STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146039	A. BUILDING _____ B. WING _____	C 02/02/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTVIEW TERRACE	**100 EASTVIEW PLACE SULLIVAN, IL 61951**

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F 309	Continued From page 7 3. The following was implemented on 12/30/06: Neuro-checks to be completed for all residents who experience a fall. 4. Implementation of phone contact with the attending physician for all residents who experience a fall. 5. Implementation of communicating any incidents or changes in the resident's condition that have occurred in the preceding 72 hours, to emergency transport personnel and when calling report to the emergency room. All staff were inserviced on these actions on 12/30/06 by the Director of Nurses.	F 309		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)3) 300.1220b)6) 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 psychosocial 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 residents.	F9999		

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F9999	Continued From page 8 b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven days a week basis: 3) 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 medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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. 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Requirements were not met as evidenced by the following: Based on observation, interview, and record review the facility failed to do initial and follow-up neurological status checks on one of one resident reviewed, R3. R3 had a witnessed fall with head trauma involvement. The failure to do ongoing neurological assessments placed R3 at increased risk of death. In addition facility staff failed to communicate the knowledge of the fall in nursing reports between shifts, to emergency medical personnel, or to hospital Emergency Department personnel. The failure to report the fall delayed treatment for R3 and placed him at an increased risk for death. R3 expired in the hospital.	F9999		

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F9999	Continued From page 9 Findings include: Physician's Orders dated 12/16/06 shows R3 had diagnoses of Arthritis, Congestive Heart Failure, and Seizure Disorder. The Minimum Data Set (MDS) dated 10/26/06 indicated R3 was cognitively impaired but had clear speech and could make himself understood and could understand others. R3 required extensive to total assist with all Activities of Daily Living (ADLs). In addition R3 was not ambulatory and used a wheelchair for mobility. The assessment showed R3 had no range of motion loss to his neck. The falls assessment dated 10/25/06 indicated R3 was a high fall risk. A facility incident report dated 1/2/07 showed, "On 12/28/06, at 6:30 PM, (R3) was leaning forward in his wheelchair. (E9) Certified Nurses Assistant (CNA) was attempting to elevate his (R3's) feet and told him to sit back in his wheelchair. When he pushed back the wheelchair turned over backwards. The CNA was unable to break the fall..." On 1/16/07 at approximately 1:25 PM, E6 Licensed Practical Nurse (LPN) stated, "(E10 CNA) came to the nurses station and told me he needed me in (R3's room) and that it was an emergency. This was about 6:30 PM on 12/28/06. I went to (R3's) room, he was laying on the floor still in his wheelchair. The wheelchair was tipped over backwards. His head was not touching the floor. I don't know if he was holding his head up or if his head was held up because his neck was contracted. But he was sitting in the wheelchair when the wheelchair tipped backward and he was on his back...(E9 CNA) told me she	F9999		

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F9999	Continued From page 10 was putting his legs up in the recliner. She said the wheelchair went over backwards and there was nothing she could do. I asked if he hit his head and she said 'no.' At that time I believed her. It did not take long and I did not believe the story she told. We picked (R3) up off the floor (me, E10 CNA, E7 CNA, and E9 CNA) and put him in his recliner. The CNA's got the (mechanical lift) and transferred him back to his wheelchair. (E10) took him (R3) and gave him his shower. (E10) came to me about one-half hour later and said (R3) was complaining of low back pain. About one-half hour after that I checked on (R3). I woke him up and asked him if his back was still hurting. He said 'yes' and went back to sleep. I did not give him anything for the pain and did not call the doctor to report the pain or the fall. When we found (R3) on the floor I did not ask him what happened or if he hit his head. I should have. I did not do neuro (neurological status) checks. I should have. I did not check on the resident anymore (before the end of my shift) after I checked him for pain at about 7:30 PM." Interview with Z2, Physician, on 1/17/07 at approximately 1:10 PM confirmed he was not notified of R3's fall. He also stated he should have been notified other than by fax if there was a suspected head injury. In addition, he stated that he would expect the nursing staff to report to emergency personnel a recent significant event like a fall, when sending a resident to the hospital. Review of facility policy titled "Physician's Notification of Resident's Change of Condition" indicated "All licensed nursing personnel" should notify the Physician for "any accident or incident."	F9999		

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F9999	Continued From page 11 On 1/16/07 at approximately 3:40 PM (E7 CNA) indicated R3 was found with his head in contact with the floor. (E7) stated, "I was in another room and (E10) came to me and said he needed help in (R3's) room. When I got to the room (R3) was on the floor. He was lying with his head on the floor. His legs (were) in the air, and he was sitting in the wheelchair. It appeared to me the wheelchair had tipped over backwards. The nurse (E6) was in the room and saw the same thing I saw..." Interview with E9, CNA, on 1/17/07 at approximately 12:50 PM per telephone relayed a different account of R3's fall. E9 stated, "It was after supper at 6:00 PM. I was helping to take residents back to their rooms. I helped (R3) back to his room. I sat him facing his recliner and locked his chair. I asked him if there was anything he needed. He said no. I turned T.V. on. As I was leaving his chair went over backwards. I did not put his feet up. I don't know for sure if he hit his head. That is, I didn't see him hit his head, but it had to have hit. I did not witness the fall. I do not remember the nurse asking me if he hit his head. His (R3's) body and head ended up in contact with the floor." The room identified by E11, LPN, as the location where R3 suffered his fall, demonstrated a tile floor that was laid over poured concrete. Review of a facility policy identified by (E1), Administrator, as the policy in effect on 12/28/06, showed procedures to follow for neurological status checks. The policy stated...7. "Ongoing assessment (vital signs and neuron [sic] checks) should take place as follows: (a.) Initially and every 15 minutes x 1 hour (b.) Every 30 min. x 1	F9999		

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F9999	Continued From page 12 hour (c.) Every one hour x 4 hours. (d.) Every 4 hours x 8 hours. (e.) Every shift for the remainder of 72 hours. 8. Assessment and neuro-checks shall be recorded on the neurological assessment flow sheet...10. Signs of increased intracranial pressure must be reported to the Physician immediately. These signs are as follows: Diplopia, Dizziness, Nausea and vomiting, Lethargy, Headache, Depressed areas of the head, Bleeding from the ear, Drainage from the ear or nose, Temperature elevation, Bradycardia, Widening of pulse pressure, Elevation of systolic pressure, Eye(s) crossing, Pupils unequal or non-responsive." Interview with E8, LPN, on 1/16/07 at approximately 1:40 PM indicated she was not aware of the possible head trauma to R3. "I clocked in at 9:45 PM on the night of 12/28/06. I took report from (E6). I was told (R3) had fallen somehow in his wheelchair, had fallen over, or tipped over, that he had no injuries. She (E6) told me she specifically asked (E9) (who was with (R3) at the time of the fall) if he hit his head and the aide said no. She told me, right after that he (R3) had reported back pain but said that had gone away...I spoke to him (R3) at about 2:15 AM. I walked up to him and said his name and told him I needed to get his (vitals). I asked him how he was doing and he said O.K. His vital signs were normal. The next time I saw him and had direct contact (I was giving him his nebulizer treatment) was at 4:20 AM. He (R3) woke up and said something like 'all you care about is that damn breathing treatment.' I continued with the (medication pass) and about 10 minutes later a CNA who was in (R3's) room walked out and said she needed me right away. She stated the resident had vomited and had become	F9999		

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F9999	Continued From page 13 non-responsive. When I went into the room I saw (R3) with vomitus on his face. He did not respond when I talked to him but he moved his head in response to the CNA cleaning his face. I then went to get a blood pressure cuff and I came back and checked his vital signs. His vitals were within normal limits and were consistent with the earlier vitals I had taken. I left the room and called the doctor. The doctor said to send him to the hospital. Then I called the ambulance. He was still non-responsive when we sent him out. I did not do neuro checks on (R3) (during any of the shift). I did not know he hit his head. I did not tell the paramedics about his history of a recent fall." Z4, Firefighter/Paramedic stated on 1/17/07 at approximately 1:45 PM that the team that transported R3 to the hospital on 12/28/06 were not aware he had recently fallen. Z4 stated, "They (facility staff) said he (R3) had just been given a breathing treatment and had a medium emesis and had (exhibited) a decreased level of consciousness. (When we arrived) He (R3) had his eyes open and would respond with yes or no whispers but I am unsure if they were appropriate responses. He could not speak in sentences. We were not told (by facility staff) of any recent falls. We did not report any recent history of falls to the Emergency Room staff." Z3, Director of Hospital Emergency Services, stated on 1/17/07 at approximately 10:50 AM the hospital was unaware of the fall history. Z3 stated, "We need all the information we can get. It can expedite care. (The right) information can direct staff in the most optimal strategies. It would have made a difference to this person because we would not have looked at this person (would	F9999		