "Pressure alarm and PBA at all times."

R4's Care Plan, revised 11/12/2014, documents, in part, "Is a high risk for falls. Interventions-Apply lap (cushion) when up in wheelchair due to leaning forward, inability to right self consistently. Monitor for proper placement. Keep in high traffic area. Do not leave in bathroom unattended. Remind her not to get up without assist."

2. The POS for 12/2014 documents diagnoses for R10, in part, as "Cerebral Vascular Accident and Dementia." The MDS dated 9/29/2014, documents R10 is moderately impaired with cognition, has poor sitting and standing balance, and requires extensive assistance from staff for transfers, with limited range of motion to the lower

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extremities.

On 12/09/2014 at 12:37 PM, R10 was sitting at the dining room table, leaning forward, with her chin resting on the table. A long, knotted string was attached with a clip to R10's blouse and to a PBA attached to the wheelchair. E23, CNA instructed R10 to sit up straight.

On 12/10/2014 at 11:00 AM R10 was in a low bed. The base of the PBA was laying next to the pillow by R10's head. The base was not attached to anything. The long string was attached to R10's blouse.

On 12/10/2014 at 11:30 AM R10 was in a wheelchair in her room, leaning far over the bedside table. The string to the PBA was attached to her blouse but was not taut enough to sound. An activity tray to the right of R10's wheelchair was positioned downward. At 11:48 AM, R10 was still in her room in the same position. The string attached to the alarm measured 19 and 1/2 inches in length.

On 12/10/2014 at 1:45 PM, R10 was seated in the wheelchair in her room, leaning forward. Her body was wedged between the left arm rest of the wheelchair and the raised activity tray. Her head was laying on the bed, with the string pulled taut, but not sounding. R10 was awake.

On 12/10/2014, at 2:40 PM, R10 was in bed. The PBA was attached to the wheelchair which was across the room.

The Safety Risk Data Collection for R10, dated 7/05/2014, documents, in part, "At risk for falls due to poor balance, poor posture, leans forward in wheelchair, poor weight bearing, confusion,

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previous falls. PBA in place when up in wheelchair. half lap tray in place for improved posture. Last fall 6/12/2014."

R10's Care Plan, revised 9/30/2014, documents, in part, "Is high risk for falls related to unaware of safety needs. Interventions-Apply PBA PRN when in bed at night due to increased confusion. Encourage her to sit up when leaning forward, Lay down between meals to prevent leaning forward as often, remind to use call light for assist to transfer and not attempt per self, 1/2 lap tray in place when up in wheelchair for proper positioning. Able to reposition 1/2 tray as she wishes."

On 12/11/2014, at 3:00 PM, E3 Assistant Director of Nursing (ADON) reported the facility has no policy related to the use of the PBA with a clip, or how long the string must be to be effective to alert staff or assist in preventing falls, or where the base of the alarm should be attached to be effective when a resident is in bed.

3. R1's 11/17/14 Incident Report documents "Description: staff was transferring resident (R1) from wheelchair to toilet and resident (R1) tried to sit down before turning, so staff lowered her to the floor. Comments: staff to use gait belt for all transfers."

R1's Care Plan, revised 11/9/14, documents the new interventions as may use mechanical lift, transfer with 2 assist and gait belt on and off toilet or may offer bedpan.

On 12/11/14 at 1:55 PM, E3 stated, regarding R1 incident 11/17/14, "I would assume from the intervention that they didn't use a gait belt."

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4. R5's MDS for 6/30/14, 8/29/14, and 11/29/14 document R5 requires extensive assist of one person for transfers. R5's 6/30/14 MDS documents R5's balance is unsteady and can only stabilize with assistance, and has severe cognitive impairment. R5's 8/29/14 MDS documents R5's balance is unsteady, but he can stabilize himself, and has severe cognitive impairment. R5's 11/29/14 MDS documents R5's balance is unsteady for transfers and can only stabilize with assistance, and is cognitively intact.

R5's Incident Reports, dated 7/13/14, 9/2/14, 9/3/14, and 11/23/14, document R5 fell in his room while trying attempting to transfer himself and had no significant injuries. The above Incident Reports continue to document for interventions the comments of remind/encourage resident to use call light to ask for assistance with transfers.

On 12/11/14 at 1:55 PM, E3 also stated, regarding R5's falls, "There weren't really progressive interventions. I would have tried to identify why he (R5) was trying to get up."

The Facility's Fall Protocol, revised 3/2011, documents, "1. On admission and readmission, a Fall Risk Assessment will be completed within 24 hours. 2. Preventative measures will then be implemented for those residents assessed as moderate to high risk. When a fall occurs: 7. Depending on the nature of the fall, preventative measures will be implemented accordingly. 8. Care plans will be updated as appropriate within 3 days of a fall occurrence."

5. On 12/9/2014 at 10:15AM R3 was lying in bed with eyes closed. E13, Treatment Nurse stated R3 has an immobilizer on the left leg from a

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fracture. E13 stated the injury happened from a fall in-house.

Nurse's Notes on 3/28/2014 at 3:30PM document, "(R3) was lowered to the floor by a CNA due to wheel chair rolled backwards during a transfer...."

Nurse's Notes on 3/30/2014 at 9:00AM document, "This nurse notified POA (Power of Attorney) that after speaking to several staff members it was discovered that Friday evening while staff was transferring resident (R3) to wheelchair, the wheelchair moved and staff had to lower resident to the floor....." . This entry was signed by E2, Director of Nursing (DON).

The x-ray report on 3/29/2014 documents, "A comminuted fracture is noted involving the distal third of the femur. Posterior displacement of the distal fracture is noted...."

A comparative x-ray report on 6/19/2014 documents, "Marked displaced healing fracture distal shaft of the femur with approximately 6.9 centimeter (cm) over-riding of the fracture fragments...".

A comparative x-ray report on 8/28/2014 documents, "Subacute supracondylar fracture of the femur with moderate displacement and angulation.....There is no significant interval of change."

On 12/22/2014, E3 Assistant Director of Nursing (ADON) stated, "(R3) was a transfer with 2 assist at the time of the fall on 3/28/2014. I am not sure why the CNA transferred (R3) by herself. We tell them (CNAs) to read the residents' Care Plans. That CNA knew (R3) was a 2 person transfer."

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