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BARTON W STONE HOME	**873 GROVE STREET JACKSONVILLE, IL 62650**

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F 490	Continued From page 38 The facility took the following steps to remove the Immediate Jeopardy: 1. Revision of nursing services which will address nursing positions to be monitored as it relates to employee performance with their respective duties. 2. In-service of the Interdisciplinary staff on MDS answers, assessment and care plan were discussed to improve understanding of the assessment process and promote an accurate summation of patient care to be reflected in the care plan to include all triggers to assessment. Importance of use of information provided to the facility via the transferring agency as communication of patient history and treatment problems was reviewed. The work study plan was provided as required to the regional nurse and included the inservice document. 3. In-service done on policy regarding condition change of residents and fall assessment at 1pm on 12/21/06. 4. CNA's in-serviced in an event when they feel a nurse does not respond to their report of a condition change, they should report it to another unit nurse or notify the Director of Nursing on 12/21/06 at 1pm. 5. On 12/21/06 at 1pm, developed and placed for newly hired employees, a record of reporting of condition changes to ensure new hires of their understanding of reporting of resident condition changes to licensed staff.	F 490		
F9999	FINAL OBSERVATIONS	F9999		

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F9999	Continued From page 39 LICENSURE VIOLATIONS: 300.1210a) 300.1220b)2)3) 300.3240a) 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 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	F9999		

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F9999	Continued From page 40 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 regulations were not met as evidenced by the following: Based on interviews and record review, the facility neglected to develop a plan of care which included interventions to prevent falls and neglected to provide adequate supervision/assistance devices to prevent 1 of 4 residents (R1) on the sample from falling on 12/6/06. This failure resulted in R1 falling from her wheelchair sustaining a fractured left hip and dislocation of her right hip requiring revision of the arthroplasty. The facility also neglected to provide adequate assessment and monitoring to R1 following the fall on 12/6/06 at 8:10pm even though R1 was exhibiting a change in condition the morning of 12/7/06 which included increased moaning, complaints of left leg pain and being cold/clammy. This neglect resulted in R1 being in pain and discomfort until she was transported to the hospital at 4:40pm on 12/7/06 and diagnosed with a fractured left hip and dislocation of her right hip. R1 expired 12/11/2006. Findings include: 1. The facility neglected to provide adequate supervision for R1 given her cognitive status and	F9999		

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F9999	Continued From page 41 history of falls/attempts at transferring herself unassisted according to their policy of falls, and neglected to provide timely assessment and adequate monitoring of R1 following her fall on 12/6/06. Review of the Admission sheet identifies R1 as an 87 year old female admitted to the facility on 11/17/06 following hospitalization for a subcapital fracture of the right femoral neck she sustained on 11/13/06 while at her home. Review of R1's assessment on admission indicates R1 had short term memory deficits with moderate cognitive impairment and required extensive to total assist of all activities of daily living including transfers and mobility. The assessment indicates R1 was unable to attempt standing balance and required assistance for sitting. A. The facility neglected to follow their policy for Falls prevention. The admission assessment failed to identify her fall within the last 30 days therefore falls/prevention did not trigger on the assessment. Review of the facility's FALL ASSESSMENT dated 11/17/06 scores her at 16 which is considered "HIGH" risk (15-24). The care plan does not reflect a fall prevention plan, nor does the RESIDENT CONDITIONS AND PRELIMINARY CARE PLAN completed on admission. Review of the POS(Physician's order sheet) indicates R1 was on toe touch weight bearing on right, abductor pillow while in bed and regular pillow between legs when in chair and "needs PT and fall precautions." According to the OCCURRENCE REPORT dated 12/6/06 at 20:10 (8:10pm), R1 was found on floor laying on left side, with back towards bed. R1 sustained skin tears to her left elbow and a bruise to left shoulder. The note states R1 was assisted to her wheelchair then to bed and was educated on the	F9999		

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importance of waiting for help and using call light. It indicates staff showed R1 how to work call light at this time. The report indicates R1 was oriented times two, vitals were taken. The incident report indicates E13, CNA(Certified Nurses Aide) was the assigned caregiver and the report was made by E7, LPN(Licensed Practical Nurse).

Interview with E13 on 12/20/06 at 2:50pm indicates she usually put R1 right to bed after supper but on 12/6/06, she took her back to her room and left her in the wheelchair "where anyone going by could see her" because she wanted to give her a shower before putting her to bed. R1's call light was given to her. E13 stated she then went down to another resident's room leaving R1 out of visual range and unattended by staff. E13 stated she heard R1 yelling "help help" and found her on the floor on her left side with her head about under the bed. The facility failed to provide adequate supervision to prevent R1 from falling at that time. E13 stated the wheelchair was across the room and it looked like R1 was trying to get into bed. E13 stated R1 couldn't remember she couldn't walk and had been told numerous times to sit back.

Interview with E19 on 12/20/06 at 3:14pm indicates she was not R1's attending nurse that night but helped E13 get R1 off the floor. E19 stated R1 looked as if she was trying to go to bed and "believed she was one the staff watched closely because she tried to transfer herself to bed."

Interview with E7, LPN, on 12/20/06 at 2:45pm indicates R1 "was one that would try to get up so they would take her potty then lay her down." E7

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stated she thought R1 fell from bed as the covers were messed up. E7 stated R1 had dementia and would try to get up unattended. E7 stated R1 had no assistance devices as the "interventions used with putting her down were working for her." E7 stated R1 would attempt to get up 1-2 times per shift on average. E7 stated R1 could use the call light but she gave her instructions how to use it following the fall due to her dementia so she'd know.

Interview with E14, CNA, on 12/20/06 stated R1 tried to get up without assistance and they would set her by the nurses station so staff could watch over her. E14 stated R1 "didn't remember she couldn't get up".

Interview with E18, CNA, on 12/20/06 at 3:10pm indicated R1 was confused but would answer the right way at times. E18 stated staff would have to put her right to bed if taken back to her room or she would try to put herself in, and added that they would keep R1 where they could see her. Interview with E5, LPN, on 12/21/06 indicated R1 was one that tried to transfer herself as she didn't realize she could not walk. E5 stated often the staff would leave her by the nurses station so they could keep an eye on her.

Interview with E10, Restorative Nurse, on 12/21/06 at 11:00am indicates R1 tried to get up on her own and that staff was aware that she needed to be within vision. E10 stated R1 was unable to use the call light as she didn't understand to use it. E10 agreed that a fall prevention plan was not in the care plan. E10's assessment dated 11/17/06 indicates R1 was partial weight bearing and at risk for falls and identifies R1 as being alert, forgetful and

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F9999	Continued From page 44 confused. It includes a statement which reads "in-serviced day & evening shift to resident on high risk for falls interventions." E11(consultant) indicated R1's fall and lack of a prevention plan on the care plan had been identified by the facility during a closed record review following discharge and in-servicing had been done to prevent further occurrences. The facility neglected to develop an effective falls prevention plan for R1 per their policy and procedure from admission given her history of falls and her repeated attempts at transferring herself without assistance. Review of the hospital's PHYSICIAN DISCHARGE ORDER FORM provided to the facility on admission indicates #10 stating "need special care to avoid fall as pt(patient) on anticoagulation; needs PT(Physical therapy) and fall precautions." On the hospital's DISCHARGE ASSESSMENT/SUMMARY, REPORT instructions, again provided on admission, states "supervise activity to prevent fall-special call bell to avoid falls as pt on anticoagulants. Needs pt and fall precautions. Hip precautions..." There is no evidence that the facility included these directions on admission. The facility neglected to follow these physician's orders and neglected to implement a prevention plan to ensure R1's safety from falls. According to the facility's FALL ASSESSMENT, RISK IDENTIFICATION AND MANAGEMENT POLICY, the facility is to assess each resident's risk on admission "to help facilitate an interdisciplinary approach for care planning to appropriately monitor, assess and ultimately reduce injury risk. Factors related to the risk will	F9999		

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F9999	Continued From page 45 be addressed and care planned." The policy continues to state the interdisciplinary care plan will be individualized to reflect the specific needs and risk factors of the residents. The facility neglected to follow their policy by failing to identify R1's repeated attempts at transferring herself to bed and failed to develop/implement a plan based on this information although all staff caring for her appeared to be aware of this behavior. Interview with Z1, R1's physician, on 12/21/06 at 1:35pm indicates Z1 was a high fall risk due to her history of falls and her prior fracture. Z1 stated the facility should have put her on fall precautions and he was concerned about her falling due to her being on anticoagulants. Z1 stated R1 was confused and would try to get up in the hospital. Z1 stated he was not made aware of R1's repeated attempts to get up unassisted at the facility and the facility "should have done more to keep her from falling if that was the case." B. The facility neglected to provide adequate assessments and monitoring following R1's fall on 12/6/06. Review of the nurses notes dated 12/6/06 at 2010(8:10pm) indicates R1's ROM was within normal limits but neglects to include any other information. The note states she was assisted back to bed and had no complaints. Vitals were 136/82, 86 pulse, 24 respirations, and 98.8 temperature. The note identifies the two skin tears to her left elbow and a bruise to her left shoulder. Steri-strips were applied to the skin tears. There is no indication any further assessment or monitoring was done with R1 during the remainder of the 3-11 shift. Interview with the attending nurse, E7, LPN(Licensed	F9999		

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F9999	Continued From page 46 Practical Nurse) indicates she did not see any other harm at the time and the direct care aides didn't report anything unusual. Interview with E19, LPN, on 12/20/06 at 3:14pm indicates she was not R1's attending nurse that night but helped E13, CNA(Certified Nurses Aide) get R1 off the floor and that she and E13 "felt around on her checked out what we could see" but R1 kept saying she was not hurt. E19 stated they sat R1 up and was putting her back in the chair when E7 came in the room. E19 stated she assessed R1 while she was lying on her left side and did not lay her flat prior to moving her to the chair. Interview with E13 on 12/20/06 at 2:50pm indicates both nurses checked her and she kept asking R1 if she was hurt. E13 stated R1 was moaning and groaning. E13 stated R1 kept moaning and the last time she checked on R1, she was "kind of in and out of it, confused" and when asked if she was in pain would say "no." E13 stated she didn't know why she was moaning like she was and thought R1 didn't know if she was in pain or not due to her confusion. Interview with E7, LPN, on 12/20/06 at 2:45pm stated she performed ROM and noted no external rotation following the fall, however at the time of her assessment R1 was in bed with the HOB elevated and abductor pillow in place. E7 stated R1 had dementia and would normally moan, adding even the family said she did. E7 said she had no complaints of pain and she checked on her one more time and she was resting in bed. There is no indication R1 was given an adequate assessment following the fall.	F9999		

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F9999	Continued From page 47 The next entry into the nurses notes is for the 11-7 shift by E12, LPN, is dated 12/7/06 at 2:45pm, and states "resting in bed c(with) eyes closed," VS(Vital signs) 124/72, 97.6 temp, 100 pulse and 20 respirations. The room air pulse oximeter was 89%. The note continues to state "res(resident) making moaning noises, asked if in pain, res stated "no, I don't think so." There is no indication that E7 did any physical assessment during the shift and there is no further entry into the nurses notes for the 11-7 shift in regards to an assessment or further monitoring. Phone Interview with E12 on 12/21/06 at 12:20am indicates she was told R1 fell during report and the only time she saw R1 during that shift was around 5:30am when she was passing her 6:00am meds. E12 stated she didn't notice anything different. E12 stated she asked R1 if she was in pain as she was moaning and R1 said "no." E12 indicated the vitals done at 2:45am were done by the CNA's and she would check the residents if the vitals are "off" but did not that night as the vitals were okay. E12 said the CNA's do bed check every two hours and did not report anything different with R1. On 12/27/06 at 8:45am, E12 was again interviewed per request of the facility and stated she had seen R1 at 2:45am and didn't notice anything different with her. The nurses notes dated 12/7/06 at 8:00am indicate R1 didn't want to get up for breakfast as she didn't "feel like getting up." Denied pain and vitals were 120/78, respirations 24, pulse 100 and temp 99 with SPO2 93%. There is no evidence that an assessment was done at that time.	F9999		

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F9999	Continued From page 48 Interview with E14, CNA, on 12/20/06 at 1:35pm stated she was caring for R1 the morning of 12/7/06. E14 stated R1 normally moaned some but it was different that day, E14 stated R1 was also acting different and was cold/clammy with sweat. E14 stated she was already dressed when she came on duty but when she went to move R1's left leg, R1 complained of pain and complained of more pain when being transferred with the sit to stand lift. E14 also stated R1's color was different and she was definitely confused. E14 stated when R1 was asked if she was in pain she would say she "didn't think so." E14 also stated this was different as she usually complained of pain in the right leg since that is the one she fractured but that particular morning, she complained of pain in the left leg as well. E14 stated she reported all this information to E4, LPN, repeatedly throughout the morning. The next entry into the nurses notes is at 9:15am when E14 documents "to therapy per w/c(wheelchair) o(no) complaints." However, interview with E8, LPT(licensed physical therapist) and E9, COTA(certified occupational therapy aide) on 12/0/06 at 11:15am and 12:50pm indicates R1 normally moaned a lot but was doing it much more severely when they took her to therapy that morning. E8 stated she seemed like she was short of breath and the moaning was much louder. E8 stated she appeared much more fatigued and was confused. Both stated they were unable to get her to participate in any therapy and returned her to her room. E9 stated she agreed that R1 was definitely different that day and asked R1 if she was in pain. E9 stated R1 said "no" but obviously was. Both therapists stated they reported the	F9999		

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unusual behavior of R1 to the nurse. E8 couldn't remember which nurse was on but E9 stated she thought it was E4. On 12/21/06, E8 and E9 clarified R1's shortness of breath and stated it was more like heavy sighing and R1 appeared definitely more fatigued.

At 10:15am, R1 was taken by wheelchair to the hospital for a previously ordered chest x-ray and returned at 11:00am. The nurses notes written at 1230pm by E4 state "to dining room for lunch ate only jello, and yogurt and took supplements and meds." There is no indication E4 assessed R1 in regards to E14, E8 and E9's voiced concerns of R1 acting differently, excess moaning, and being cold and clammy, appearing in pain.

Interview with E17, RN(Registered Nurse) on 12/20/06 at 1:51pm indicates she was working on the other hall on 12/7/06 and noticed R1 in the dining room at lunch. E17 stated E14 said to her "look at her, there's something wrong with her." E17 noted R1 to be not as alert and looked like she had no strength. E17 also noted her color was bad. E17 stated she did not follow up on E14's concerns as she was not assigned R1 during that time.

On 12/26/06 at 2:55pm, E20, transport person, stated she was told by E14 when she went to get R1 to take her to the hospital for her chest X-ray that R1 had been complaining about her leg a lot. E20 stated she stopped at the desk and told E4 about R1's complaint of pain and R1 denied pain at the time so she went ahead and took her to the hospital for the chest Xray. E4 did no assessment following this.

Interview with E4 on 12/21/06 at 10:05am

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indicates she saw R1 at 8:00am on 12/6/06 when she was passing medications. E4 did recall being told by therapy that R1 did not do like she normally did in therapy and did not remember being told she was definitely different or was more fatigued and possibly in pain. She did not recall being told repeatedly by E14 that she was complaining of left leg pain on movement and that she was moaning more. She stated she did recall being told that R1 was not acting herself but she she went down and checked on her, she did not seem different. E4 stated she went down several times and "looked at her, stomach and up" and did not see anything wrong. E4 acknowledged that R1 was in bed with the head of the bed elevated and the abductor pillow in place between her legs during these assessments. E4 stated R1 was confused at times and other times was not. E4 stated she did not think to give any pain medication when R1 denied pain and "figured if she's not in pain" there is no reason to give medication. E4 stated she was unaware of the pain assessment and the fact that R1 could not pinpoint pain at times due to her confusion. E4 stated the last time she saw R1 was after lunch and she was laying in bed as she was earlier. There is no evidence E4 did a thorough assessment of R1 following repeated concerns voiced by several staff members and no evidence that E4 actually did a hands on assessment to determine pain on movement of the left leg as she indicated R1 had the abductor pillow in place with the head of the bed elevated when she saw her.

On 12/26/06 at 3pm, E4 indicated she wanted to clarify what she did for R1 and stated she "palpated her arms, stomach, legs" while the abductor pillow was still in place and had done so

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146059	A. BUILDING _____ B. WING _____	C 12/27/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARTON W STONE HOME	**873 GROVE STREET JACKSONVILLE, IL 62650**

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F9999	Continued From page 51	F9999		

earlier when the girls first told her R1 was in pain. E4 then stated she wasn't told by E14 that R1 was complaining of pain. E4 stated she passed on all information in report to E5, LPN. E4 stated she felt she had documented everything she did for R1 on 12/7/06 except the assessment she did after lunch.

The nurses notes at 1545(3:45pm) state R1's daughter is at bedside and R1 is complaining of left hip pain with moaning and facial grimacing noted. The note states no outward rotation is noted but R1 refuses to be repositioned due to pain. Tylenol was given and the physician was called. At 1600(4pm), Z1(R1's physician) called back with an order to send to the hospital. Family was notified.

On 12/21/06 at 11:50am, E5, LPN on 3-11 shift, stated she was told in report by E4 that R1 had fallen the day before and that R1 had been complaining of pain. E5 stated R1's daughter was in attendance and insisted that something was wrong and wanted her to go to the hospital. E5 stated she assessed R1 and found her to complain of pain left hip when palpated and when the left leg was moved, and she was moaning constantly. She notified the physician and received orders to transport. E5 stated she was unaware of R1's pain assessment but did know she would say no when asked if she was in pain. E5 stated she had been told that R1 had shown no other signs of discomfort as she went to and from therapy, to and from the hospital for the chest Xray. E5 stated R1 was no different than when she saw her any other day except when she palpated her left hip area, she complained of pain and grimaced.

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	146059	A. BUILDING _____ B. WING _____	C 12/27/2006

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F9999	Continued From page 52	F9999		

R1 was transported to the emergency room where x-rays revealed fracture of both hips. R1 required revision of the right hip due to it being dislocated and had hemiarthroplasty of the left hip with pinning. She expired on 12/11/06 at the hospital.

According to the assessment on admission, R1 exhibited moderate pain less than daily. Review of the Pain Assessment dated 11/20/06, "resident cannot pin point area of discomfort at times due to confusion-c/o(complaint of) R(right) hip at times." The assessment indicates R1 describes pain as aching, sharp, stabbing. Under NONVERBAL/NONCOGNITIVE SIGNS OF PAIN, the facility has identified R1 grimacing, frowning/scowling and moaning. The Intensity section of the pain assessment is not completed and medication is identified as Darvocet N 100 every 4 hours PRN(as needed) and Tylenol 650 mg PRN. There is no pain management plan on R1's care plan although it triggered on the assessment and interviews with E4 indicated she was unaware of R1's inability to identify pain and pinpoint it due to her confusion.

Interview with Z1, R1's physician, on 12/21/06 at 1:35pm indicates he would expect a more thorough assessment since R1 had already had a fracture and was on anticoagulants. Z1 said asking R1 if she was in pain would not be a good assessment tool to use due to her confusion.

Review of the facility's policy on CHANGES IN A RESIDENTS CONDITION OR STATUS stated nursing services will be responsible for notifying the resident's attending physician when there is a significant change in the resident's mental, physical or emotional status. It states further that