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	146023	A. BUILDING _____ B. WING _____	C 12/11/2007

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F 323	Continued From page 10 E2 was interviewed on 12-5-07. E2 shared her investigation report into R3 fall. E2's summary was, "Alarm did not sound due to equipment not working properly. Staff will be in serviced on proper procedure when equipment does not work."	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)6) 300.1220b)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. Restorative measures shall include at a minimum the following procedures: 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:	F9999		

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F9999	Continued From page 11 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 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. (Section 2-107 of the Act) These regulations are not met, as evidenced by the following: Based on observation, record review and interview, the facility failed to provide adequate supervision for 2 of 5 residents (R1 and R3) with a history of falls. Staff failed to ensure that the sensor pad alarm system functioned as designed to provide supervision for R1 and R3. Staff failed to thoroughly investigate each fall to identify trends/patterns and root cause, and failed to assess and implement additional interventions following each fall for R1. R1 fell, sustaining right rib fractures and a right pneumothorax. R1 expired four days later. R3 fell and sustained a fractured left hip. The findings are:	F9999		

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F9999	Continued From page 12 1. According to R1's Physician's Order Sheet (POS) for 10-1-07 to 10-31-07, R1 was admitted on 1-3-05 with diagnoses that includes Hypertension, Cerebral Vascular Accident (CVA), Osteoarthritis, History of Right Hip Fracture, and Osteoporosis. The POS listed to use a sensor pad when in bed, wheelchair, and recliner. The sensor pad for the bed was ordered on 5-2-07, and for the wheelchair and recliner on 5-17-07. On 11-26-07 at 3:30 P.M. the Director of Nurses (DON), E2 explained that the sensor pad is a part of the resident alarm device to alert staff when R1 rises from the bed, wheelchair (w/c) or recliner. R1's assessment of 10-22-07 lists R1 to have no memory problems and to be independent with daily decision making. R1's mood is easily altered. The assessment in the Physical Functioning section lists R1 is capable of transferring self with set up and supervision, capable of walking in her room and corridor with limited assistance from one person, capable of using the toilet with supervision, and requires extensive assistance with bathing. R1 required partial physical support to balance while standing. R1's Activities of Daily Living (ADL) functioning levels have deteriorated in the past 90 days. The Fall Assessment for R1 dated 7-24-07 listed R1 at high risk. According to the fall assessment, R1 has intermittent confusion, had falls in the past, had unsteady gait or used a w/c, and attempted to ambulate without assistance. The Fall Assessment included the following dates of falls: 1-14-07, 3-7-07, 3-10-07, 4-12-07, 4-23-07, 4-25-07, 5-13-07, 5-17-07, 6-16-07, 6-18-07, 6-22-07, 7-20-07, 7-27-07, and 10-22-07.	F9999		

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F9999	Continued From page 13 According to R1's 5-17-07 Nurses Notes at 6:00 P.M., "Res had call light on. CNA went into room and found Res on floor next to bed with w/c behind her. Res stated she was putting self to bed stood (up) et (and) w/c went out from behind her. She lost balance et went down. She stated she hit head on w/c. - - - Sensor pad in chair et bed." The Nurse's entry did not address if the alarm was on and sounding at the time of the fall. An entry at 7:30 P.M. on 5-17-07 states "Sitting (up) in w/c in room (with) sensor pad in place and functioning." In the "comment and/or steps taken to prevent recurrence" section of the facility's incident report, the facility entered "Sensor pad alarm in place in chair et bed." On 6-16-07 at 12:00 A.M., R1's Nurses Notes documents, "answered call light to find res seated atop bed linens on floor next to bed. Res stated she slid off bed. Denied any injury then stated she bumped her head on table that wasn't close to res (at) the time but she stated she scooted over that way to pull call light. Bed alarm on bed but did not sound." The entry does not mention if the bed alarm was on at the time of the incident or if it was functional. The facility's incident report comment section was blank. On 6-18-07 at 5:45 P.M., the Nurses Notes documents, "Res slid from w/c on the floor." The entry did not include any information to support that alarms were in place and functioning. The facility's incident report comment section had no additional information about the incident. The Nurses Notes dated 6-22-07 at 12:45 A.M. documents, "Resident pulled call light, was on floor on buttocks (with) legs extended in front of	F9999		

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F9999	Continued From page 14	F9999		

her. Reported she had used her w/c to get a piece of gum, slid out of w/c onto buttocks. Sensor alarm did not sound." The incident report comment section was blank.

According to the 7-20-07 Nurses Notes at 7:30 A.M., "Called to Res room, CNA found Res sitting on the floor in front of her bed. Res insisted to CNA and Nurse that she did not fall and that she was trying to pull her pants up and lost balance." The entry does not contain information that the sensor alarm was in place and functioning. An incident report was not provided.

On 7-27-07 at 2:15 P.M., Nurses Notes document, "Res found on floor in front of recliner. Res stated that she slid out of recliner onto floor. Alarm was shut off. Ask resident if she shut it off. Res stated 'Yes, I did because I thought I could do it on my own.' " The incident report comment section entry was "Trial w/c (with) auto brakes. Started 8-4-07."

The facility's "Restraint - Recliner- Non Restraint Alarm Assessment" for R1 dated 8-5-07 was reviewed. The assessment lists, "sensor alarm in bed and chair, seatbelt alarm in wheelchair and auto brakes on wheelchair." This assessment also notes an increased fall risk when in wheelchair, and that R1 gets up without assistance.

R1's Care Plan of 7-28-07 listed the following approaches: Encourage R1 to use grab bars in the bathroom to assist with transfer on/off of toilet, utilize walker as needed to assist with transfers and ambulation, remind R1 to lock w/c brakes when providing supervision during transfers, assist of one with all transfers, sensor

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F9999	Continued From page 15 alarm in bed and chair, and seat belt alarm in recliner. The Care Plan did not address the placement of the alarm so that R1 could not turn the alarm off without it sounding. No new Care Plan interventions were documented between 7-28-07 and 10-22-07 for falls. The pharmacy "Consultation Report" dated 8-30-07 notes in the comment section, "As part of our polypharmacy focus, this individual with frequent falls has been identified as taking Ambien, Ziac, Zoloft, Wellbutrin, fluticasone, and Periactin. There is a potential for drug/disease interaction with the risk of increased falls related to impaired psychomotor function, onset of ataxia or more pronounced syncope." In the recommendation section of the report, the Pharmacist wrote,"Please re-evaluate continued Ambien, Ziac, Zoloft, Wellbutrin, fluticasone, and Periactin use and consider discontinuation or alternative therapy." On the pharmacy "Consultation Report", the Physician declined the 8-30-07 recommendation without rationale. The October 2007 POS shows R1 was receiving these listed medication at the time of the 10-22-07 fall. The Nurses Notes dated 10-22-07 6:40 P.M. documents, "Res bathroom light was going off. Writer went into the room and found Res sitting on the floor leaning against w/c. Res stated, 'I lost balance and fell hitting my head.' Laceration to the back of head approx (approximately) 1 1/2 - 2 inches. And c/o (complained of) severe (right) shoulder pain. Full body assessment done. - - - - doctor and family notified - - - Send to (hospital) ER (Emergency Room) eval (evaluation) and Tx (treatment) per (by) ambulance. - - - Sensor pad alarm was (not) in place. CNA stated she had	F9999		

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F9999	Continued From page 16 put in place before supper." The hospital "Emergency Room Report" of 10-22-07 was reviewed. The section, "History of Present Illness" documents R1 "apparently was standing in front of a mirror, lost her balance and fell over backwards. She struck the back of her head against the frame of the door and then somehow landed on her right side against the wheelchair." The report documents the impression as "Right rib fractures, Right Pneumothorax, Status Post Fall, and Scalp Laceration." Nurses Note dated 10-23-07 at 9:45 A.M., and documented as a late entry for 10-22-07, reads, "CNA stated to writer that she had put alarm on resident prior to supper and when resident was found on the floor, sensor pad was in w/c but alarm was off. Alarm was found next to the bed on off mode. Res stated, 'I was taking myself to the bathroom and getting ready for bed then I fell.' " The hospital "Discharge Summary" of 10-26-07 was reviewed. The Discharge Diagnosis was listed as R1 "passed away on 10-26-07 from cardiopulmonary arrest as a result of rib fractures and pneumothorax." The Attending Physician, Z1, was interviewed on 12-4-07 at 9:20 A.M. Z1 stated that R1's fall did contribute to the death, but it was not the cause of death. On 11-26-07 at 3:30 P.M. E2, Director of Nurses, was interviewed about the operation of the sensor pad and alarm system. The facility was using a sensor pad and alarm system that was	F9999		

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F9999	Continued From page 17	F9999		

designed to sound to alert staff if the resident rises from bed, wheelchair, or chair. The pads are pressure sensor devices that are connected to battery operated alarm. The alarms are to sound when pressure is removed. The alarm box was observed to have an on/off switch. E2 stated that the alarm box and pad was found be to functional following the incident on 10-22-07. E2 also stated that if the alarm box was on and the plug-in cord to the sensor pad became disconnected, the alarm would sound. On 12-5-07, E1, the Administrator, and E2 called the manufacturer to verify the operation of the sensor pad alarm system.

E5, CNA stated on 11-26-07 at 11:20 A.M., that she had been told by other CNAs that R1 turned off the alarms. E5 had seen the alarm box attached to the back of the chair and the bed.

E10, CNA was interviewed on 11-26-07 at 1:10 P.M. E10 stated that R1 loved her independence. R1 told E10 that she did not like the alarms and stayed to herself in her room. E10 had seen R1 fiddle with the alarm. E10 said E10 was told by R1 or staff that R1 would turn off the alarm.

E9, CNA was interviewed on 11-26-07 at 3:30 P.M., E9 stated that she would find the alarm in places E9 did not put the alarm. E9 would find the alarm on the bed when E9 put the alarm on the wheelchair. E9 stated that she had told her charge nurse that the alarm had been moved. E9 was aware of changes made in the placement of the alarm.

E11, Licensed Practical Nurse (LPN) was interviewed on 11-26-07 at 2:00 P.M. E11 was

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F9999	Continued From page 18 the charge nurse on 10-22-07. E11 stated she was aware that R1 could remove and turn the alarm on and off. E11 stated that she did notify her supervisor but she did not recall the date. E11 thinks it was a few weeks before the 10-22-07 incident. E4, the Care Plan Coordinator, was interviewed on 12-4-07 at 2:35 P.M. The Care Plan was reviewed and E4 had added auto brakes to R1's wheelchair (stops the wheelchair from rolling backward when the resident stands up) on 8-4-07. 2. According to R3's Physician's Order Sheet (POS) for 11-1-07 to 11-30-07, R3 was admitted on 9-14-07 with diagnoses that include Dementia, Osteoporosis, and Parkinson's Disease. The POS lists an order for, "Sensor pad on bed as directed and in D/R (dining room). Seat belt alarm in recliner." On 11-26-07 at 3:30 P.M. the Director of Nurses, E2, explained that the sensor pad is a part of the resident alarm device to alert staff when R3 rises from the bed, chair or recliner. R3's assessment dated 10-25-07 lists R3 to have short term memory problems, moderate cognitive impairment for daily decision making and a behavior of repetitive questions and repetitive anxious complaints and concerns. The Physical Functioning section of the assessment lists that R3 requires limited assistance of one person for bed mobility, transferring from bed to chair and walking. R3's balance is listed as unsteady, but able to re-balance self without physical support. The assessment documents a decline in Activities of Daily Living in the 90 days and	F9999		

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F9999	Continued From page 19 history of falls. R3's Care Plan of 11-6-07 listed that R3 had falls on 3-21-07, 3-27-07, 4-2-07, 5-23-07, 7-6-07, 7-1-07, 7-18-07, 8-11-07, 8-20-07, 9-5-07, 9-24-07, and 10-7-07. The initial Care Plan of 11-16-06 listed R3 "is at moderate risk for falls due to cognitive impairment and periods of confusion. History of falls. - - - A sensor pad alarm is being used for (R3) in bed and chair." The Care Plan listed that on 10-4-07 the sensor alarm in the chair was discontinued due to causing increased agitation and further risk of falls. On 10-4-07 the following approach was added: "Provide frequent reminders of (R3) to pull call light when needing to get up from recliner." On 11-4-07, the Care Plan documents "Noted non-compliance (with) bed alarm. res. (resident) turned off alarm (and) placed in bedside drawer." On 11-6-07 "Attempt to place bed sensor alarm unit out of res sight when in use and initiate 15 minute visual (checks) due to res frequent attempts to transfer / ambulate per self" was documented. On 11-14-07, a seat belt alarm in recliner was added. On 11-17-07, R3 was added to the Falling Star Program. On 11-26-07 at 5:15 A.M., the Nurses Notes documents, "Resident seen walking into hallway from (R3's) room, stumbled tried to catch self (with mechanical lift), tripped over leg of (lift and) fell, landing on (left) side. - - - - Noted sensor pad alarm cord was pulled out of box for alarm had not sounded." The hospital "Consultation Report" from the Orthopedic Surgeon dated 11-29-07 lists R3's diagnosis of Fracture Left Femoral Neck.	F9999		