STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145371	A. BUILDING ______ B. WING ______	C 09/07/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER OF BLOOMINGTN	1509 NORTH CALHOUN STREET BLOOMINGTON, IL 61701

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F 353	Continued From page 15 timely manner to care for his wife's incontinence problems R1 stated "...it has happened quite often in the last month.) one day my wife had to wait forty-five minutes to be put on the toilet, and forty-five minutes to be gotten off. I finally had to get her off myself... on Saturday afternoon (approximately two weeks ago on the 11th of August) There were two aides for the whole building - they started with three and one walked out. I had to put my wife on the toilet that day and I'm not supposed to..." Resident Council Notes indicated some residents at the meeting felt their needs are not being met. The notes dated "August 7, 2007 2:00 PM stated, "...Residents voted for the D.O.N (Director of Nurses) to come in the meeting they addressed her with old business. She apologized and explained to Residents that she was doing the best she can and she would love to answer their every need but things aren't that simple...(R8) asked why 3rd shift is leaving things for first shift to do... (R1) says that CNA's are not answering call lights on night shift. ...(R1) asked why is there only one CNA per hall..." A confidential interview with a staff member on 8/27/07 at approximately 11:20 AM confirmed a severe CNA shortage. The interviewee stated, "...we have been working short for 5 - 7 months...many times on days we have worked with one CNA on a hallway. You cannot supervise that many residents (80 - 90 residents) with just one CNA on each hallway...we have residents falling because we cannot supervise properly. There is not enough of us..."	F 353		
F9999	FINAL OBSERVATIONS	F9999		

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F9999	Continued From page 16	F9999		

LICENSURE VIOLATIONS

300.1210a)
300.1210a)5)
300.1210b)6)
300.1230a)

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:
5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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.

Section 300.1230 Staffing

a) Staffing shall be based on the needs of the residents, and shall be determined by figuring the number of hours of nursing time each resident

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F9999	Continued From page 17	F9999		

needs on each shift of the day. This determination shall be made separately for both licensed and nonlicensed nursing personnel.

These regulations were not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide supervision to R3, one of three residents sampled for accidents and injuries. The facility also failed to complete a root cause analysis for each fall to identify the effectiveness of interventions and identify the need for alternate interventions to prevent recurrent falls.

R3 experienced several falls from February 2007 through April of 2007. In addition the facility failed to provide sufficient staff to respond to resident needs.

These failures resulted in R3 having a fall after he stood from his wheelchair. R3 sustained a fractured hip and two days later died from the hip fracture complications.

Findings include:

Review of a Nurses Note dated 7/1/07 showed R3 had a fall from his wheelchair. The note stated,
"...4 PM. (The) Resident (R3) (was) heard yelling in room. Staff attempted to open door. resident lying on floor in front of door. Writer (and) staff went through bathroom found resident lying on right side on floor clutching (right) hip. (R3) States '...I was getting my stuff...' Hip bent and knee, resident unable to straighten leg without yelling out in pain. 4:15 PM. MD (Medical Doctor) notified order received to transfer (to hospital) ER

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F9999	Continued From page 18 (Emergency Room) for X-Ray RT. (right) hip..." Review of a Hospital X-Ray Report dated 7/1/07 showed R3 fractured his hip. The report stated, "... One View of The Pelvis with Two View Right Hip Dated 7-1-07...Conclusion: ...an impacted subcapital fracture being noted..." Review of a "Coroner's Certificate of Death" dated 7/3/07 as date of death, and signed by the coroner, showed R3 died of "... Complications of Hip Fracture...Due to, or as a consequence of (b) Fall..." R3's most recent Physician's Orders dated August of 2007 indicated R3 had diagnoses of Dementia, Psychosis, Delirium, and History of Cerebral Vascular Accident. The orders showed R3 is to have "...safety devices chair and bed alarm..." R3's most recent full assessment dated January of 2007 showed R3 was unable to attempt the standing balance test. This also showed R3 was cognitively impaired and needed extensive assist with most of his Activities of Daily Living (ADL's). Review of R3's most recent Falls Assessment dated 4/22/07 showed R3 is at "HIGH RISK" for falls. Review of R3's current working Care Plan noting a Target Date of 7/24/07 showed R3 should have been wearing an alarm. The care plan notes "... Approaches, (#8) bed alarm, Chair alarm...." E3, Licensed Practical Nurse (LPN) stated on 9/4/07 at 10:05 AM that she was one of the first responders when R3 fell on 7/1/07. E3 stated, "...I was paged to 100 hall - he, (R3) was on the floor. He was complaining of hip pain. We called the doctor and received orders to send him into	F9999		

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F9999	Continued From page 19	F9999		

the hospital...He did not have an alarm on when I got there. He had a history of removing the alarm. I do not remeber hearing an alarm going off when I responded to the fall...."

Review of facility documents indicated R3 sustained several falls prior to the hip fracture. Falls were documented as having taken place on 2/17/07 when R3 fell in the bathroom, on 3/1/07 when R3 fell after standing from his wheelchair, on 3/14/07 after R3 stood from his wheelchair, and again on 4/7/07 after R3 was found in the bathroom after getting up from his wheelchair.

Review of the "Falls Investigation Tool" for the falls R3 took on 2/17/07, 3/1/07, 3/14/07 and 4/7/07 showed documents that were not completely filled out. Also, there were no conclusions or reasons postulated, based on the collected data, as to why R3 was falling. Consequently, there were no interventions proposed that could prevent R3 from falling again.

Review of R3's Care Plan titled, "...Potential for Injury r/t (related to) falls..." showed no new individualized approaches were added after the falls on 2/17/07, 3/1/07, 3/14/07, and 4/7/07. All eight approaches listed on the Care Plan were listed in January of 2007. The exception was number nine that stated, "...yellow tape on w/c (wheelchair), yellow dots on door et (and) name (at) diningroom table to alert staff he has frequent falls...."

Interview with E1, Administrator, on 8/29/07 at approximately 2:00 PM demonstrated the facility failed to develop any individualized Care Plan approaches to keep R3 safe. E1 stated, "...the

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F9999	Continued From page 20	F9999		

only new intervention that was added to (R3's) Care Plan (after the other four falls) was the 'Yellow Dot' intervention. This program alerts staff to increase supervision of the particular resident. No, I don't have a written policy explaining what the 'Yellow Dot' program is...."

E4, Certified Nurses Assistant (CNA), on 8/27/07 at approximately 10:15 AM indicated staff were routinely working very short handed. E4 stated, "...Since I have been here on 100 hall (the hall R3 resided on) I have worked by myself everyday. On the day (R3) fell he and (R5 roommate) had a physical fight. I know because (R5) had an injury (to his) arm. This is (the rancor between R3 and his roommate) since the beginning of June. They would scream at each other..." one person cannot provide adequate care on that hallway. One person cannot provide good supervision. If people fell there was no one around. (R3's roommate) fell (one day) and I didn't know it because I was on another hallway helping...." E4 further demonstrated R3 was unreliable about staying in his wheelchair. E4 stated, "...he was confused and sometimes he would get up on his own....He had a chair alarm on and he would take it off often - almost everytime...I told the DON (Director of Nurses),and other nurses were aware also, that he would remove his alarm...(R3's) room mate would yell and this would agitate (R3)."

Review of time clock records for 1st and 2nd shifts, 7/1/07, the day R3 sustained the fractured hip, showed there were three CNAs (for approximately 75 residents) for each shift. That is one CNA for each of the three facility hallways where residents reside. Interview with E1, Administrator, on 8/24/07 at approximately 1:00

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F9999	Continued From page 21 PM confirmed these three hallways combined had approximately 75 residents. E1 stated the optimum staffing level for each single hallway is two. That would be a total of six CNAs for 75 residents. E1 stated 75 was the patient population routinely housed outside the special care unit. The special care unit has another 13 residents. The special care unit is closed from the other hallways and is staffed separately. (A)	F9999		