STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003073	A. BUILDING: _____ B. WING _____	C 03/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE OF BELVIDERE	1701 5TH AVENUE BELVIDERE, IL 61008

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S9999	Final Observations STATEMENT OF LICENSURE VIOLATION: 300.610a) 300.1210a) 300.1210b) 300.1210d)6 300.1220b)3 300.3240a) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. 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, 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel,	S9999		

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S9999	Continued From page 2	S9999		

representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.
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 are not met as evidenced by:
Based on interview and record review the facility failed to identify the cause of a resident ' s fall, failed to implement interventions to provide a safe place for R1 to sleep, and failed to supervise R1 to prevent a fall.
This applies to 1 of 3 residents (R1) reviewed for falls in the sample of 3.
This failure contributed to R1 falling and sustaining a Subdural Intracranial Bleed on 2/7/15.

The findings include:
R1 ' s facility face sheet shows R1 had diagnoses to include High Blood Pressure, Senile Dementia, and Hallucinations.
R1 ' s admission fall assessment dated 1/30/15 shows R1 was at high risk for falls due to " intermittent confusion, medications, and predisposing diseases."
R1 ' s care plan dated 2/4/15 shows R1 is high risk for falls related to confusion, deconditioning, wandering, and impaired cognition secondary to dementia.
R1s progress notes dated 2/3/15 at 17:19 (5:19pm) show " at 1430 [2:30PM] resident fell forward out of chair he was sitting in ...When we

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S9999	Continued From page 3 got him up asked resident what happened he said " I fell asleep." Has small laceration above right eye-steri strips applied, small bump also to same area, neuro checks have been started ...Resident on daily 325mg aspirin so he was sent to ER ... " R1 ' s 2/4/15 3:56 PM progress notes shows " hematoma to right forehead. Ecchymosis to right eye, forehead and check. 2 steri-strips intact to forehead ... " R1s 2/6/15 at 9:18 PM progress note shows " at 1845 [6:45 PM] I was alerted by another resident that Robert had fallen out of chair. I first to arrived and observed resident face down on floor by 300 nurses station, resident has laceration above left eye and bump, resident state he did have pain ...3 steri strips applied, ice bag to forehead ... " R1 ' s Incident/Accident Report dated 2/3/15 shows " resident [R1] was in chair behind me ...he fell out of chair landing on forehead, when we got resident up he said he fell asleep." This report shows " Resident is recently admitted to facility. He is ambulatory and confused ...He fell asleep in chair at nurse station, falling forward and striking his head. Resident is generally very busy ambulating through the facility. He would greatly benefit by lying down and taking a rest in the afternoon. This should prevent the drowsiness that prompted the fall." R1 ' s 2/6/15 Incident/Accident report shows " I was alerted by another resident [R1] had fallen out of chair while sitting by 300 nurse station ... [R1] said " I was sleeping then I was on the floor somehow." This report shows " [R1] is ambulatory and wanders through the facility. He will occasionally sit down to chat and become drowsy. Staff attempt redirection to bed for a nap ...Occasionally he will deny being tired and refuse to go ...He may awaken 20-30 minutes later and resume walking. "	S9999		

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S9999	Continued From page 4	S9999		

R1 ' s 2/6/15 at 11:56 PM progress note shows " at 2300 neuro check resident was very lethargic, would not wake up ...obtained ok to send resident to ER ..."
R1 ' s Emergency Department physician documentation dated 2/7/15 at 12:04 AM shows " 82 year old male presents to ER ...with complaints of ...fall injury, Unresponsive."
The 2/7/15 at 1:28 am ER note shows " diagnosis are fall, Intracranial Bleed: Subdural, Hypertension.
On 2/19/15 at 2:10 PM, E3 (Licensed Practical Nurse- LPN) said he was working both days R1 fell. E3 said R1 was new to the facility and he cared for him most of the 3-11 shifts since he was admitted. E3 said R1 was " very confused " and he " couldn ' t understand why he was here." E3 said after the first couple days at the facility R1 " got it through his head that he would not sleep in his room because there was another guy in there." E3 said R1 would say " I ' m not sleeping with another guy " and R1 would not go in his room and sleep. E3 said he was getting report at the nurse station on 2/3/15 and R1 " fell forward out of the chair." E3 said after the first fall, if the staff members saw R1 sitting in the hall they were to " keep an eye on him [R1] and try to get him to lie down in bed." E3 said if they took R1 to his room he would come back out and wander in the halls or sleep in chair at the nurse station.
E3 said he was working the second time R1 fell from the same chair. E3 said R1 was sitting in the same place, and in the same chair (located at the 300 wing nurse station). E3 said " I left and went to the side dining room to let the smokers out and another resident came and told me he fell and was laying on the floor." E3 said R1 was sitting in a regular, hard back chair (like in the dining room) and there were no witnesses to the fall because he was in another room and the

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S9999	Continued From page 5 Certified Nurse Assistants (CNA ' s) would have been laying other residents down for bed. E3 said when he assessed R1, R1 said " I was sleeping and next thing I know I was on the floor." E3 said R1 had a laceration to his head from the fall. E3 said after the second fall he moved a recliner to the nurse station so R1 could sleep in it and recline back. E3 said R1 could put his feet up in the recliner and lay back which was " safer to sleep in than the other chair " . E3 said no changes were made after R1 fell the first time except to try to get him to lay down in his bed. E3 said R1 would not sleep in his room but would lay down on the physical therapy bed outside the dining room, sleep in the dining room chairs, or sleep in the chair outside the nurse station. E3 said after R1 fell the second time he called R1 ' s wife to let her know. E3 said R1 ' s wife told him to talk to R1 about fishing trips he used to take and remind him he slept in a cabin with men for many years. E3 said about an hour after talking with R1 about the fishing trips, R1 agreed to go sleep in his room. E3 said prior to this R1 would sleep in chairs in the hallway or wander throughout the facility during the night. E3 said every time they tried to direct him to his room he would come back out to the hall. E3 said he was not sure if another room was offered to R1 but the Director of Nursing - DON, and " all staff " knew R1 was not sleeping in his room. On 2/19/15 E4 (CNA) said she had provided care for R1. E4 said R1 was very confused and would wander a lot during the night. E4 said R1 would not sleep in his room and would say " I have never slept with a man for 35 years and I ' m not going to now." E4 said R1 would " a lot of times go to the dining room on second shift " or he would sit in the chair by the nurse station and sleep. On 2/191/5 at 3:00 PM, E5 (LPN) said R1 was	S9999		

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S9999	Continued From page 6	S9999		

confused and would pace a lot. E5 said they would try to redirect R1 to his room on day shift and he would " become agitated and attempt to leave." E5 said R1 would not stay in his room on day shift, and would often sit in the chair in the hall outside of the 300 wing nurse station.
On 2/19/15 at 1:00 PM, E2 (DON) said R1 was a high risk for falls on admission to the facility. E2 said R1 was confused and would wander throughout the facility. E2 said R1 fell two separate times on (2/3/15 and 2/6/15) from the same chair, located in the same spot. E2 said R1 hit the right side of his head with the first fall, and the left side of his head with the second fall.
On 2/19/15 at 2:40 PM, E2 said after the first fall, the only intervention added was to lay R1 down after meals so he would not fall asleep in the chair. E2 said R1 would leave his room and come out to hallway, wander around, and fall asleep in the chair at the nurse station. E2 said there was an issue with R1 not staying in his room. E2 said the fact R1 was not sleeping in his room should have been care planned and attempts at a room change should have been made. E2 said the family should be interviewed about possible ways to fix the problem. E2 said after the first fall, another chair could have been put at the nurse station to help prevent R1 from falling. E2 said a recliner could have been used or a reclining wheelchair which would prevent R1 from falling forward.
On 2/19/15 at 2:45 PM, E6 (Social Service Director) said R1 was very confused. E6 said she was not aware that R1 would not sleep in his room. E6 said if she had been made aware, she would have talked to R1 and his family to identify what the problem was, or met with the inter-disciplinary to come up with interventions to get him to sleep in his room. E6 said she also would have tried to move R1 to a different room if

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S9999	Continued From page 7 he did not get along with his roommate. On 2/20/15 at 11:15 AM, Z1 (Medical Physician) Z1 said he would expect the facility to identify why R1 was falling. Z1 said " yes " the facility should have provided a safe place for R1 to sleep if he did not want to sleep in his room. Z1 said after a fall occurs he would expect them [facility] to assess the situation and put new interventions in place to prevent the fall from happening again. Z1 said " according to the sequence of events " ; R1 ' s subdural hematoma was a result of the fall. On 2/4/15, R1 ' s fall care plan was updated to include one additional intervention to "Encourage resident to lie down for a rest/nap after lunch d/t falling asleep in chair." There were no interventions to address that R1 would not sleep in his room, or to provide a safe alternative place for R1 to sleep. There were no interventions to change the chair available outside the nurse station for R1 to sit/sleep in. There were no interventions to increase supervision for R1. The 8/13 facility policy " Fall Prevention Program " shows " The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents ...The program will be inclusive of measures which determine the individual needs of each resident by assessing the risk of falls, and implementation of appropriate staff interventions to assure adequate supervision is provided, and that assistive devices are utilized when necessary ...Fall incident reports will be studied t codetermine any significant factors that may have caused the fall and to identify additional fall prevention strategies that may be indicated. " (A)	S9999		

PARK PLACE OF BELVIDERE:

Failure to identify the cause of a resident's fall.

1. Audit of last 20 incident investigations for root cause identification and appropriate intervention and appropriate intervention (See Attachment A). DON to perform. Completion Date: 3/23/15 Accepted

2. Targeted inservice to nursing leadership team from nursing consultant on root cause analysis (See Attachment B). Nursing Consult C to perform. Completion Date: 4/2/15 Accepted

3. Follow-up audit of subsequent 20 fall incident investigation for root cause identification and appropriate intervention and appropriate intervention. Remediation as indicated (See Attachment C). DON to perform. Completion Date 4/2/15 Accepted

Failure to implement interventions to provide a safe place for R1 to sleep.

1. Survey of admissions since 3/3/15 with resident and/or family interview as indicated evaluating usage, comfort, and safety of sleeping arrangements (See Attachment D). Social Service to perform. Completion Date: 3/23/15 Accepted

2. Nursing staff inservice on reporting of resident sleep dysfunction and/or room dissatisfaction (See Attachment E). Nurse Consultant C. Pending to perform. Completion Date: 4/2/15.

3. Alerts added to EMR for communication of sleep related concerns. (See Attachment F). DON to perform. Completion Date: 3/23/15. Accepted

4. F/U audit of admission for two (2) months evaluating usage, comfort, and safety of sleeping arrangements. (See Attachment G). Social Service to perform. Completion Date: 3/23/15 Accepted

Failure to supervise R1 to prevent a fall.

1. Baseline random audit of common areas of resident congregation of presence of staff supervision. (See Attachment H). Administrator to perform. Completion Date: 3/23/15 Accepted

2. All Staff inservice on fall prevention, supervision and safety. (See Attachment 1). Nurse Consultant C pending to perform. Completion Date: 4/2/15. Accepted

3. Random audit of common areas of resident congregation for presence of staff supervision. Weekly for 4 weeks, then monthly for 2 months. (See Attachment J). Administrator to perform. Completion Date: 4/2/15. Accepted

Attachment B
Imposed Plan of Correction