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	IL6008841	A. BUILDING: _____ B. WING _____	C 05/06/2015

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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, seven-day-a-week basis:	S9999		

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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:
Based on observation, interview and record review, the facility failed to implement individualized safety measures, and follow their care plan interventions to prevent recurrent falls for 3 of 5 residents (R1, R3, R4) reviewed for falls in the sample of 9. This failure resulted in R4 sustaining a 15 centimeter (5.9 inch) laceration to her head requiring medical intervention of 18 sutures.

Findings include:

1. The Minimum Data Set (MDS) dated 04/10/2015 documents R3 is severely impaired with cognition, does not ambulate and requires extensive assistance with transfers.

The facility's Fall Risk Assessment, dated 04/18/2015, documents R3 is disoriented x (times) 3 (person, place, time) at all times and is a high risk for falls.

R3's Care Plan, documents R3 fell on 4/17/2015 and sustained hematoma and abrasion on head. On 04/17/2015 the Care Plan documents an intervention as " keep resident in direct

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supervision when up in wheelchair, hourly checks when in bed, mats to sides of bed. "

On 04/27/2015, at 11:20 A.M. , R3 was active in his wheelchair, propelling himself in the hallway, and at times out of staff's field of vision. In the middle of his forehead was a large hematoma (bruise) the size of a golf ball, and to the right of R3's forehead was another open gash the size of a quarter.

On 04/28/2015 at 12:30 PM, R3 was asleep in his room and no safety fall mats were present in his room.

On 04/30/2015 at 2:21 PM, R3 was asleep in his room on his bed and no fall mats were present in the room.

On 05/01/2015 at 1:31 PM, R3 propelled himself into another residents room and was there for over five minutes without staff present.

On 04/30/2015 at 2:50 PM, E5, Licensed Practical Nurse (LPN), stated there was no indication for R3 to have a bed mat in his room.

On 4/30/2015 at 3:00 PM, E3, Certified Nursing Assistance (CNA) stated R3 does not have or need any bed mats.

On 4/30/2015 at 3:14 PM, E4, CNA stated R3 does not need any bed mats and checked his record, and stated there were no orders for R3 to have a mat by his bed.

On 4/30/2015 at 3:18 PM, E6, Licensed Practical Nurse (LPN) Case Management, stated R3 is supposed to have mats in his room, and stated she was not sure why the mats were not present,

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as it is one the interventions implemented for falls for R3. E6 added that recently R3 had changed rooms, and perhaps the mats did not transfer with R3.

2. The Physician's Order Sheet (POS) for R4 for 4/2015 documents, diagnoses, in part, as Rheumatoid Arthritis and Weakness. The MDS dated 2/12/2015 documents R4 is moderately impaired with cognition, requires assistance of one staff for transfers and has limited range of motion to the lower extremities.

The POS for 4/01/2015 documents, in part, "PBA (personal body alarm) in wheelchair in wheelchair related to history of falls. Check placement and functioning every shift."

The Incident/Accident Report for 2/24/2015 documents R4 slid out of her wheelchair because her underwear was too tight, and tried to remove them. The intervention applied was a non-skid pad to the wheelchair.

R4's Care Plan, revised 2/28/2015, fails to address the use of a non-skid pad in the wheelchair or a personal body alarm to the wheelchair.

During tour of the facility on 4/28/2015 at 11:12 AM, R4 was seated in her wheelchair, asleep and leaning very far forward in the wheelchair. There was no personal safety alarm attached to R4 or the wheelchair. R4 continued to fall forward as she slept, requiring immediate intervention of the surveyor. There was no staff in the area at that time. When R4 was addressed by name, she immediately woke up and sat upright. R4 stated, "I need someone to help me to bed." A foam safety fall mat was folded under R4's bed.

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On 4/28/2015 at 11:17 AM, E9, CNA applied a gait belt to R4. E9 and E10, CNA transferred R4 to bed. R4 did not bear any weight on her lower extremities during this transfer. There was no alarm on R4's bed.

On 4/29/2015 at 10:35 AM, R4 was not in her room. The wheelchair had a rubber, non-skid pad placed on top of the pressure relieving cushion in R4's seat. A twice-folded, cloth incontinent pad was placed on top of the non-skid pad, enabling it's effectiveness.

On 4/29/2015, at 12:10 PM, R4 was in the dining room, asleep and leaning forward in the wheelchair. On 4/29/2015, at 1:43 PM, R4 was again in her wheelchair in her room, out of staff supervision. R4 was leaning progressively forward in the wheelchair, but sat up when her name was said. There was no safety alarm on R4's wheelchair.

On 4/29/2015 at 2:20 PM, E11, CNA stated, "I was walking past (R4's) room at 2:15 PM and found her lying on the floor next to her bed. (R4) does not have an alarm. She just fell forward out of the wheelchair. She doesn't have an alarm, as far as I know."

On 4/29/2015 at 2:25 PM, E8, Registered Nurse (RN) stated, "She (R4) has a laceration on the left side of her forehead. No loss of consciousness. I'm sending her out by ambulance. It's a pretty good laceration!"

The Incident/Accident Report, dated 4/29/2015 at 2:15 PM, documents, in part, that R4 fell asleep while sitting in the wheelchair and was found on the floor with a head laceration. No staff was

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present at the time of the fall. The intervention documented after R4's fall is documented as, "Encourage (R4) to lay down after every meal."

The Nurses Note, dated 4/29/2015 at 2:45 PM, documents R4 was sent by ambulance to the local hospital and had sustained a 15 cm (centimeter) laceration to the left side of her head. The Nurses Note, dated 4/29/2015 at 8:00 PM, documents R4 returned to the facility at 8:00 PM with 18 sutures in her head and personal safety alarm was applied.

3. The POS for 4/2015 documents R1 has diagnoses, in part, as"Dementia, Rheumatoid Arthritis and Anxiety. The MDS, dated 2/02/2015, documents R1 is moderately impaired with cognition and decision making, is non ambulatory, requires the assistance of one staff for transfers and has limited range of motion to the lower extremities.

The Fall Risk Evaluation, dated 2/02/2015, documents R1 is a high risk for falls.

On 4/29/2015, at 11:30 AM, R1 was lying on her back in bed. A PBA was attached to R1's blouse, but the base of the alarm was laying next to her on the pillow, not attached to anything. A fall mat was folded under R1's bed.

On 4/30/3015 at 10:36 AM, R1 was in bed with the clip of the alarm attached to her blouse, but the base of the alarm was laying next to the pillow. This would disable the alarm from sounding if R1 tried to get out of bed. The fall mat was under R1's bed. At 11:00 AM and 11:25 AM, R1 remained in the same position without the alarm attached, and the fall mat under the bed.

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On 430/2015 at 11:26 AM, E12, CNA applied a gait belt and assisted R1 to a seated position, then transferred R1 to the wheelchair. R1 had poor weight bearing to both lower extremities. E12 removed the clip from R1's blouse and noted the base was not attached to anything. E12 stated, "It's supposed to go back there", pointing to the hook and pile attachment located at the head of R1's bed. E12 demonstrated how the PBA should be attached and reported she felt the string was too short.

On 4/30/2015 at 12:55 PM, R1 transferred herself from the wheelchair to bed and the PBA sounded. E8, RN came immediately and applied the alarm to the head of R1's bed.

On 4/30/2015 at 1:40 PM, R1 was asleep in bed with the base of the PBA not attached to the head of the bed. Again the fall mat was under the bed.

The Incident/Accident Reports dated 3/24, 4/15, 4/20, 4/27 and 4/28/2015 all document R1 was found on the floor with no alarm sounding.

R1's Care Plan documents a personal alarm had been initiated for R1 on 8/07/2014.

The facility's policy and procedure, entitled, 'Fall Management', reviewed 1/2015, documents, in part, "It is the policy of the facility to have a Fall Prevention Program to assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Quality Assurance Program will monitor the program to assure ongoing

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