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S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010i) 300.1210a) 300.1210b)5) 300.1210d)6) 3001220b)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 300.1010 Medical Care Policies i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid procedures. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility,	S9999		

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S9999	Continued From page 1 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 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. (Section 3-202.2a of the Act) 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. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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	S9999		

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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, 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. (A, B) (Section 2-107 of the Act)

These Requirements are not met as evidenced by:

Based on observation, interview and record review the facility failed to ensure that a resident who was assessed as needing two person assist

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using a gait belt was assisted with transfers per plan of care and per facility policy and procedure. This applies to 1 of 3 residents (R1) reviewed for falls with injury.
This failure resulted in R1 sustaining bilateral femur fractures.

The findings include:

R1 has multiple diagnoses which included decreased functioning and altered mental status based on the face sheet. R1's restorative program care plan indicated that the resident has diagnoses of arthritic pain in bilateral knees and end stage Alzheimer ' s.

R1's quarterly MDS (Minimum Data Set) dated 2/23/15 shows that the resident has severely impaired cognition and would require extensive assistance x two or more with most ADL's (Activities of Daily Living) including transfers. The same MDS shows that R1 is non-ambulatory.

R1's incident/accident report dated 4/30/15 (7:30 AM) shows, "CNA (Certified Nursing Assistant) reported resident, "lowered to floor" during transfer from bed to wheel chair. CNA reported resident "grabbing my shirt" as retrieving wheel chair. Resident off of bed - guided to floor."

In an interview held on 5/4/15 at 2:00 PM, E3 (CNA) stated that she was the assigned CNA who took care of R1 on 4/30/15 during the 6:30 AM to 3:00 PM shift. Per E3, on 4/30/15 at around 7:30 AM she went inside R1's room to transfer the resident from the bed to the wheel chair. According to E3, R1's bed was on the lowest position so, she raised it up for easy transfer. E3 stated that after elevating the bed, she assisted

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R1 to sit up on the edge of the bed. Per E3 while assisting R1 into the sitting position, R1 verbalized, "Ow" while holding on to the side rail. E3 stated that she did not apply a gait belt to R1 and that she intended to transfer R1 from the bed to the wheel chair on her own. According to E3, while R1 was sitting up on the edge of the bed, she (E3) turned around to get the wheel chair which was at least 5 steps away from the bed, but as soon as she started walking, R1 held on to the back of her shirt. Per E3, she turned around and saw R1 sitting halfway on the edge of the bed. E3 stated, "since I don't have the muscle strength to pull her on the bed, " I eased her down the floor." Per E3, R1 landed on the floor, sitting more on her right buttock (sideways) with both left and right legs bent backwards towards left side of the body. E3 stated that R1 was almost sitting on her legs while on the floor. E3 stated that she called the two other CNA's (E4 and E5) to assist in getting R1 off the floor but did not call E6 (nurse) to assess R1's condition. According to E3, E4 came and attempted to straighten R1's legs (to move both legs forward) but resident was resisting, touching her knees and saying, "Ow." E4 continued to straighten R1's legs and was eventually successful. Per E3, E4 and E5 held on to R1's underarm (on each side), lifted R1 from the floor and transferred the resident to the wheel chair. E3 stated that E4 and E5 did not use a gait belt or any lifting device to assist R1 off the floor. When R1 was up in the wheel chair she wheeled the resident to the dining room to eat but did not inform E6 of the incident. Per E3, R1 was transferred by the staff (does not know who) on 4/30/15 at around 9:30 AM, from the wheel chair to the reclining chair.

In an interview held on 5/4/15 at 2:23 PM, E4 stated that on 4/30/15 between 7:35 and 7:40

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AM, E3 came to get her from another resident's room, to assist in picking up R1 from the floor. Per E4 she immediately went to R1's room and saw the resident sitting on the floor with both lower extremities under her buttocks, "resident was sitting on them." E4 stated that she asked E3 what happened and E3 informed her that R1 slid off the bed and that she (E3) guided the resident to the floor. Per E4 she also asked E3 if the nurse was informed of the incident and the condition of R1 to which E3 responded, "yes." According to E4, E3 told her that the nurse said it is okay to get R1 off the floor since the resident did not fall. E4 then stated that she and E5 started repositioning R1 to straighten the legs and then transferred R1 to the wheel chair by holding under her arms (each side) and holding on to R1's pants (waist area) since the resident does not have a gait belt in place.

In an interview held on 5/4/15 at 2:43 PM, E5 stated that on 4/30/15 at around 7:30 AM, E3 came to get her from another resident's room, to assist in picking up R1 from the floor. Per E6 she immediately went to R1's room and saw the resident on the floor leaning towards her left side with both legs bent back. E5 stated that R1 did not verbalized pain but appeared to be grimacing in pain. Per E5, she and E4 picked up R1 off the floor by putting one arm (on each side) under R1's thigh area and one arm under (on each side) resident's armpits. E5 stated that during the manual lifting and transferring of R1 from the floor to the wheel chair, the resident had facial expression of pain (grimacing). Per E5, no gait belt was used during the transfer. E5 stated that she asked E3 if the nurse was notified that R1 is on the floor. Per E5, E3 responded, "no" because R1 did not fall. According to E5, E3 stated that, "resident slipped off the bed to the

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floor." E5 stated that, I know we should have told the nurse first, but the way the resident was sitting on her legs, resident needed to be assisted to the wheel chair right way and at that time the nurse is passing meds, so she might not come right away & resident needs to be assisted."

In an interview held on 5/4/15 at 3:10 AM, E6 stated that she was the nurse assigned to R1 on 4/30/15 during the 6:30 AM through 3:00 PM shift. Per E6 on 4/30/15 at around 10:30 AM, she was informed by E3 that R1 was lowered to the floor during transfer from bed to wheel chair at around 7:30 that morning. E6 stated that per E3 she lowered R1 to the floor during transfer from bed to wheel chair because the resident was grabbing her shirt as she (E3) was getting the wheel chair. Per E6, E3 also told her that E4 and E5 helped to get R1 off the floor. According to E6 she was not notified by the staff (E3, E4 or E5) about R1 being on the floor. Per E6, she assessed R1 between 10:30 and 11:00 AM (after E3 reported the incident). R1 was saying, "Ow, Ow" when her right knee and leg was touched. According to E6, R1 had chronic bilateral knee pain and receives narcotic pain medications three times a day and pain patch on the left knee every morning and off before bed time. Per E6, R1 cannot verbalize pain due to her advanced Dementia. Per E6, R1 did not have any bruising, no rotation and no shortening of the extremities when assessed. The NP (nurse practitioner) was notified of the incident and no order was given at that time. According to E6 she left the unit at around 3:00 PM on 4/30/15 and endorsed the incident to the next shift. E6 further stated, CNA's are expected to report any incident, so resident could be assessed - in this case, resident needs to be assessed while on the floor to make sure it is safe to move her."

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R1's computerized nursing notes dated 4/30/15 (8:52 PM) showed that the resident is on fall follow up. The nursing notes indicated that R1 was guarded during ADL's with CNA and would not put weight on either foot during transfers.
The same nursing notes documented that R1 had decreased appetite for dinner and was less verbal than per her routine baseline. R1's physician was notified and ordered for bilateral knee and hip x-rays to be done on 5/1/15 to rule out any acute injuries.
Review of the X-ray done at the facility on 5/1/15 showed an acute displaced distal right femur shaft fracture and an acute displaced comminuted distal left femur shaft fracture. R1's physician was notified and the resident was sent out for evaluation and treatment.
Review of the hospital X-ray results showed that there is an oblique fracture of the right distal femur shaft. The left femur demonstrates an incompletely characterized acute distal left femur fracture. There is likely an acute, poorly visualized left superior pubic bone fracture.

Review of the hospital history and physical dated 5/2/15 made by Z1 (primary physician) shows, "The patient has had multiple falls, but the last fall led to significant pain in both hips and difficulty with transfers and elevated pain with transfers. X-ray was ordered to bilateral hips, which showed bilateral femur fractures."

In an interview held on 5/8/15 at 1:07 PM, Z1 stated that the cause of R1's fracture was most likely a fall. Per Z1, "you could not fracture both femur, just by standing, there was an impact/trauma that caused the fracture." Z1 further stated that he expects the staff to follow R1 ' s plan of care to ensure safety of the

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S9999	Continued From page 8 resident. On 5/8/15 at 1:24 PM with E2 (Director of Nursing), R1 was observed sleeping in bed with bilateral mid-thigh to lower leg immobilizer in place. E2 stated that due to R1's age and condition of the bones, no surgery was performed. R1's restorative program care plan initiated 5/26/14 and was last reviewed on 3/25/15 with a goal date of 6/24/15 showed that R1 will transfer safely at each opportunity with gait belt and maximum assistance of 2 persons as needed. May transfer with sit to stand mechanical lift with 2 person assist as needed and may transfer using a full body mechanical lift with 2 person assist as needed. Review of the facility gait belt policy and procedure dated 8/06 showed, "A gait belt will be used with any resident who requires a 1 or 2 person assist to transfer or ambulate." Review of the facility's policy and procedure regarding resident falls showed that "When a resident falls or is found on the floor, do not move the resident or place anything under their head. Remain with the resident and call for help." "The nurse assigned to the area is responsible to perform an immediate and through assessment." (A)	S9999		