

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145058</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C. <b>3/23/04</b>
NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE MANOR-CHILLICOTHE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1028 HILLCREST DRIVE CHILLICOTHE, IL 61523</b>		
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F9999	<p>FINAL OBSERVATIONS</p> <p>Licensure Violations</p> <p>300.1010h) The facility shall notify the residents' physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety, or welfare of a resident.</p> <p>300.1210a) Adequate and properly supervised nursing care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>300.1210c)4) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further</p>	F9999			

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F9999	<p>Continued From page 9</p> <p>medical evaluation and treatment shall be made by nursing staff.</p> <p>300.3240a) An owner, Licensee, Administrator, employee, or agent of a facility shall not abuse or neglect a resident.</p> <p>Based on record review, interviews and observations the facility failed to assess and analyze possible similarities of a series of falls, failed to devise and implement individualized care plan approaches to prevent/deter future falls; and failed to monitor the effectiveness of care plan approaches for all prevention for 1 of 8 sampled residents (R7). R7 fell 5 times from his bed. R7 fractured his neck and died from postural asphyxia after his last fall.</p> <p>Findings include:</p> <p>The Nurses Admission Record dated for 5/8/02, notes R7 to be "unsteady on feet", with a "History of falls". According to the Admission Record Diagnosis Detail, R7 had the following diagnoses: "Alzheimer's Dementia (A/D), Depressive disorder, Anxiety, Dementia with Behavior Disturbance. R7 had also had a previous History and Physical done prior to his admission dated 5/7/02 which stated that R7 had a "History of Intracranial Hemorrhage secondary to trauma", from a previous fall.</p> <p>R7 was assessed for his quarterly (MDS) Minimum Data Set on 1/27/04, 8/11/03 and 10/27/03, and an annual assessment on 4/30/03. He was determined to be moderately impaired in making decisions. He was not aware of staff names or faces, location of his room, or that he was in a nursing home. R7 was assessed as</p>	F9999		

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F9999	<p>Continued From page 10</p> <p>having behaviors such as repetitive verbalizations asking for help, repetitive physical movements. R7 was assessed at this time as being totally dependent on staff for transfers and was non-ambulatory. According to his MAR (Medication Administration Record) dated 1/1/04-1/31/04, R7 was receiving Risperdal for agitation; Lorazepam bedtime for anxiety; and Depakote 2 times a day for mood swings.</p> <p>R7's Care Plan dated for 5/5/03 states that R7 had a fall "on 1/3/03. Has decreased cognition ability for safety. Restless and yells out at times. Non ambulatory. Improper balance awareness." In addition to the previous notations, the care plan was updated on 9/22/03 and states, "At times gets upside down or sideways in bed." The care plan also reflects that R7 sustained falls on 10/28/03 and 11/29/03 but does not refer to the fall on 9/22/03 or 10/17/03. R7's care plan reflected the following approaches to R7's risk of falls: 1. Put side rails up when in bed; 2. Place call light within resident's reach; 3. Allow sufficient rest periods (additional written note: naps in a.m. and p.m. as needed); 4. Keep bed in low position at all times; 5. Observe resident for signs of fatigue when sitting in chair, place in bed for nap; 6. Check on frequently; 7. Check on him if calling out; 8. Out of bed in geriatric chair during day." Additional handwritten notes dated for 10/28/03 are: "9. May place pillows or other positioning aides along sides when in bed; 10. Check bed rails before leaving-pull up and locked in position; 11. May consider use of bed alarm; 12. Have maintenance check rails for function properly and lock in place when up episodically; 13. if becomes too restless in bed-get out of bed in his wheel chair and place where can be easily monitored."</p>	F9999			

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F9999	Continued From page 11  According to the review of the facility documentation in the Nurses Notes and Incident reports, R7 sustained 5 falls from from 9/22/03 to 1/28/04. R7's Nurses Notes dated 9/22/03 at 3:00 p.m. states: "CNA (Certified Nurse Assistant) went to room and resident was lying on floor by bed.....has reddened area below hip bone. The facility "Fall Management Care Plan Tool" dated for 9/22/03 following R7's fall from the bed at 3:00 p.m., stated "Check resident frequently", but there are no specific approaches in the care plan as to the frequency of these checks. An interview was conducted on 3/10/04 with E8, CNA (Certified Nurse Assistant) at 1:45 a.m. E8 stated, We would peek in more often on him. If he was yelling we would go in because that's when he was moving around."  According to the Nurses Notes and the facility Incident Report, R7 sustained a fall on 10/17/03 at 4:00 p.m. The Nurses Notes stated the following: "Resident in room yelling 'Help I fell'.....has reddened area on forehead. Unknown if from fall." No follow-up assessment was documented for this fall, nor were any changes made in the care plan to reflect additional interventions. This was verified by E5, Corporate nurse on 3/16/04, when she stated that they did "not have follow-up tool for that fall."  An interview was conducted on 3/15/04 in the afternoon with E9, LPN (Licensed Practical Nurse) who was the nurse on duty for the following falls. E9 confirmed the side rails were up and that R7 had fallen from the bed for the 9/22/03, 10/17/03, and the 11/28/03 falls as well as the final fall on 1/28/04.	F9999		

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F9999	<p>Continued From page 12</p> <p>On 10/28/03, R7 sustained a fall at 10:25 p.m. According to the Incident Report for that date the narration included, "Resident yelling. Entered room. Bed railing down. Resident on head falling off bed. Second shift nurse was just in the room and the railing was up. Abrasion on the top of head". The Fall Investigation Tool for this incident stated: "Have maintenance check workability of locking mechanism on rails. Up for all meals so not as restless when in bed". The facility Fall Management Care Plan Tool states the following: "Consider use of bed alarm; check resident frequently, encourage exercise--up for all meals. The care-plan states "Consider use of bed alarm"; however there is no documentation in the Nurses Notes or the Physician Orders through 1/04 that validates the use of a body or bed alarm.</p> <p>According to the facility Incident Report dated for 11/28/03, R7 incurred a fall at 8:30 p.m. The documentation stated he "was found on the floor at the head of the bed...Reopened small skin tear on Left elbow." The Nurses Notes state, "He went out end of bed at head of bed." The Fall Management care Plan Tool stated the following intervention to be added to the care plan--"If calling out, check on. If too restless get out of bed. This was verified by E9, LPN, in an interview on 3/15/04 , who was the nurse on duty when this fall occurred. E9 stated "his side rails were up and he went between the rails and the head of the bed".</p> <p>According to the facility Incident Report dated 1/28/04, R7 was "found by CNA's (Certified Nurses Aides) lying on floor at Head of Bed. No pulse, No respirations. No blood pressure. No apparent bruises or lacerations noted."</p>	F9999		

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F9999	<p>Continued From page 13</p> <p>An interview was conducted on 3/11/04 at 9:55 a.m. with E14, CNA (Certified Nurse Assistant) who was the CNA who first found R7's body. E14 stated that she opened the door and went into R7's "room at about 9:30 p.m." when she "found him on the floor....he was lying against the wall with his butt in the air and his head was tucked underneath him....his hands were cold. His face was blue.....I panicked. Then I went and got the other aide and the nurse. I told them, 'he's on the floor and I don't think he's breathing!'" The Nurses Notes dated 1/28/04 for 9:30 p.m. further stated that R7's "head under armpit".</p> <p>When asked when she had last checked on R7, E14 stated, "I was walking past his room at 8:50 p.m. and heard him yelling. So, I opened his door.....He was lying on his right side." E14 stated R7's "side rails were up" at both the 8:50 p.m. check and when she found his body at 9:30 p.m. She further stated that at the 8:50 p.m. time, she "just checked on him. He was ok" When asked how long he had been in bed, she stated that "he had his supper in bed." When asked if R7 moved around a lot in his bed, E14 stated that he would often be up "on his hands and knees....feet over the rails....turned completely upside down in the bed".</p> <p>An interview was conducted with E9, LPN (Licensed Practical Nurse) on 3/10/04 at 1:55 p.m. E9 stated that she had been in R7's room somewhere between 7:15 p.m. and 7:30 p.m. to pass his evening medications. E9 further stated in a subsequent interview on 3/15/04 that she had found R7 lying in bed on more than one occasion with his head through the side rails. She stated,</p>	F9999		

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F9999	<p>Continued From page 14</p> <p>"Sometimes his whole head would be through the side rail. One time he had gotten his head through the side rail and the side rail had come down on him." Asked this question, How far was his head through the rails? She stated, "All the way through. It was just lucky that I came in at that time." E9 was further questioned regarding precautions that were taken for this resident. She stated, "We tried to check on him frequently.....we did try a body alarm on him shortly after he was admitted but he would remove it and throw it on the floor.....we tried padding the rails, but he would get his face caught between the mattress and the padding and we were afraid he would suffocate."</p> <p>According to an interview with E3, Assistant Director of Nurses (ADON) conducted in the afternoon on 3/16/04, E3 stated that she had attempted to use "a body alarm" on R7, but it had to be removed as he "would pull it off". E3 was unable to give specific dates when the device was applied or discontinued. An interview was conducted on 3/16/04 with E2, Director of Nurses who stated that there had been "no body alarm" used on R7 since "October of 2003". She was asked if a physician order was necessary for the use of this alarm and she said "yes". R7's physician orders were reviewed from 10/03-1/04 in which there was no order for the use of this device.</p> <p>A telephone interview was conducted with Z2, Deputy Coroner on 3/10/04 at 3:40 p.m. Z2 stated that he arrived on the scene at 9:57 p.m. on 1/28/04 after receiving the call. He stated that he had alerted the local police department to be there as well. He stated that R7 "was lying on the right side of his bed, rolled up into a ball....the side rails were up...had a history of falls....rigor mortis had</p>	F9999		

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F9999	Continued From page 15 set in." Z2 related the final cause of death on the autopsy as, Positional asphyxia due to compression of the neck, with a ruptured cervical disc due to a fall from the bed."	F9999			