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F 364	Continued From page 32 methods that conserve the nutritive value and appearance. Findings include: Observation during the lunch trayline for two days showed that vegetables were prepared with a large amount of water that affects the nutrients and appearance of the vegetables. 1) On 6/9/08 at 12:15 PM, surveyor observed lunch tray line in the second floor dining room. E17 (Dietary Aide) took the temperature of the food in the steam table. When E17 was done, surveyor asked her to also take the temperature of the soup. E17 stated that there was no soup and it was peas and mushrooms, the vegetables being served to the residents. The pan with these vegetables was half full of water. The color looked pale and unappetizing. Interview with E16 who was in the dining room during this observation, stated that the residents prefer well cooked vegetables. Surveyor emphasized to E16 the importance of maintaining the nutritive value and appearance of the vegetables. 2) On 6/10/08 at 12:10 PM, surveyor observed lunch tray line in the first floor dining room. In the steam table there was a pan of green beans covered with water. The green beans also looked very pale in color. The facility failed to prepare the vegetables by a method that conserves the nutrients and appearance.	F 364		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS	F9999		

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300.1210a)
300.1210b)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.
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.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Requirements were not met as evidenced by:

Based on record review and interviews the facility failed to assure that one of three residents in the sample, R22, was appropriately assessed and received timely medical care when a significant

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change in condition was observed. Between 4:00a.m. & 7:20a.m., R22 had six falls, slurred speech and was found with several medication vials; some with the caps off. No vital signs or assessments were documented for any of these incidents. An order for R22 to be sent to the hospital was not obtained until 7:15a.m. R22 was found without vital signs at 7:20a.m. and pronounced dead at 7:32a.m. by paramedics. These failures resulted in the delay of R22 receiving treatment and death.

In addition, the facility failed to provide timely care for two residents in the sample in the areas of respiratory care and pain medication administration, R5 & R21.

Findings include:

1. R22 was admitted to the facility on 04/15/08 for occupational and physical therapy. R22's diagnoses include osteogenesis imperfecta, abnormal posture, sacroiliac pain. History indicated R22 had a possible opiate abuse. R22 was assessed by psychiatrist on 04/24/08. Impressions were atypical depression, rule out adjustment disorder and opiate dependence. Current medications include acetaminophen with hydrocodone every four hours as needed, Duragesic Patch 125mcg/hour every three days, morphine sulfate 5mg. at 9:00p.m., Norco 325/10mg. every four hours, Abilify 5mg. at 9a.m., Xanax 0.5mg four times daily and Trazodone 50mg. at 9:00p.m

R22 was 54 years old. R22 was scheduled for discharge from facility on 05/05/08.
Nurses note of 05/03/08 3:00p.m. to 11:00p.m. states R22 in bed, then in wheelchair asking for

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all her medications. That has been going on all during the shift. R22 up to nurses station every two hours for Xanax, Vicodin or Morphine. R22 doesn't even state pain anymore just the need for med because it's time. This note was written by E15 (Staff Nurse).

Documents indicated R22 received the following medications prior to the following incidents of 05/04/08: 05/03/08 Abilify 5mg., Roxanol 5mg. and Trazodone 50mg at 9:00p.m., 05/04/08 Xanax 0.5mg. and Roxanol 5mg. at 12:00a.m. and Norco325/10mg. at 2:00a.m. Nurses note of 05/04/08 at 2:00a.m. states R22 received all medications that were due but resident always appearing "stoned." Vital signs are stable but low, will continue to monitor.

Note at 4:00a.m. by E15 states R22 yelling, observed patient hanging onto bed rail between wheelchair, floor and bed. R22 with slurred speech and gaze. Statement written by E15 indicate he lifted R22 back to bed.

Note at 4:30a.m. by E15 states he went back into R22's room and found R22 in the same position as at 4:00a.m.. On the floor was a cloth tote bag with four prescription medicine vials spilled out on the floor. Three vials were empty and one had 30 white tablets, one different white tablet, 30 peach tablets and four pink oblong tablets. Physician was notified however notes of 06:30a.m. state awaiting return call by physician.

Notes of 6:45a.m. by E15 state R22 found on floor lying next to bed, placed back to bed with two staff. Notes of 06:55a.m. by E15 state R22 calling for help, went to see R22 and was on the floor again. R22 has placed herself on the floor or

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F9999	Continued From page 36 she has fallen, but in same position both times. Note of 07:05a.m. by E15 states R22 again on floor and calling. Note of 07:15a.m. by E15 states physician called and ordered R22 to be sent to the emergency room for evaluation of possible overdose. Note of 07:20a.m. by E15 states went into R22's room, found R22 lying face sideways in pool of dark blackish fluid. Called Code Blue, called 911, started cardio-pulmonary resuscitation, chest compressions, oxygen and suctioned oral cavity. Note of 07:23a.m. by E15 states Fire Department paramedics arrived, R22 in asystole, R22 never had pulse or respirations. Note of 07:32a.m. by E15 states Paramedics called code off. R22 in asystole. Paramedic notified Chicago Police Department due to medications being found. Between 4:00a.m. and 7:20a.m., R22 had six falls, slurred speech and was found with several medications. No vital signs or assessments were documented for any of these incidents. An order for R22 to be sent to the hospital was not obtained until 07:15a.m. R22 was found without vital signs at 7:20a.m. and pronounced dead at 07:32a.m. by paramedics. 2. R21 was readmitted to the facility on 03/19/08 with the following diagnosis: Chronic Obstructive Pulmonary Disease, Shingles, Isolation and Congestive Heart Failure. On June 10, 2008 at 5:00pm, R21 complained of shortness of breath and was given a nebulizer treatment. R21's condition was noted to improve, however at 10:00pm the resident was noted to be diaphoretic with an elevated blood pressure and abdominal breathing. At 11:30pm, the physician called back and gave orders to send the resident to the	F9999		

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emergency room for evaluation. At 12:15am the resident was transported via regular ambulance to the hospital and was admitted to the hospital for respiratory distress. The facility failed to document R21's response to treatment and act when the resident's vital signs were noted to change significantly. It took over two hours for R21 to be transported to the hospital after showing a significant change in condition.

3. Nursing notes for R5 dated 5/16/08 at 10:00pm stated that the resident was assessed and found to have bruises at the left inner thigh and right leg with swelling. The resident was complaining of pain upon examination. Resident denied falling from bed and CNA (Certified Nursing Assistant) denied that the resident had slid from her wheelchair. X-Ray done on 5/17/08 revealed a distal femur fracture and the resident was sent out to the hospital for treatment on 5/18/08.

POS dated 5/16/08 states only to order a x-ray of the lower extremities. The resident had a order for Tylenol 650mg every four hours as needed for pain. The Medication Administration Record (MAR) for May 16-18 showed that no pain medication was given to the resident before or after the fracture was identified. There is no documentation to show that the resident was assessed for pain, offered pain medication or given any type of comfort measures.

(A)

300.1210a)
300.1210b)6)
300.1220b)2)3)
300.3240a)

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Section 300.1210 General Requirements for Nursing and Personal Care
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.

Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.
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.

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Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Requirements were not met as evidenced by:

Based on observation, interview, review of policies and procedures, and clinical record review, the facility failed to ensure that six residents were supervised to prevent falls; to address the increased amount of falls per month or the types of interventions being taken to decrease the number of falls; to have in place an effective fall program that included identification of residents at risk for falls, updated assessments, care plans, interventions, monitoring, documentation of any interventions tried, and follow-up to assess the effectiveness of any interventions tried and to provide effective training to all staff on falls and fall prevention. These failures resulted in six residents in the sample (R3, R8, R10, R12, R14 & R15) who sustained multiple falls that resulted in injuries or the potential for further injuries.

Findings include:

1. During the annual survey from 6/9-6/12/08, incident reports were reviewed from January 2008 to May 31, 2008. The following is the number of falls documented for each month: January = 20, February = 27, March = 19, April = 21 and May = 23. There were also 10 falls that were reported to the state agency where the residents were sent out for evaluation to the hospital and five residents sustained injuries that

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required treatment. No revision of the facility's fall prevention policy was found; no explanation was given by E1 or E2 as to why the facility has so many falls, why this rise in falls was not addressed or why the fall program was not updated or revised.

2. R14 is a 74 year old resident with the following diagnosis: Syncopal Episode, History of Facial Laceration and Contusion, Anemia and Cataract. R14 was noted to have a history of alcohol abuse.

R14 was noted with the following fall incidents:
10-13-07 at 9:55pm fell in the hallway. Nursing notes state, "resident fell shortly after taking a bath." "Long history of falls and facial laceration...please page physician and family in the morning." A review of the nursing notes indicate that the physician was not notified of the incident.

11-17-07 at 12:45pm, R14 fell in the room. The resident was noted to hit the left side of the forehead and had a moderate size lump. Resident was noted to vomit after the incident. The physician was notified and ordered a Physical Therapy evaluation. The family was notified and stated, "he has a drinking history."

2-3-08 at 3:30pm, R14 was noted on the floor in the bathroom, the physician was notified of the fall.

5-09-08 at 3:00pm, R14 was reported to have fallen on the street and was noted with an abrasion on his forehead.

5-29-08 at 6:00pm, R14 was noted sitting on the

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floor in front of the elevator. During this episode, R14 was noted with jerky movements. The physician was notified and ordered an EEG. The resident was noted with continued movements and at 10:35pm, the physician ordered R14 transferred to the hospital for an evaluation. During this time, a wound was noted on his head. Nursing notes stated, "Wound noted on the head...asked the resident how he sustained the wound and he stated he fell again on the way to the toilet." At 11:45pm, R14 was transferred to the hospital. R14 returned from the hospital on 5-30-08 and was noted with a wound on the occipital area.

6-5-08 at 1:30pm, R14 left the building without permission and fell in the community. R14 was taken to the Emergency Room and was treated. R14 required sutures to the forehead and had a wound on the bridge of his nose.

6-6-08 at 6:55pm, R14 stated he fell in bathroom on his buttocks. The physician was notified and ordered R14 to be evaluated by physical therapy for gait and balance training.

On 4-1-08, R14 was moved from the first floor to the third floor. According to E12 (Activity Director), E10 (Infection Coordinator) and E9, R14 had been moved due to his increasing care needs and increased number of falls. In addition, on 5/31/08, R14 was placed in contact isolation for a Methicillin Resistant Staph Aureus (MRSA) of the nares.

A review of the care plan dated 4-14-08 indicated that the fall care plan for R14 had not been revised. In addition, Z1 (Physician) stated during phone interview of 6/11/08 that R14 should not

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be allowed to leave the building. Z1 confirmed that R14's condition had declined physically and that he would be sent out to the hospital for additional evaluation. R14 stated during the interview of 6-11-08 that he, "fell more inside the building" and "the wind pushed me down 6-5-08."

The facility failed to update and revise R14's plan of care after numerous falls with injuries. The facility failed to supervise R14 to prevent him from leaving the facility without an escort after a change in his physical ability. R14 sustained a head injury that required outside care.

3. R15 is an 82 year old resident with a noted problem in ambulation and gait. R15 had a fall in December of 2007 and had been deemed to be at low risk for falls however, R15's MDS assessment dated 4-7-08 indicated that R15 had an unsteady gait and impaired balance. R15 was noted on 6-9-08 to fall in his room at 9:30am. R15 was noted with a large laceration to the head along with bleeding and was transported to the hospital for treatment. R15 was treated and returned to the facility on 6-9-08 at 11:48am with staples on the left temporal area near the left eye.

R15 was observed on 6-9-08 at 1:55pm in his room. R15 was confused and visibly agitated and attempting to leave his room. R15 was noted to be wearing a hospital gown and was in bed with both bilateral side rails in the upright position. R15 was very restless. Surveyor notified a staff member who attempted to calm R15 down. Surveyor returned to R15's room again at 2:15pm and found that R15 was alone in his room, agitated and attempting to leave the bed. R15 was visibly agitated and confused. Surveyor

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pressed the call light and a nursing assistant and E9 responded. E9 stated that she had directed the staff to check on R15 every 10 minutes. E9 left the room and at 2:20pm, R15 was noted to be alone and very agitated. The nurse placed a staff person in the room to monitor R15. The facility did not provide adequate supervision to R15 after he suffered a traumatic head injury that required staples. The facility did not provide a plan for monitoring this resident until prompted by the surveyor.

4. R10 is an 83 year old resident with the following diagnosis: Dementia, Seizures, Osteoporosis and Hyperlipidemia. R10 was assessed on 4/8/08 to be high risk for falls. R10 uses a Velcro belt as an enabler. R10 was noted to fall in the dining room on 6/5/08 and required emergency room services. R10 was in the dining room with her Velcro belt in place at 6:05pm when she fell to the floor. R10 had a lump on her forehead that was still visible during the survey of June 9-11, 2008. During observations of 6-10-08, it was noted that R10 was in the dining room from 9:30am until after 1:00pm in her wheel chair with the belt in place. R10 was noted to be sleeping and leaning forward in her chair during the observations. A review of the plan of care dated 4-9-08 and updated 6-5-08 states, "will increase supervision, put back to bed after dinner." The plan of care as related to falls was not individualized to R10's needs and the interventions have not been adjusted to aid in preventing further incidents.

5. R3 is a 36 year old resident who was admitted to the facility on 3/21/08 with diagnoses of Traumatic brain injury, S/P (status/post) Cranioplasty, ETOH, S/P Epidural hematoma,

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F9999	Continued From page 44 S/P Pneumonia and possible depression. R3 is also legally blind. Observation during the initial tour of the second floor on 6/9/08 at 9:45 AM, showed that R3 was in a wheelchair outside his room with a soft waist belt on and a sensor pad. E14 (Care plan coordinator) stated that R3 is at risk for falls. Review of the facility fall risk assessment dated 3/21/08, showed that R3 is at moderate risk for falls. Review of the nurses notes and incident reports showed that R3 had eight falls since admission. 1) 4/8/08, 2 PM-Resident noted sitting on the floor in front of wheelchair in the room. Resident stated: "I want to go back to bed." There was no apparent injury. 2) 5/17/08, 12:30 PM-Resident noted crawling on the floor next to bed with siderail up. Resident denies pain. No injury noted. 3) 5/19/08, 11 AM-Resident sitting on the floor at the end of his bed. Denies any pain. No injury noted. Resident stated: "I have to go to the bathroom." 4) 5/20/08, 4 AM-Resident found on the floor beside his bed. Per resident, he was trying to go to the bathroom. No injury noted. 5) 5/29/08, 9:30 AM-Resident found on the floor beside bed. Resident stated: "I need to go to the bathroom." No injury noted. 6) 6/1/08, 8:20 PM-Resident was trying to crawl out of bed and fell. A visitor was in the resident's room, who notified the staff about the fall. 7) 6/6/08, 6:20 PM-Resident fell trying to get out of bed. Per nurses notes, resident hit his head on the wall. Had small scratch, but no deep cut on the head. Resident was sent to the hospital emergency room for evaluation, per physician's order. 8) 6/8/08, 11:15 PM-Resident was found on the floor kneeling beside his bed. Resident was trying to go to the bathroom and fell. No injury noted.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145654	A. BUILDING ______ B. WING ______	06/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F9999	Continued From page 45 Review of the care plan for falls for R3, showed that in spite of the multiple falls, the approaches remain the same and the above falls were not addressed. There were no revisions of the care plan to help prevent further falls. This issue was discussed with E14 on 6/9/08, who did not give any further explanation why the care plan was not revisited or revised. Additionally, review of the incident report, dated 5/9/08, showed that E2's final disposition was that R3 "will be placed on scheduled toileting to prevent recurrence." This plan was not added in R3's care plan. Interview with R3 on 6/9/08 at 2:00 PM, in R3's room, revealed that he climbs up the siderails if he wants to get out of bed to go to the washroom. R3 was asked if the staff come right away if he put on the call light. R3 responded: "Sometimes." R3's MDS was scored two under cognition/decision making area, which means moderately impaired. On 6/10/08, the physician ordered "Bed on the floor at all times." 6. R8 is a 51 year old resident who was admitted to the facility on 6/7/07, with multiple diagnoses that include Cirrhosis, Mental status change, Osteoarthritis, Chronic Renal Failure and Degenerative Joint Disease. Review of the nurses notes and incident reports showed that since 11/07, R8 had 15 falls that took place in the room and in the bathroom. Most of the time the reasons for falls were unlocked wheelchair and transfers. Of the 15 falls, there were three incidents with injury as follows: 1) 2/2/08, 3 PM-Resident was transferring from wheelchair to commode, in the bathroom and fell. Resident had discomfort on the right and left hip. X-ray was negative. 2) 3/9/08, 11:24 AM-Resident sitting on the floor. Stated she tried to go to the bathroom	F9999		

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F9999		F9999		

Continued From page 46
and slid off the chair. Resident was noted bleeding with laceration on the left arm. First aid was given. Resident was redirected. Five minutes later, resident fell in the bathroom. Resident was sent to the hospital for evaluation. 3) 4/28/08, 10:30 AM- Resident was found on the floor by staff. Resident sustained a little bump on her forehead.

Review of the facility fall risk assessment dated 3/12/08, showed that R8 was on a low risk for fall. R8 had 11 falls from 11/07 to 3/12/08, but was still considered a low risk for fall per assessment. Review of the care plan for falls showed that since 6/22/07, the approaches were only revised once on 3/6/07. On 6/10/08 at 11:00 AM, at the second floor nursing unit, surveyor discussed the above concerns with E14.

Interview with R8 on 6/10/08 at 11:35 AM, in E2's office revealed that she has a history of a fractured right clavicle and it gets worse when she falls. R8 further stated that her balance is off because she is a liver patient, R8 is alert and oriented.

7. R12 is a 53 year old resident with diagnoses of dementia, mild mental retardation, obesity, hypertension and arteriosclerotic heart disease. R12 was admitted on 4-15-08. Assessment dated 5-20-08, R12 was determined to have an unsteady gait, even with the use of a walker for ambulation.

Record review showed that R12 had several falls since admission. On 5-26-08 at 8:00 A.M., R12 was found on the floor lying on his left side and complained of neck pain. R12 was sent to the hospital and was admitted with diagnoses of fall

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F9999	Continued From page 47 with head injury and roll up syncope. R12 was readmitted on 5-28-08. On 6-3-08, R12 was found lying on the floor close to his bed. R12 stated that he was trying to get up from bed and slipped on the floor. R12 did not have any injury. On 6-6-08, while in the first floor dining room as R12 walked to his chair after looking out of the window, R12 slipped to the floor and landed on his buttocks. No visible injury was noted. After these falls, the facility failed to develop a care plan, failed to reassess the cause of R12's falls and failed to identify the fall risk factors which may have contributed to the falls. 8. Review of the facility's inservice education documentation for nursing staff from 6/07 to 6/08 showed that no inservices regarding falls/fall prevention have been done. (A)	F9999		