STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145389	A. BUILDING _____ B. WING _____	C 08/29/2007

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F 323	Continued From page 9 will be analyzed to track for trends and individual patterns, with review of current interventions and initiation of new interventions as needed. Implemented 8/24/07 by IDT. Documentation of personal resident alarm checks to be done daily with batteries and spare alarms made available at nurses station. Implemented 8/24/07. All-staff inservice on Assessment, Falling Star Program, fall prevention and interventions, post-fall procedures, monitoring and placement of alarms. Completed on 8/23/07 for current and oncoming staff prior to working the floor, then on 8/24/07 for all staff prior to paycheck distribution. Completed by E1 on 8/24/07.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a)b)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 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	F9999		

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F9999	Continued From page 10 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on record review and interview, the facility failed to provide adequate supervision for 1 of 1 resident with a history of falls by failing to thoroughly investigate each fall to identify trends/patterns and root cause, and by failing to assess, implement, and monitor effective interventions following each fall. R1 fell resulting in a subdural hematoma and subarachnoid hemorrhages, and expired with the subdural hematoma as a contributing factor. Findings include: According to admission records and the Physician Order Sheet (POS) for 7/07, R1 has been at the facility since 2/3/06 with diagnoses including Cerebrovascular Accident, Vertigo, Parkinson's Disease, Anxiety, Hypertension and Degenerative Arthritis of the Thoracic Spine. The POS includes orders for a walker, and "w/c (wheelchair) alarm to alert staff when resident attempts to get up unassisted. Bed alarm to alert	F9999		

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F9999	Continued From page 11 staff when resident attempts to get up." R1 receives the antidepressant Mirtazapine, the anxiolytic Xanax and the Meclizine at bedtime. The most recent Minimum Data Set dated 4/24/07 assessed R1 with memory problems, moderate cognitive impairment, and requiring limited assistance for bed mobility, transfers, and ambulation in the room. R1 wheeled herself in the wheelchair and was independent for locomotion in the facility. R1 had a history of falls, and was assessed as high risk - with 10 points or more being high risk - on the following dates: 11/3/06 - 17 (points); 1/12/07 - 20; 2/1/07 - 19; 3/4/07 - 22; 4/23/07 - 20; and 6/18/07 - 23. Nurses notes reviewed from 12/5/06 through 6/07 indicated several elopement attempts. The Nursing Monthly Summary dated 5/17/07 stated that R1 had been moved to the Alzheimer's unit on 5/9/07. The most current care plan dated 4/30/07 identifies a problem of "has some confusion {with} cognitive deficits, has impaired standing balance and unsteady gait, uses diuretic and psych. (psychoactive) medication and has hx (history) of falls so is fall risk. Is elopement risk." Interventions include, "Restorative nursing program for ambulation. . . . Call light within reach & encourage her to use it to summon staff to assist as needed & not to do unsafely per self. . . Bed & chair alarms to alert staff when attempting to transfer self. Check for alarm placement/ function q (every) shift. Attach chair alarm to shirt at middle of back where she can't easily reach it to disconnect it. Provide reorientation as needed & assist as needed {with} making safe decisions. Monitor frequently to anticipate needs. . . " A hand-written entry dated	F9999		

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F9999	Continued From page 12 6/17/07 states, "Encourage/ remind her of need to always have staff present to assist as needed with transfers @ all times and for her not to disconnect alarms/transfer self." The Incident Report form dated 6/28/07 with attached investigation faxed to the Illinois Department of Public Health Regional Office states the following: "Certified Nurses Aide (CNA) heard a noise "thud" from resident's room. CNA responded and observed resident on floor against bathroom door. Resident had removed shirt and personal alarm per self. Resident still had other clothing on. When asked what happened, resident stated 'Honey I was just going to the bathroom.' Laceration noted to right side of head. . . Ice applied. . . Complained of pain to head. . . " The facility's Quality Care Reporting Form with Investigative Report for Skin Tears/Bruises dated 6/28/07 states that "Resident removed alarm and walked to bathroom unassisted. Resident receives restorative for muscle strengthening and gait training. Resident also has w/c and bed alarms in place. Has also been educated to ask staff for assistance with transfers and about not turning personal alarms off." The reports state that R1 was sent to the local hospital. Hospital records include the brain CT (computerized tomography) scan dated 6/28/07 that notes ". . . A moderate sized acute subdural hematoma along the inner table of the left frontal, parietal and temporal bones. . . Subarachnoid hemorrhage obliterating the right sylvian fissure. . . subarachnoid hemorrhage in the left parietal lobe as well as a small hemorrhagic contusion in the right parietal lobe. . . " R1 was transferred to a larger medical center on 6/29/07 at 1:45am,	F9999		

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F9999	Continued From page 13 and expired on 7/3/07. The Coroner's Certificate of Death identifies the "immediate cause of death as Respiratory Failure, due to Renal Failure, with other significant conditions contributing to death. . .Subdural Hematoma. . ." Z2 (Coroner) stated on 8/22/07 at 1:15pm that R1 had undergone a Craniotomy on 6/29/07, was in shock, and subsequently declined and expired. Interview with Z3 (attending physician) on 8/22/07 at 3:40pm stated it was very possible for the subdural hematoma and hemorrhages to occur on both sides of the brain if R1 "hit her head hard enough." The facility's investigation packet presented by E1 (Administrator) on 8/21/07 at 9:30am included a typed and signed statement by E5 (CNA) which describes the incident of 6/28/07: "I was sitting in a chair in the hallway getting ready to start my last rounds when I heard a loud thud. I went down the hall to see where the thud came from and found {R1} lying face down with her head against her bathroom door. . . " The statement continues how E5 paged the nurse, stayed with R1 throughout the nurses assessment, holding ice on R1's head, and keeping R1 awake - which she did stay awake and alert - until R1 was transported to the hospital. E5's statement continues, "Only a few minutes before I was down checking on {R1} to see if she was ready to go to bed, and she was rummaging through her nightstand putting her beads away. She told me she was not ready yet. I told her I would be back in a few minutes to help her get ready for bed. When I asked {R1} what happened and how she fell, she said she was not sure what happened, only that she was starting to get ready for bed and was going to use the toilet first." E5's statement did not mention anything regarding the	F9999		

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F9999	Continued From page 14 chair alarm or R1 removing her clothing with the alarm on it. There was no statement by E4 (charge nurse at the time of the incident) in the investigation packet except for the incident report. Interview with E5 on 8/22/07 at 9:00am confirmed information in her signed statement. E5 also stated that staff were "short-handed" on 6/28/07, and she was working that hall by herself. When asked regarding the chair alarm, E5 stated that R1 "had a bad habit of taking off the alarm." E5 stated that "yes" R1 did have her alarm on that evening and when E5 had checked on her prior to the fall. When asked, E5 stated that the alarm did not sound when R1 fell, that "she (R1) had taken it off." E5 was asked where the alarm had been placed on R1, and E5 stated, "I suppose on the middle of her back. But those things have long strings and she can reach back and take it off." E5 stated that the alarm was not attached to any clothes R1 had taken off. E5 was again asked if R1 had taken her blouse or top off and E5 stated "no." E5 stated that E5 was present when R1 fell "a few weeks ago." R1 was transferring from the wheelchair to the bed and the bed slipped. At that time R1 had said that she "didn't like that alarm and she (R1) took it off." E5 was asked if R1 was on any kind of a restorative or walking program and E5 stated she did not know - she "didn't think so." E5 also stated that staff have no system or documentation to ensure that personal resident alarms are properly placed and are functional. Approximately 10:30am on 8/22/07, E1 (Administrator) was questioned regarding the alarm removal and the discrepancy between the 6/28/07 incident report, and E5's statement and	F9999		

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F9999	Continued From page 15 interview. Also noted was that there was no statement by E4 (nurse) in the investigation other than the incident report. At 11:00am, E1 produced a hand-written statement by E4 dated 6/28/07, stating "this wasn't with the rest of the information." The statement dated 6/28/07 stated the following, "Summoned to ___ hall. Resident observed to be lying on floor. . . . . Resident had no shirt on and stated she removed it. . . ." Also, after meeting with E1, E6, E7, and E8 (Corporate) on 8/27/07 at 2:45pm, E1 faxed an additional statement from E4 dated 8/27/07 stating the following, "On the night {R1} fell, when I walked into her room, {R1} was naked from the waist up when I found her on the floor. The blouse that she was wearing that evening was hanging on her wheelchair still attached to the alarm. After turning {R1} onto her back and cleaning up some of the blood, I put a hospital gown on her so she would not be lying there naked, and to be sent out to the hospital." Interview with E4 (charge nurse) on 8/22/07 at 11:15am confirmed information on the incident report and Nurse Notes for 6/28/07. E4 stated that about 9:30pm on 6/28/07 she was summoned to that hall, that R1 fell. R1 was on the floor with her head against the door, and was trying to get up. E4 stated that R1 was not moved other than to turn her slightly to get her head away from the door to better assess for injuries, other than the cut/bump on her right forehead. E4 applied ice, and did neuro checks and Range of Motion. R1 did not lose consciousness and kept saying, "I know I'm not supposed to go to sleep." E4 stated that R1's shirt with the alarm attached was still on the wheelchair, "she was a good one to get out of the alarm." When asked what R1 did have on, E4	F9999		

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F9999	Continued From page 16	F9999		

stated that she had one of the facility's hospital-type gowns on with her own pants still on. E4 stated R1 probably had one on her bed if E4 was getting ready to put R1 to bed, and that R1 would have been capable of putting the gown on herself. E4 stated that R1 was in a low bed with a pressure alarm, and that R1 could even get at that and take it out. E4 stated that R1 could get at the chair alarm even when it was in the middle of her back. E4 also stated that there was no system or documentation to confirm placement and functioning of personal resident alarms.

Further review of R1's Nurses Notes from 12/5/06 to 6/28/07 and incident reports reveals the following falls prior to 6/28/07:
1/11/07 - 9:20pm - "Took off sweater chair alarm was hooked to - stood up to get undressed for bed by herself - she refuses to ask for help." The "Nursing measures to prevent" section on the Investigative Report for Falls states to "attach chair alarm to shirt and not outer sweater."

3/3/07 - 6:00pm - "Resident found on floor in room. Hematoma on R' (right) side of head. . . Resident has bed and chair alarm but resident takes them off per self. Resident able to reach bed/chair alarm to turn them off then transfers self and falls. . ." Measures for prevention include "1) Bed and chair alarm 2) attach chair alarm to shirt on the middle of back where resident can't reach 3) check for placement and function of chair/bed alarm q (every) shift 4) monitor." The care plan at that time, dated 2/6/07, had listed bed and chair alarm, but did not include the intervention of attaching the alarm to the shirt, as identified in the previous 1/11/07 incident report. Hand-written additions to the

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F9999	Continued From page 17	F9999		

care plan dated 3/6/07 included with the chair alarm, "attach to shirt on middle of back where she can't reach it and disconnect it. . . Check for placement, function of bed/chair alarms q shift."

6/16/07 - 11:10pm - "Found on floor in room in seated position. Res. states she took off chair alarm and was trying to transfer to her bed and it (bed) slipped. . . " The Nurses Notes stated that staff was alerted by the bed alarm, and that it had slipped to the edge of the bed. Nurses Notes also state that R1 was last toileted at 10:30pm and the chair alarm was in place at that time. The Review section of the Quality Care Reporting Form states, "Discussed possible restraints but felt it would cause more harm making resident agitated and {decrease} independence." The care plan at that time - 4/30/07 - did have the interventions as previously recommended. But the only new interventions for Falls/Activities of Daily Living were for a restorative bathing program dated 6/8/07, and to encourage/remind her of need to have staff present (as stated above) dated 6/17/07.

Review of facility's staff assignment sheets confirm that only one staff person was assigned to the Alzheimer's unit after 6:00pm on 6/28/07. Random observations on 8/21, 8/22 and 8/23/07 note that some residents on that unit are in wheelchairs and some are ambulatory. On 8/21/07, 21 residents were on the Alzheimer's unit.

The incidents of 1/11/07, 3/3/07, 6/16/07 and 6/28/07 all involve R1 removing the chair alarm in some way, all involve R1 attempting to stand/transfer from the wheelchair, and all occurred during evening hours. None of the

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F9999	Continued From page 18 above incident investigations include an individual trend or root cause analysis of times or why R1 was removing her alarm or attempting to transfer. E1 stated on 8/22/07 approximately 11:00am that the facility does track falls in QA (Quality Assurance), including patterns, shifts, etc. in the facility as a whole. E1 confirmed that the facility does not do tracking or root cause analysis on individual residents. E1 also confirmed that no other interventions other than changing the location of the alarm was tried following the repeated falls. (A)	F9999		