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	146077	A. BUILDING _____ B. WING _____	C 11/01/2006

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F 324	Continued From page 5 to all aspects of resident safety. Employees found to be in violation will be immediately inserviced with return demonstration as to the proper techniques that pertain to resident safety and ways to prevent the risk of injury. All policy and procedure manuals will be reviewed with addendums added to address resident safety. 3. On-going inservicing pertaining to resident safety will be provided on a quarterly basis. The certified nursing instructor, is scheduled for a mandatory inservice on resident safety on 12/6 and 12/7/06. The inservice will include return demonstration by the employee. All policy and procedure manuals will continue to be reviewed and updated on a quarterly basis at the QA meeting. The facility has initiated a safety committee with representatives from each department that meets two times per month to identify potential safety risks. 4. Rounds will be conducted by the Department head, and/or a designated representative, a minimum of 1 x per week on each shift to ensure that ALL employees are following proper policy and procedure in regards to all aspects of resident safety.	F 324		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION	F9999		

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F9999	Continued From page 6 Section 300.610a) Section 300.690a)1) Section 300.1210a) Section 300.1210b)6) Section 300.1220b)8) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.690 Serious Incidents and Accidents a) The facility shall notify the Department of any incident or accident which has, or is likely to have, a significant effect on the health, safety, or welfare of a resident or residents. Incidents and accidents requiring the services of a physician, hospital, police or fire department, coroner, or other service provider on an emergency basis shall be reported to the Department. 1) Notification shall be made by a phone call to the Regional Office within 24 hours of each serious incident or accident. If the facility is unable to contact the Regional Office, notification shall be made by a phone call to the Department's toll-free complaint registry number.	F9999		

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F9999	Continued From page 7 Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must 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 assessment and plan of care. 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: b) 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: 8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and restorative/rehabilitative nursing techniques through out-of-facility or in-facility training programs. This person may conduct these programs personally or see that they are carried out.	F9999		

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F9999	Continued From page 8 These requirements were not met as evidenced by the following: Based on observation, interview and record review the facility failed to ensure that: 1. One nurse aide (E4) was able to demonstrate competency during repositioning of one resident confined to bed (R3), 2. Policy and procedures were available which reflect safety issues for proper bed repositioning, 3. Direct care staff receive training, evaluations and re-evaluations in the areas of basic skills and techniques to meet the residents needs. As a result of these system failures, on 9/1/06, R3 was pushed over in her bed on to the floor (bed was in high position with no safety measures in place to prevent the fall) by the facility's direct care staff (E4). R3 was sent to the nearby community hospital and admitted with diagnosis of Pontine Bleed and a fracture to the left hip. Consequently, R3 expired on 9/2/06. The immediate cause of death, according to the Coroner's report is Cardiac Dysrhythmia due to, or as a consequence of Stress due to, or as a consequence of Fracture of the Femur due to a Fall. Findings include: A review of the facility's incident report faxed to the regional office on 9/5/06, the following information read: "On 9/1/06, R3's linen was being changed by E4 (unit cna). R3 was lying on her right side, she was playing with the bed controls. As E4 went to change the linen, R3 raised the head of the bed causing her legs to slide off the bed. R3 slid off the bed onto the	F9999		

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F9999	Continued From page 9	F9999		

floor. R3 sustained a hematoma to the back of her head. R3 was still alert and answering questions. R3 also complained of some nausea. R3 was sent to hospital evaluated and admitted with diagnosis of a Pontine bleed with a fracture to the left hip. R3 subsequently expired at the hospital at 3:30 AM on 9/2/06."

The Illinois Department of Public Health was not notified of this incident until 9/5/06.

A review of the facility's Nurse's Notes dated 9/1/06 at 2:45 PM, found "During bed linen change by E4, R3 moved suddenly and E4 could not catch R3 from falling out of bed. Nurse called to room to fined a large hematoma on posterior aspect of head. R3 having some nausea also at this time."

During an observation of R3's room and bed, it was observed that R3 had a Resident Long Term Care Bed. (see exhibit 01) The bed was observed with no side rails. However, the bed is equipped with a control panel on each side of the bed only.

During an interview with E4 on 9/11/06, E4 stated that she was making her end of shift rounds. E4 stated that she was providing R3 with routine incontinent care. E4 stated that R3's bed was in the high position, and she (E4) was standing on the left side of the bed with R3 positioned on her left side. E4 stated that after she positioned the clean linen under R3, she (E4) pushed R3 away from her to the other side of the bed. E4 stated that R3 just kept rolling, her legs went out first and that R3 just kept going. I could not catch her. R3 rolled out of bed and landed on her back. That's when I called for help. A review of E4's

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F9999	Continued From page 10 employees record found that E4 has worked at this facility for 4 years. There were no information found to ensure that E4 has been trained, evaluated and re-evaluated in the area of safety while providing direct care to residents. During an interview with E3 (LPN) on 9/11/06, E3 stated that when she entered the room, she observed R3 lying on the floor on her back slightly to her left side. There was blood coming from the back of her head. She was alert and oriented. She had a large bump on the back of her head. She remained on the floor the entire time. The bed was observed to be in a flat position." During an interview with E2 (DON) on 9/11/06, E2 stated that E4 should have came around and turned R3 toward her or had another person standing on the other side of the bed to prevent R3 from rolling out of bed. E2 also stated that R3 had been assessed that side rails were not needed. R3 was able to understand and that most of the time she remained in one position until staff returned to reposition her. E2 stated that there were no routine facility inservices given to ensure that the facility's direct care staff were competent in skills and techniques necessary to care for residents needs in a safe manner. A review of the facility's Minimum Data Set dated 8/11/06 found that R3 was assessed as moderately impaired for cognitive skills for daily decision making. R3 was assessed as limited assistance for bed mobility. A review of the facility's care plan for R3 found that R3 requires extensive assistance with her daily functions. R3 is bedridden by choice for past 2 years. The facility's admission sheet indicated that R3 was	F9999		

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F9999	Continued From page 11 admitted to the facility on 5/1/06 with diagnoses which included Dysphagia, Reflux Esophagitis, Anorexia Nervosa, Failure to thrive-adult and Chronic Backaches. A review of the facility Care Plan for R3 found no specific approaches for repositioning. A 10/27/06 review of the Coroner's report, dated 10/4/06, showed the immediate cause of death as: (a) Cardiac Dysrhythmia due to, or as a consequence of, (b) Stress due to, or as a consequence of (c) Fracture of the Femur due to a Fall (A)	F9999		