STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146078	A. BUILDING ______ B. WING ______	12/20/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSHING CONVALESCENT HOME	**3900 SOUTH OAK PARK AVENUE BERWYN, IL 60402**

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F 501	Continued From page 71 observation of pressure sore dressing changes for R3 and R4.	F 501		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)6) 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. b) General nursing care shall include at a 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. These REGULATIONS are not met as evidenced by: Based on observation, interview, review of policies and procedures, and clinical record	F9999		

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F9999	Continued From page 72	F9999		

review, the facility:

1. Failed to ensure that 3 residents (R1, R2, R11) were supervised to prevent falls that caused injuries.

2. Failed to have in place an effective fall program that included identification of residents at risk for falls, updated assessments, care plans, interventions, and documentation of any interventions tried.

Findings include:

1. R1 is 85 year old admitted to the facility 07/04/07 with diagnoses including Dementia with Associated Behavior Symptoms. R1 was observed during 3 days of the survey (12/10/07, 12/11/07 and 12/12/07) in a recliner with a tray table or in bed, quiet. The resident communicates verbally but has trouble relating the correct information as asked and, requires total staff by staff.

During record review (incident reports and nurses' notes), it was determined that R1 has had 4 unwitnessed falls with injury within a 3 month period time. The last fall was preventable. The resident was admitted 07/04/07 and began an odyssey of falls extending from 07/18 to 10/31:

-On 07/18/07 at 4:00pm, the resident was found in the room on the floor. A skin tear noted to the right arm. R1 was assessed as being confused and disoriented times 3.

-On 08/09/07 at 8:00am, R1 was found in R1's room. The resident fell out of the wheelchair

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F9999	Continued From page 73 and sustained a laceration to the right forehead. The resident was sent to the hospital, and returned to the facility the same day with sutures to the 2CM laceration of the right forehead. -On 09/05/07 at 3:45pm, according to incident report and nurses' notes, R1's family member approached the nurse's station to inform staff that R1 fell upon family member entering the room. R1 was face-first on the floor in front of the wheelchair with 2 hematomas to the top of the head. The resident sent to the hospital and returned with a discharge diagnosis/clinical impression of Abrasion: Head. -On 10/31/07 at 3:30pm, R1 found on the floor with a moderate amount of blood from the mouth and nose. 911 was called and R1 was sent to hospital for evaluation. R1 returned to the facility at 7:15pm the same day with a diagnosis of Closed Fracture of the Nose. Surveyor looked for and requested any assessments completed before and/or after each fall. There were none to be found. On 12/11/07 at 2:20pm, E3 (Director of Nurses) was asked: "what is done after each fall?" E3 stated, "We only do one fall assessment, and quarterly for the side rails assessment - coordinates with the fall re-assessment." Then on 12/12/07 at 10:45am, surveyor asked E3 (Director of Nurses): "Do you have any assessments after each fall?" E3 stated, "No." In addition, there is no plan of care to address the falls. A review of R1's 07/07 and 10/07 Minimum Data Set (MDS) indicates there are no falls for the 3	F9999		

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F9999	Continued From page 74 month period of time. On 12/12/07 at 11:50am, E3 was questioned about the quality assurance meetings and whether or not incidents/falls are discussed. E3 stated, "No discussion on falls. We don't address too much falls. We just do right then and there. We instructed (certified nurse assistant) CNA to increase visual checks, frequent rounds, and there should be somebody always supervising them. We never discussed it as a fall. There is no summary of falls. This is discussed informally from shift to shift." Surveyor interviewed Z1 (Medical Director) via telephone on 12/12/07 at 12:15pm about falls being discussed at quality assurance meetings. Z1 stated, "Yeah, every 3 months I attend the quality assurance meeting. We discuss all topics; all department staff are there. Yes, the team discusses incidents and falls. Every time we meet, I talk about falls. E2 (Assistant Administrator) should document that. Specifically, I say how many falls they have and what we are doing to correct that. The nursing staff, including aides, are there in the meeting, and we discuss how to correct that. E2 should have the protocol. We always discuss falls. Every fall has an incident report. Those people who are unsteady, observe them more and help them. E2 should provide you specific information what you are looking for." At 2:05pm the same day, surveyor requested the quality assurance information related to falls and injuries from E2. E2 stated, "I don't have it." On 12/13/07 at 3:55pm, E2 read several excerpts from the 2007 quality assurance minute meetings	F9999		

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F9999	See text below	F9999		

F9999

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as follows:

November 15, 2007 - instructed nursing to work diligently on falls.

August 15, 2007 - nothing about falls.

May 30, 2007 - nothing about falls.

February 7, 2007 - no mention of falls.

2. R2 is an 87 year old with diagnoses that include Alzheimer's Dementia, Weakness, and Unsteady gait. Review of R2's current (06.24.07) MDS (Minimum Data Set) does not trigger for falls or accidents. However, R2 does have a history of falls and injuries of unknown origin.

The facility's Incident and Accident Reports document fall incidents on 01.12.07, 05.27.07, and 07.23.07 for R2. Per review of the incident report of 01.12, R2 was "observed on the floor in a sitting position." He stated, "I was putting on my shoes and I fell...." The incident dated 05.27 states, "Resident was found twice by CNAs on floor. He keeps sliding down in his chair, rocking it, and tipping it over..." The incident report for 07.23.07 states, "Resident was found on floor in room 25 laying on right side in front of w/c & bruises/breakdown noted..."

Two incidents related to injuries of unknown origin were found for R2 in the facility's Incident and Accident Reports. The first is dated 01.29.07 and states: "found...upon assessment with swelling and ecchymosis (bruising) of left hand-pinky. Unable to move finger (left pinky) upon command, pain upon movement when

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touched at time of assessment". X-rays were performed and were positive for a non-displaced fracture (oblique) of the 5th proximal phalanx (finger).

The 2nd incident report has an "unknown" date of incident listed (the report was completed on 04.20.07). This report states: "on middle of back 2 abrasions (scrapes) found on back (1) about 6 inches and the other about 2 inches in length..."

No care plan for falls/accidents was found. Nor was any response to any of R2's falls/injuries of unknown origin found upon review of R2's medical record.

3. R11 is a 91 year old with some diagnoses that include Dementia and Unsteady gait. Review of R11's current MDS does not trigger for falls or accidents. However, review of the facility's Incident and Accident Reports documents multiple fall incidents since R11's admission to the facility on 09.30.07.

Further review of R11's MDS documents a RAP (Resident Assessment Protocol) for falls. This RAP states: "at high risk for falls...dementia, unsteady gait. Noted with attempts of getting up from wheelchair unassisted. Staff provides re-direction, reminders, and safety at all times."

Review of the facility's Incident and Accident Reports documents 3 fall incidents for R11 (09.19.07, 10.12.07, and 11.27.07). The report of 09.19 states, "was on the floor in a sitting position. Could not explain why she's sitting there." The report dated 10.12 states, "Resident standing up in wheelchair by herself and lost

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balance and fell in a sitting position on the floor of dayroom." The incident of 11.27 documents the following, "Attempted to stand from w/c. Found on floor..."

R11 was care planned for falls (provide re-orientation as needed; provide safety at all times). However, approaches/interventions were not observed to be followed by staff during the survey, and R11's care plan was not updated/revised after each fall incident.

4. During various times of the survey, both R2 and R11 were observed sitting at the 2nd Floor Dining Room with no staff present, or staff not intervening or intervening inappropriately.

On 12.10.07 at 1:19 PM, R11 was observed up and out of her wheelchair in the Dining Room attempting to clean a food spill on the floor. E8's (CNA) response was to position both the dining room table and R11 in her wheelchair in such a manner that R11 was unable to move her wheelchair in any direction and was unable to get up out of her wheelchair. No other intervention was attempted.

At 1:33 PM on 12.10.07, R2 was observed sliding down in his wheelchair at the Dining Room table and attempting to move his wheelchair backwards by pushing against the table with his hands and attempting to use his feet to move his wheelchair. E8's response was to yank R2 up by his pants. No other interventions were attempted.

At 10:30 on 12.11.07, R11 was observed sitting in her wheelchair at the Dining Room table. E8 stated during interview (at 10:45 AM) that she

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F9999	Continued From page 78 was the CNA responsible for R11's care that day and had gotten R11 up and placed her in the Dining Room at the table. No staff were present in the Dining Room at this time. At 1:00 PM residents (including R2 and R11) were observed unattended by staff in the 2nd Floor Dining Room. At 1:16 PM, E6 (LPN) was overheard calling out to staff: "The lady (surveyor) is sitting in there, you can't leave them alone in the Dining Room. Someone has to be in there with them." Staff then came into the Dining Room. (A)	F9999		