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RIDGELAND NRSG & REHAB CENTER	**12550 SOUTH RIDGELAND AVENUE** **PALOS HEIGHTS, IL 60463**

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F 492	Continued From page 34 documented swelling to R1 right ankle. R1 required additional x-rays of the right ankle. The surveyor asked the facility's Administrative Staff to provide documentation that this additional information had been forwarded to the state agency. No documentation was provided. 2. Review of the facility's Incident and Accident reports documents that R6 was found on the floor 2 times in July of 2007. Both incidents resulted in R6 requiring the services of an outside vendor. On 07/11/2007 R6 was sent to the hospital for evaluation and treatment and on 07/13/2007, R6 received x-rays of the left ribs and left hip. No documentation was presented to the surveyor that these incidents had been forwarded to the state agency. 3. Review of R13's medical record documents R13 fell on 02/19/2008 while attempting to adjust her tray table. R13 required x-rays of the right hip for complaints of discomfort to that area. No documentation was found, nor did facility staff provide documentation (after numerous requests by the surveyor) that this incident had been forwarded to the state agency.	F 492		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)3) 300.1210b)6) 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	F9999		

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practicable physical, mental, and psychosocial 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:
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.
6) All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These requirements are not met as evidenced by:

Based on observation, record review and interview the facility failed to provide appropriate services and supervision for 7 of 13 sampled residents (R1, R8, R12, R13, R14, R15, R18) who were identified with a fall risk or have a history of falls with injury by not:

-thoroughly investigating each fall incident to determine the reason(s) for each resident's falls.

-evaluating the effectiveness of interventions for fall and injury preventions.

-consistently tracking falls, and implementing or

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updating fall interventions.

These failures resulted in falls with injury for the following residents:

-R8 sustained an ankle fracture post fall occurring 2/19/08 and/or 2/20/08.

-R18 sustained a laceration to the forehead and a fracture to C1 and C2 (spinal fracture) on 5/28/07.

-R15 sustained a fractured finger from fall incident on 2/2/08.

-R14 sustained a laceration to the forehead requiring sutures post fall occurring 10/30/07.

-R1 sustained a laceration to the head which required sutures and a fracture to the clavicle post fall occurring 11/14/07.

-R12 sustained an injury to the head post fall occurring 2/13/08.

Findings include:

1. On 2/25/08 between 10:00am and 11:15am, the surveyor conducted a tour of the facility's 100 and 200 units. The surveyor was accompanied by E2 (director of nurses) for a portion of the tour (one hundred unit) and by E6 (nurse) for a portion of the tour (two hundred unit). During the tour of the 200 unit, a visitor came out of a resident room asking for assistance for R8. E6 and the surveyor were in the area, and E6 went to assist the resident. The visitor commented to the surveyor, after introduction, she was concerned about the many falls R8 has had since

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the admission (10/4/07).

The surveyor observed that the left side of R8's face had a purple-blue color bursting, from the top of the head down to the chin area. R8 stated she fell last week in the bathroom. R8 showed the surveyor a cast on the lower part of the left leg and foot. R8 stated, "This happened when I fell." R8 was noted in bed without any monitoring device.

On 2/25/08 at 3:00pm, the surveyor returned to R8's room to have a conversation with the resident. R8 stated she did not remember talking to the surveyor earlier. On 2/26/08 at 10:10am, the surveyor attempted to talk with R8 but R8 was not interested and told the surveyor she wanted a blanket. The surveyor did not observe any monitoring device attached to the bed or the resident.

The following information was found as a result of a review of the facility's incident reports, nursing documentation or physician's documentation:

- Incident report 2/20/08 at 9:10pm, nurse aide responded to call light and resident was observed lying on the floor between the two beds. The nurse assessed her and she (R8) sustained a hematoma to the left side of her forehead and a laceration to her left elbow. Resident was transferred to hospital. Emergency room unable to tell us her diagnosis. The hospital documentation indicated: x-ray of the ankle revealed fracture of the fibula and the fifth metatarsal bone. Impression: multiple falls. Parkinson's disease. Fracture of the lateral malleolus on the left side and fracture of the fifth metatarsal bone and dementia.

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F9999	Continued From page 38 - Nurse's progress notes dated 2/20/08 at 12:39am, called in room by CNA (nurse aide), observed resident on floor between beds, bump noted on left side of forehead able to make need known assisted in wheelchair................... resident sent to emergency room for evaluation. -Incident report dated 2/19/08 at 5:00am unwitnessed fall, found on bathroom floor. Bed/wheelchair alarms for fall precaution. Injury: skin tear to left elbow. -Resident progress notes dated 02/19/08 at 5:00am, resident toilets self, found on floor by CNA (certified nurse aide) in bathroom resident lying on her back to bed without complaints skin tear to left elbow cleansed with normal saline solution TAO (triple antibiotic ointment) and dry dressing applied ROM (range of motion). Body assessment reveals no other injury. -Incident report 2/19/2008 at 9:25am, unwitnessed fall, noted side rails up. Resident attempted to go to bathroom without assist, urinated on the bathroom floor, slipped falling on her left buttocks. Injured: skin tear to left wrist 2.5cm (centimeter) by 2 cm and skin tear on left bunion 0.5 cm. No use of alarms indicated. Intervention include: get nurse for assistance. -Incident report 2/19/2008 at 9:24pm, unwitnessed fall, CNA found resident on the floor. She didn't have a alarm on. Between the two beds on her left side. Noted a big knot on left side of forehead. -Incident report of 1/28/2008 at 7:25am, unwitnessed fall, side rails up indicated. No alarm devices in use. Resident stated attempted to pick up something on bathroom floor, lost balance sat down on buttocks to keep from falling. Attempting to get up without assist. Bilateral knees red from	F9999		

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F9999	Continued From page 39 pressure. Intervention: monitor resident activity and encourage to use light for assistance. -Incident report of 1/24/08 at 8:25am, unwitnessed fall. While in the dining room, resident stated attempted to stand up from wheelchair, unlocked wheels, causing chair to move. Sat on floor on her buttocks. No apparent injury. No intervention documented. -Physician's progress notes dated 1/9/08 at 3:20pm, says she fell recently in bathroom. doesn't seem concerned about it. -Incident report 10/20/07 at 5:00am, unwitnessed fall. Resident from bed B came out to call staff and advised us that resident was on bathroom floor. Observe resident sitting on bathroom floor. Wheelchair off to one side, feces over top of toilet, on floor and wheelchair. No apparent injury. Intervention was to be the use of a safety alarm. On 2/27/08, E2 (director of nursing) was interviewed during the daily status meeting about the incident surrounding R8's fall of 2/20/08. E2 denied the fall occurred on 2/20/08. According to E2 the fall happened on 02/19/08. The surveyor asked E4 (administrator) for all the investigations and nursing progress notes and documentation surrounding R8's falls. However, no fall investigation was given for R8 for 2/20/08. The computerized documented information gathered on 2/25/08, prior to the surveyor's request from E1 and E2, revealed R8 had a fall on 2/20/2008 and was sent to the hospital. The facility was not able to demonstrate how they documented and tracked R8's falls between 02/19 and 2/20/08. There was no investigation done to determine why R8 was getting out of a wheelchair and or bed and falling. The	F9999		

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F9999	Continued From page 40 investigation given to the surveyor only repeated the information from the incident report. In addition, the care plan interventions for the use of a chair and bed alarm were not observed being implemented during the survey. 2. R18 is a 99 year old female resident who has several diagnoses including status post fall, closed cervical vertebra fracture of C1 and C2, Alzheimer's and dementia. R18 was admitted to the facility on 2/24/06. R18 was discharged to another facility on 1/3/08. Review of the nurse's notes in R18's closed record indicates on 5/28/07 at 7:00am R18 was noted in a wheelchair during the fire alarm. At 7:40am, the nurse was called to the room by CNA (certified nurse aide). R18 was found laying on the floor with right side of her face on the floor. R18 sustained a laceration and hematoma to the forehead. R18's physician was notified and gave orders to send out to the hospital for evaluation. Upon assessment at the hospital it was discovered R18 had sustained a fracture to the C1 and C2 of the spine. Z2 returned the page and is documented as saying "This was a very serious accident, life threatening. It's good (R18) was sent out to the hospital." Further review of the nurse's notes indicates on 6/22/07 at 3:50am, R18 was noted on the floor in her bedroom in a sitting position. On 12/13/07 at 3:07am, R18 was observed sitting on her buttocks next to her bed. R18 told the nurse she attempted to get up by herself. Review of the risk form injury care plan with problem dates of 4/23/07, 7/19/07 and 10/15/07	F9999		

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did not show the falls of 5/28, 6/22 and 12/13/07 were addressed, and the goals and approaches were not updated.

3. The surveyor reviewed the facility's incident reports for the last 6 months. The following incident reports were found involving R15, who has Parkinson's disease:

-2/6/08 at 12:00pm, unwitnessed fall, resident was in room observed on floor on side of bed, floor dry, and chair alarm did not sound. No apparent injury. Intervention: Physical therapy screened 2/6/08 and recommended custom wheel chair to address posture concerns and use of recliner geriatric chair with tray, until wheel chair comes in, to maintain resident safety.
-2/2/08 at 5:00pm, unwitnessed fall, resident was observed lying on his bed room floor next to his wheel chair and his left hand was under his buttocks. Resident's personal alarm was in use and sounded. CNA (certified nurse aide) responded to the alarm. The nurse assessed resident and his 5th digit of his left hand was displaced. The resident was transferred to the hospital.
-12/24/07 at 12:30pm, unwitnessed fall, resident was sitting in wheel chair in hall way reached over to pick up an object from floor and fell out of wheel chair. No apparent injury. Chair alarm in use. Incident report statement stated Resident was sitting in wheel chair with alarm in place on carpeted hallway. Reached over to pick up something from floor and fell out of chair. Alarm sounded. No new interventions indicated.
-12/17/07 at 4:15pm, unwitnessed fall, resident stated he was trying to get into his wheel chair from side of bed, when he slid to floor. No apparent injury. Chair and bed alarm in use.

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F9999	Continued From page 42 Report statement by staff stated, yes, alarm was in use but it did not sound because he wasn't far enough for it to be released. No new interventions indicated. -12/12/07 at 11:25am, unwitnessed fall, resident observed on floor in front of bed lying on left side. No injury. Chair alarm in use but did not sound because the pull cord pulled off resident's shirt. Reason for the fall: resident dropped candy wrapper on floor and attempted to retrieve. Intervention: staff to check area for items on floor before they leave his room and pick them up. -12/9/07 at 4:00pm, unwitnessed fall, resident observed on floor next to bed, sitting on buttock. No apparent injury. No alarm sounded because there is not one. No interventions indicated on follow-up report or assessments. -12/7/07 at 3:00pm, unwitnessed fall, resident was observed on floor by his roommate. Roommate hit nurses button to notify nurse. No apparent injury. Resident self transferred to get food family left. Intervention : staff to ask him if he needs anything from the refrigerator before leaving room. No alarm indicated in use or sounding. -11/5/07 at 7:30pm, unwitnessed fall, resident observed on his knees on the floor in his room. Resident was assessed and he sustained a 4cm (centimeter) by 0.5 cm open area to the top of his head. There was minimum bleeding noted from area. Resident sent out to hospital and returned 11/6/07 with staples to the area. Intervention: none new. Continue to check for dropped items and to put call light on for assistance. -10/3/07 at 7:30pm, unwitnessed fall, resident observed on the floor on his right knee and had his right hand on his fore head. Resident was assessed and he sustained a 6cm long and 1.5 cm wide laceration to his forehead. Resident was	F9999		

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F9999	Continued From page 43 sent to hospital and returned with sutures and a diagnosis of head injury with laceration. Intervention bed and chair alarm to continue. Incident report stated, Protective device; chair alarm. Not in use- takes off , resident gets up ab lib. (as desired). -9/28/07 at 1:30pm, unwitnessed fall, noticed on floor on buttock. No apparent injury. Resident stated he was trying to get his chess game from the top of refrigerator. Intervention: Resident is to ask for assistance, have Occupational therapy to evaluate for walking balance. -9/21/07 at 9:05am, unwitnessed fall, observed on floor on hands and knees in front of chair. Resident was given a grabber by occupational therapy and refuses to use it. Resident claimed he bent down to pick up candy from floor and fell from chair. Interventions: resident instructed to call staff for help to pick up things when he drops them. -9/15/07 at 11:00am, unwitnessed fall, housekeeping staff observed resident on the floor in kneeling position. Resident claimed he knelt down to pick up the grapes on the floor. No apparent injury. No protective device. Intervention: resident reminded not to pick anything out from the floor and to ask for assistance. On 2/27/08 the surveyor observed R15 in the main dining room. R15 was positioned in a reclining geriatric chair approximately one foot from a dining table. R15 was positioned in the up position (90 degree). No additional device was observed in the chair or attached to the resident. At 10:00am the surveyor observed one activity staff in the area. R15's chair was not facing this staff. On 02/27/08 at 12:00pm and 12:32pm, the surveyor observed R15 in the main dining room.	F9999		

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At both times, R15 was positioned in the geriatric chair in a non-reclined position. No devices were attached to the resident or the chair. The surveyor attempted to have a conversation with the resident, but no response was given to surveyor.

The surveyor reviewed R15's record and noted a physician's order dated 2/7/2008 for up in reclining geriatric chair with tray for resident's safety. The care plan was reviewed with start date of 12/7/07 with a goal to reduce the risk of falling and allow resident to be free of fall- related injuries by next review of 3/7/08. Since this care plan, R15 experienced an additional six falls. The interventions included reevaluation from therapy for use of wedge cushion & non-slip mat, staff checking floor, and asking if he wanted anything before leaving the room (12/24, 12/22, 12/17, 12/7/07). The last one was for 2/7/08 which was the use of geriatric chair with tray.

On 2/28/08 at 10:00am E7 (care plan coordinator) told the surveyor interventions were changed for each fall and the dates were indicated in the care plan under approaches. No interventions were indicated for the fall of 12/9/07 and 2/2/08 which included an injury of a fracture of 5th proximal finger of the left hand.

On 2/28/2008 at the daily status meeting, the surveyor asked how the facility evaluated the effectiveness of the interventions for R15's fall prevention and no evidence was presented. The personal alarm was not used properly and was not effective to prevent R15 from falling again. Surveyor observations confirmed care plan interventions were not consistently implemented for R15.

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F9999	Continued From page 45 4. R14 is a hospice resident. R14's last assessment dated 2/1/08 indicated R14 has a severely impaired cognitive status. The surveyor, on 2/25/08 at 3:00pm, attempted to communicate with R14 while visiting with the resident. The surveyor entered the room because R14 was yelling out for help. R14 was observed to be laying on a low bed. An alarm was observed attached to the top-back portion of R14's garment and the top (headboard) part of the bed. The surveyor did intermittent observations of R14 from 3:00pm to 4:00pm, while R14 was in the low bed. No staff entered the room during the observation. R14 was observed moving her feet and lower leg over the right side of the bed. The bed alarm cord was long and did not sound because the resident's upper body was not leaning out the bed. The following information was found on review of the facility's incident reports: -12/23/07 at 7:30pm, unwitnessed fall. Found resident on floor lying on stomach in front of geriatric chair. -10/13/07 at 9:15am, unwitnessed fall. Resident was observed on floor on side of her bed lying on right side. Skin tear indicated but location not documented. The use of triple antibiotic ointment and Band-Aid applied to area. Has use of a bed/chair alarm. However, no documentation if staff was alerted. No investigation was documented to address why R14 was found on the floor. However, the incident was documented. -10/30/07 at 1:25am, unwitnessed fall. Yes, the alarm sounded resident was on the floor. No the floor was not wet. Yes, she was incontinent in the	F9999		

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F9999	Continued From page 46 middle of the floor on her right side. According to staff the alarm was heard and the staff found R14 on the floor. R14 was sent to the hospital for evaluation. The hospital records indicated R14 had a head laceration. On 2/28/08 the surveyor gathered information from E15 (minimum data set / MDS coordinator) which indicated R14 had a fall on 10/25/07. E15 presented nursing documentation dated 10/25/07 indicating a fall. E1 and E2 were informed about this information and the surveyor asked for a incident report. E2 informed the surveyor the fall took place on 10/24/07 and no incident report could be found. The surveyor was not provided with any evidence of the fall being investigated. The surveyor reviewed R14's care plan with a start date of 10/31/07 and a goal target date of 1/31/08. There was no change in the interventions initiated on 10/31/07 to indicate the care plan was modified before the fall on 12/23/07. The facility was unable to demonstrate they were tracking and investigating each of R14's falls, since the staff was unable to retrieve an incident report of a documented fall in 10/07. 5. R1 is an 88 year old with diagnoses that include: Dementia, Syncope, Congestive Heart Failure and Osteoporosis. Medications include: Aspirin, Digitek, Furosemide, Plavix and Megace. Review of R1's current quarterly MDS scores R1 as a 1 for cognition (modified independence) and a history of falls.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145779	A. BUILDING ______ B. WING ______	03/04/2008

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F9999	Continued From page 47	F9999		

Continued From page 47

Review of the facility's Incident and Accident Reports faxed to the state agency documents that on 11/14/07 R1 was observed lying on her side on the floor outside of her room. R1 sustained a laceration to the back of her head with a moderate amount of bleeding. R1's physician was notified and ordered R1 to be transferred to the emergency room for evaluation and treatment. R1 returned to the facility the same day with the diagnosis of scalp laceration and staples to the left side of her head.

Review of the facility's Incident Summary, dated 11/14/07, documents R1 had a protective device in use (chair/bed) at the time of the incident due to fall risk. Review of the facility's Incident Report Statement dated 11/14/07 states: "Alarm was not in use." E14 (Nurse) confirmed during interview that R1's bed alarm was not in use at the time of the fall.

Further review of the facility's Incident and Accident Reports document that R1 had fallen numerous times in addition to the fall on 11/14/07. On 05/8/07 R1 stood up in the dining room and fell to the floor. R1 was transferred to the hospital for evaluation and treatment after this fall. X-rays of the right shoulder indicated a fracture of the distal clavicle. On 7/1/07, R1 fell while ambulating with her walker into the dining room. X-rays of the hips and pelvis were ordered as a precaution for R1's complaining of pain to buttocks and lower back.

R1's care plans were not updated after any of the above falls and assessments were not done to determine the appropriate interventions after these falls. R1's care plan was not updated until 1/8/08 with the following intervention:

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F9999	Continued From page 48 "Wheelchair alarm at all times when up in chair to alert staff of unassisted transfers. Monitor for use and function every shift." Review of R1's Fall Risk Assessment (dated 11/14/07) scores R1 as 14. Total score of 10 or above represents HIGH RISK. R1 had previously scores of 10 and 12 prior to the fall on 11/14/07. 6. R12 is an 84 year old with diagnoses that include: End Stage Cardiovascular Disease and Seizures. Review of R12's current MDS (quarterly 01/17/08) scores R12 as 2 for cognition (moderately impaired...decisions poor, cues/supervision required) and a history of falls within the last 30 days. Review of the facility's Incident and Accident Reports documents that on 2/13/08 R12 was observed lying on the floor next her assigned seat in the main dining room. R12 was sent to the emergency room for evaluation and treatment of a laceration to the right side of her head. R12 returned to the facility with 5 staples to the lacerated area. Review of R12's medical record included an outdated care plan (10/31/07-01/31/08) for: "Resident at risk for falling related to inadequate standing balance and use of diuretic and antidepressant." The last time the care plan was updated was on 1/29/08 with the following intervention: "Wheelchair/bed alarm at all times when in wheel chair and bed to alert staff of unassisted transfer. Monitor for use and function every shift." R12 was not re-assessed after her fall nor was her care plan updated for more appropriate interventions.	F9999		

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F9999	Continued From page 49 7. R13 is a 74 year old with diagnoses that include: Renal disease, Hypertension and Diabetes. Review of the Event Report in R13's medical record documents the following incident on 02/19/08: "Observed resident on floor in room. Stated she was adjusting her tray table and slipped. Patient stated she only had on regular socks and not her gripper ones..." Review of R13's current care plan (2/20/08-5/20/08) shows "Potential for fall injury from falls related to poor balance, decreased cognition and history of fall." While R13's care plan was updated on 2/26/08, the intervention is not appropriate to the fall...."Family member inserviced in proper use of gait belt to be used while walking with resident." Ensuring adequate non-slip footwear is worn was already listed as an intervention, however that intervention was not reinforced. (A)	F9999		