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	145142	A. BUILDING ______ B. WING ______	C 09/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN ALMA NELSON MANOR	550 SOUTH MULFORD AVENUE ROCKFORD, IL 61108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 11 Policy and Procedure Review, Falling Star Program, and Fall Assessments, beginning on 9/4/07. Any staff on vacation or off duty during this time will be required to be inserviced before working on the units. A QA/QI tool has been developed to monitor compliance. Addendum: 1. The alarm checks were initiated on 9/11/2007 (all alarms placed properly and functioning properly.) 2. The alarm checks were completed on 9/12/07. 3. The shift alarm checks will be completed by a nurse or C.N.A trained in alarm checks. 4. The alarms will be checked to monitor if sounding properly and placement. 5. The inservicing for nursing department employees was initiated on 9/12/07. Nursing staff not in attendance for inservicing on 9/12/07, will be trained prior to their next scheduled work shift. 6. The results of alarm monitoring, audits and corrections for F323, will be reviewed by the Quality Assurance Committee.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210b)6) Section 300.610 Resident Care Policies a) The facility shall have written policies andprocedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at	F9999		

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F9999	Continued From page 12 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 300.1210 General Requirements for Nursing and Personal Care b)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. These Regualtions were not met as evidenced by: Based on interview and record review the facility failed: 1) To reduce R1's risk for falls after R1 fell on 8/31/07. On 9/3/07 at 7:40pm, the facility failed to activate R1's mechanical alarm. R1 got out of bed after that time, unassisted and unknown to staff. R1 ambulated into room 413. R1 fell and received a head injury and sustained an intracranial hemorrhage. R1 expired on 9/4/07 at 3:20am. R1's death summary dated 9/4/07 reflected "Final diagnosis: Massive intracranial bleed. Most likely cause of death: Massive intracranial hemorrhage."	F9999		

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F9999	Continued From page 13 2) To ensure that mechanical alarms were working for R3 and R10 to reduce their risk of falling. This is for 3 of 40 residents who have mechanical alarms to monitor their safety. Findings include: R1's nurses notes dated 9/3/07 showed: 7:58pm - R1 found on floor in bathroom with a laceration to the left occipital lobe and hematoma and laceration to the right occipital lobe. R1 only complained of belly pain, lungs clear, pupils equal and brisk and reactive bilaterally. R1 able to track with eyes....; 8:40pm, Doctor re-paged...R1 with intermittent snoring respirations, pupils brisk/equal and reactive, squints eyes with prodding. No verbalization at this time. Generalized weakness noted. 9:00pm - R1 with sonorous breaths...squints eyes with shaking, R1 is nonverbal with generalized weakness. 9:10pm - Ambulance here...R1 transferred to the hospital." On 9/10/07 at 1:15pm, Z2 (Physician) stated, "Potential complications from a fall with hitting the head would be an intracranial bleed. That would be the most severe complication. A resident would bleed if on Aspirin and Plavix." Z2 was asked what snoring respirations after a head injury meant and Z2 replied, "A person would be out cold, very sonorous, sleeping deeply. Possible airway obstruction." Z2 was asked what safety measures should be put in place for a resident who is confused and is at high risk for falls and Z2 replied, "It depends, close	F9999		

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F9999	Continued From page 14 observation, moving to the nurses station, may have a restraint." The ambulance report for R1 dated 9/3/07 showed, "Staff stated that there were no changes in level of consciousness. R1 can not talk, is normally alert and oriented x 0 (not oriented to person, place or time). They were sending R1 in for possible stitches.... R1 also had a golf ball size lump to the back of his head. Initial: R1 breathing 30/min/snoring and using abdominal muscles." R1's head CT report dated 9/3/07 showed, "There is a massive parenchymal hemorrhage in the left frontal parietal region which measures approximately 10.5 by 4.4cm in transaxial dimension. A large hemorrhage is present in the right parietal region measuring 6.7cm in greatest dimension. There is a large amount of intraventricular hemorrhage in the right lateral ventricle, third ventricle and fourth ventricle. A small right temple subdural hematomas present measuring 5mm in width. There are scattered areas of subarachnoid hemorrhage. In the right frontal subdural hematoma is present measuring 5mm in width." R1's death summary dated 9/4/07 showed, "Final diagnosis: Massive intracranial bleed. Most likely cause of death: Massive intracranial hemorrhage." The expiration form for R1 at the hospital showed R1 expired on 9/4/07 at 3:20am. The incident report dated 9/3/07 for R1's fall showed, "Room number, 411-2.; Location of incident: In 413's bathroom.; General	F9999		

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F9999	Continued From page 15 Ambulation Status - Chair bound, side rails up.; Was resident wearing a restraint? Yes, what kind? Bed/chair alarm (turned off).; Describe incident: R1 found on floor in the bathroom with tab alarm on gown, on back with head against plumbing of the sink.; Describe injuries - Laceration to left occipital lobe and laceration with hematoma to right occipital lobe. Usual status of resident: Confused, not aware of safety needs, impulsive behaviors and poor judgment.; Communication: Unable to make needs known.; Is the resident able to use a call light? No. If no, why: Alzheimer/dementia.; Was there any behavior or mood factor that may have influenced the fall? Yes. If yes explain: Confusion, family had just left.; Is a restraint/safety device in use? Yes. bed alarm and chair alarm. Other: (R1) in bed and tab to alarm on R1. The alarm was in the off position." The visitor sign-in log for the facility dated 9/3/07 showed Z1 arrived at 6:10pm and left at 7:35pm. On 9/13/07 at 11:40pm, Z1 stated, "The girl had just finished cleaning R1 up before we left. Isn't it her job to make sure the alarm was on?" Z1 was asked if she or their family friend ever turned off R1's mechanical alarm? Z1 stated, "I didn't shut off the alarm. I knew R1 would wander. I always worried about that. When R1 was in the hospital he had to have a sitter because he would try to get out of bed. They told me R1 had pushed his wheelchair to the bathroom and fell at 8:04pm. They didn't tell me he fell in someone else's room. A CNA that took care of him there told me he fell in someone else's bathroom." On 9/11/07 at 1:20pm, Z1 stated that when she left on 9/3/07 she did inform the nurse passing	F9999		

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F9999	Continued From page 16 medications in the hallway of 400 wing that she was leaving. The nurse said she would check into R1's complaints of stomach pain. Z1 stated R1's wheelchair was not next to his bed. Z1 stated, "R1 had a sitter in the hospital because R1 would try to get up out of bed on his own. R1 was very weak." Z1 stated R1 had only fallen one time at home and that was months ago. Z1 stated that a certified nursing assistant told her that R1 was not in his room but another resident's room when he fell. Z1 stated she left that night due to staff's advice that after she left R1 would settle down. On 9/12/07 at 4:25pm, E8 (Certified Nursing Assistant - CNA) stated, "I talked to R1's God-Daughter a few days ago and I asked her if they had ever turned R1's alarm off and she said, "No." R1 did most of his moving around at night. It would have taken R1 awhile to climb over the side rail and do these things and get to someone else's room. R1 couldn't walk very well. I was shocked that no one would see him. I only walked him one time and he couldn't walk very well." E1's (Administrator) Time Line for R1 and the incident that occurred on 9/3/07 showed, "7:58pm - R1 found on the bathroom floor in the room next to his on the floor." R1's nurses notes show R1 was admitted to the facility on 8/29/07 at 3:00pm and was "alert with some confusion." R1's nurses notes from, 8/27/07 up to his first fall in the facility on 8/30/07, showed R1 was alert to his name only, restless in bed at times, had a bed alarm, does not use the call light, tried to get out of bed and took off his oxygen frequently.	F9999		

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R1's nurses notes dated 8/30/07 at 10:30am showed, "R1 alert and confused..... 10:30am - R1's wife in to visit. R1's wife out to her car and R1 remains in his room and alarm went off. This writer went to check and found R1 up walking. This nurse unable to stop R1 from falling down."

R1's nurses notes from 8/30/07 to 9/3/07 show R1 had bladder incontinence, a bed alarm, tube feeding, developed a fever (highest of 100.9), diminished lung sounds, rales/cough, oxygen saturation as low as 81%, respiratory rate of 32 and would dangle legs on the sides of the bed.

On 9/6/07 at 12:00pm, E3 (Director of Nurses - DON) stated, "R1's first fall, the wife was in the room and left to get her cell phone. The nurse went to check on R1 and he was standing and fell. On the 3rd (9/3/07) they found R1 right before 8:00pm. The string was attached to R1 but the box (mechanical alarm device) was on the bed and turned off. After the first fall we just talked to the family not to leave R1 by himself when she leaves. R1 was a fall risk at admission and an alarm was put on him."

R1's physician order sheet (POS) dated 8/29/07 showed diagnoses including Head and Neck cancer and Recurrent Aspiration. The POS showed R1 was on the following medications: Amlodipine, Aricept, Hydralazine, Namenda, Oxybutynin, Paxil, Plavix, Seroquel, Aspirin, Norco, Lipitor, Albuterol nebulizer treatments, Levaquin, Tylenol and tube feeding.

R1's fall risk assessment dated 8/28/07 showed a score of 14. According to the fall risk assessment tool 12 and above is high risk for

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F9999	Continued From page 18 falls and individualized high risk interventions are to be implemented. R1's care plan dated 8/30/07 showed, "Potential for injury due to falls and/or high risk for falls. History of falls at home. Fall score = 14." R1's fall care plan dated 8/30/07 showed the following generic approaches: 1. Assess history for falls. 2. Assess mental status and level of consciousness. 3. Assess medication side effects for drowsiness and/or dizziness. 4. Assess and monitor residents for deficits in mobility. 5. keep environment free of obstacles. 6. keep bed in low position. 7. Keep floors clean and dry. 8. Assess and monitor for visual deficits. 9. notify M.D. and family of any falls. 10. Encourage resident and family to participate in care planning process. 11. do a fall assessment with each fall. 12. Encourage resident to participate in activities to increase monitoring to decrease falls." After R1's fall on 8/30/07 at the facility the care plan was updated with the following intervention, "Falling star program. educate family to not leave R1 in room in wheelchair unattended." The facility's Fall Risk Assessment Policy showed, "Residents shall be assessed upon admission, re-admission, with significant change and quarterly using the Fall Risk Assessment Form. The resident who scores 12 or greater shall be considered at High Risk for falls and will have individualized High Risk interventions implemented including the falling star program." The facility's Falling Star Program policy and procedure showed, "Initiate/update fall risk care plan. Educate resident and/or family on Falling star Program and resident's individualized high	F9999		

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F9999	Continued From page 19 risk interventions." The resident/family education flow sheet for R1 was blank. The facility's policy and procedure on care plans showed, "A preliminary plan of care will be developed for each resident admitted within 72 hours to assure the residents immediate care needs are met." R1's care plan dated 8/29/07 for decreased functional mobility showed the approaches for this resident included gait training, transfer training, bed mobility training, strength exercises and balance activities. R1's activity of daily living functional assessment dated 8/31/07 showed independence for bed mobility, total dependence for transfers and walking did not occur. R1's care plan dated 8/30/07 showed, "Potential for hemorrhage due to anticoagulant therapy, Aspirin and Plavix." R1's care plan for the use of Paxil dated 8/30/07 showed, "R1 is at risk for adverse reactions related to psychotropic/psychoactive drug use. Monitor vitals signs as needed and ordered for signs and symptoms of low blood pressure (hypotension). Assess/monitor resident for signs and symptoms of over-sedation such as: drowsiness, lethargy, sleeps at unusual times of the day." On 9/10/07 at 1:00pm, E6 (Licensed Practical Nurse - LPN) was asked to describe the falling star program. E6 stated, "It is a green star on the	F9999		

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F9999	Continued From page 20 door that tells staff who is at risk for falls. The nurses do the fall risk assessment and put it with the CNA kardex. It is in the admission packets. Residents are automatically put on the falling star program if they have had a previous fall in the last 3 months or have general weakness." E6 was asked if nurses review papers from a resident's hospital stay and E6 stated, "Yes, there is a transfer sheet and History and Physical. We review it all. That's how we get to know them." E6 was asked about the mechanical alarm devices for residents and when they are used to which E6 stated, "Anyone who is a fall risk to let us know they are trying to get up on their own. It's not supposed to be turned off. It should be turned on or it won't work." 2) R3's POS dated 9/7/07 showed diagnoses including Weakness and History of Cerebral Vascular Accident. R3's Minimum Data Set progress notes showed R3 fell on 8/9/07, 8/11/07, 8/17/07, 8/22/07 and 8/28/07. R3's MDS notes dated 8/27/07 showed, "R3 attempted to get out of wheelchair and chair alarm did not go off. No injuries noted. Will re-educate staff to remove wheelchair and check chair alarm to see if it is working." R3's nurses notes dated 8/22/07 show, "This nurse found R3 laying on the floor next to wheelchair. Alarm intact. Alarm didn't sound. System failure alarm string did not separate from the alarm box. Confused, R3 does not recall why he attempted to get out of the chair without assist." On 9/11/07 at 12:30pm, E3 (DON) stated, "I don't	F9999		

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know why the mechanical alarm malfunctioned."

3) On 9/6/07 at 1:39pm, R10 was observed propelling her wheelchair to the front door of the facility. R10 had to be redirected away from the door by staff.

R10's MDS progress note dated 6/15/07 showed, "R10 found on floor in bathroom, no injuries. Check bed/chair alarm for functioning."

R10's care plan conference report dated 6/5/07 showed, "R10 has diagnoses of dementia, depression, she is on antidepressants.... R10 continues to need minimal assistance of staff. Does not ambulate. Propels wheelchair by self."

R10's MDS dated 5/29/07 showed impairment of short term memory, long term memory and cognition. R10 requires supervision for transfers and does not walk.

R10's nurses notes dated 6/14/07 showed, "Found R10 sitting on floor in her bathroom...sitting on buttocks with legs outstretched...." R10's nurses notes dated 6/14/07 showed no documentation of resident's alarm being applied and not working.

R10's POS dated 9/7/07 showed diagnoses including Senile Dementia, Osteoarthritis and Pagets disease of the Femur. R10's POS shows she is taking Lexapro and Risperdal.

R10's care plan dated 3/5/07 and continued on 5/30/07 and 8/23/07 shows, "5/4/07 - Apply bed/chair alarm. A later entry with no date showed, "Nursing states resident turns off

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F9999	Continued From page 22 bed/chair alarm, takes them off at times." No new interventions were put in place as of R10's fall on 6/15/07." On 9/6/07 at 1:30pm, E7 (LPN) stated, "R10 won't keep one (alarm device) on. R10 removes it. R10 pretty much stays in her room. The CNA's check on R10 every hour or so, I think." R10's last Fall Risk assessment was dated 5/1/07. R10's fall assessment was scored at an 8 and should have scored at a 13. The assessment did not show that points were given for a previous fall or medications that alter the thought process. A score of 13 would put R10 at high risk for falls and "individualized high risk interventions" would be implemented. R10's Resident Assessment Profile Summary dated 3/5/07 showed, "R10 is supervised with transfers and has had a fall when transferring. R10 is not able to ambulate...and can get agitated with care." (A)	F9999		