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	145699	A. BUILDING _____ B. WING _____	C 07/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERMAN WEST COURT	**1950 LARKIN AVENUE ELGIN, IL 60123**

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F 498	Continued From page 12 Coronary Artery Bypass Graft (CABG), Degenerative Joint Disease (DJD), Mobility Dysfunction, Right Knee Arthroplasty, Left Hip Fracture, Hypertension, Diabetes Mellitis, Chronic Anemia, and Benign Prostate Hypertrophy. R1 was receiving medications for the treatment of Hypertension and pain medications. Staff failed to seek instructions to monitor R1 for his orthostatic hypotension when getting him up from bed to wheel chair and wheel chair to stand him up. The facility based on (Physical Therapy) PT; Occupational Therapy (OT); Fall Risk Assessment; Interdisciplinary Monthly Assessment of Patient Progress (MAPP) evaluations failed to determine the extent of CNAs assistance required to transfer R1. E4 also failed to ensure he clarified with R1's plan of care and with the nurses about extent of assistance required to transfer him.	F 498		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.660e) 300.1210a)5) 300.1210b)6) Section 300.660 Nursing Assistants e) During inspections of the facility, the Department may require nursing assistants to demonstrate competency in the principles, techniques, and procedures covered by the basic nursing assistant training program curriculum	F9999		

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F9999	Continued From page 13 described in 77 Ill. Adm. Code 395, when possible problems in the care provided by aides or other evidences of inadequate training are observed. The State approved manual skills evaluation testing format and forms will be used to determine competency of a nursing assistant when appropriate. Failure to demonstrate competency of the principles, techniques and procedures shall result in the provision of in-service training to the individual by the facility. The in-service training shall address the basic nursing assistant training principles and techniques relative to the procedures in which the nursing assistants are found to be deficient during inspection 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. 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) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:	F9999		

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F9999	Continued From page 14 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, record review, and interview, the facility: 1. Failed to develop and implement interventions to transfer a resident (R1) from wheel chair to toilet safely and to prevent him from falling. 2. Failed to ensure that a Certified Nurse Aide (CNA) E4 monitored R1 to prevent him from falling when transferring him to toilet. 3. Failed to maintain a clutter-free environment to prevent incidents and accidents. 4. Failed to identify fall risk factors including: Orthostatic Hypotension, Gait Stability, Pain, and required staff assistance to transfer R1. 5. Failed to have an effective system to investigate and determine if a resident's accidents were avoidable or not. 6. Failed to evaluate if the facility's system provides an environment that is as hazard-free as possible and minimize the potential harm. As a result: (1) On 6/23/08 at 7:30 a.m. when E4 had R1	F9999		

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F9999	Continued From page 15 stood up from his wheelchair in bathroom and left him unsupervised while R1 was holding on to a grab bar, R1 fell backwards, hit the back of his head on metal arm rest of his wheelchair, and became unresponsive. (2) R1 was sent to the hospital and admitted to the Critical Care Unit with an admission diagnosis of Hypotension. At the hospital Computed Tomography (CT) indicated he had subdural hematoma. R1 underwent Craniotomy to release pressure from subdural hematoma and expired on 6/28/08. This is for 1 of 7 residents in the sample. Findings include: On 6/25/08 the facility reported an incident to the Department involving R1 having fallen on 6/23/08 at 7:30 a.m. R1's admission record indicated he was a 77 year old male admitted to the facility on 6/18/08. R1's diagnoses included status post Coronary Artery Bypass Graft (CABG), Degenerative Joint Disease (DJD), Mobility Dysfunction, Right Knee Arthroplasty, Left Hip Fracture, Hypertension, Diabetes Mellitis, Chronic Anemia, and Benign Prostate Hypertrophy. R1 was receiving medications for the treatment of Hypertension including: Lisinopril 20 mg every 12 hours, Metoprolol 50 mg every 12 hours, Potassium Chloride 20 mEq. every day, and Bumex 2 mg every day. R1 was also receiving Tramadol 50 mg three times daily as needed and Hydrocodone 5/500	F9999		

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F9999	Continued From page 16 one tab every six hours as needed for the treatment of pain. On 6/18/08 when R1 was admitted to the facility from the hospital, the transfer sheet noted his base line vital signs to be: Blood Pressure 148/90, Pulse 73, Respiration 20 and the current vital signs to be: Blood pressure when transferring the vital signs when transferring to be: Blood Pressure 123/59, Pulse 80, Respiration 20. The facility documented the following blood pressure readings: 6/18/08 120/58; 6/19 (illegible); 6/20 102/60; 6/21 88/47 and 105/60; 6/22 113/54; 6/23 88/55. The facility did not have any blood pressure readings for R1 standing, sitting and or lying to determine if he was experiencing any orthostatic hypotension. The facility also did not conduct pain assessment to include cause or the pain site of the pain, if the pain medications were effective to alleviate his pain or if the pain was contributing to his stability when standing on his own. R1's 6/18/08 transfer sheet from the hospital noted he needs two staff assistance to ambulate him. R1's 6/18/08 Interdisciplinary Monthly Assessment of Patient Progress (MAPP) conducted on admission Section-I Mobility / Activities of Daily Living (ADL) transfer and toileting column self performance scored '3' meaning Extensive Assistance while resident performed part of activity. Under the Section Most Staff Support Provided Over All for R1 scored '3' meaning two plus persons physical	F9999		

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F9999	Continued From page 17 assistance. R1's 6/18/08 admission Minimum Data Assessment (MDS) Section G for transfer noted he needed extensive assistance of one person physical assistance. R1's 6/19/08 Physical Therapy (PT) diagnosis noted 'difficulty in walking' and the evaluation showed he needs Moderate to Maximum Assistance for transfers and pivoting. R1's 6/19/08 Occupational Therapy (OT) treatment diagnosis noted 'muscle weakness' and evaluation of ADL status for transfers, and to toilet showed he needed Maximum Assistance. In progress report it was noted 'no significant change with ADL performance noted since the evaluation' and R1 was discontinued from PT/OT due to his falling and hospitalization. R1's Fall Risk Screening done on admission (6/18/08) scored (7) meaning Preventative Fall Precautions needed to be implemented. The fall preventative precautions were not specified. The fall screening tool has a section for scoring Blood Pressure for Orthostatic Hypotension. This section was left blank for R1. It was noted in the screening tool that R1 is receiving Cardiovascular agents, Diuretics, Narcotics and Psychotropics. These medications were not evaluated if they were optimal and not contributing for falling. The fall risk tool also did not evaluate predisposing diagnosis for falls such as Cardiovascular problems and Fractures for R1. R1's Interim Interdisciplinary Care Plan for High Risk for fall secondary to decreased strength and weakness and fall incident dated 6/23/08 intervention section had 19 interventions	F9999		

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F9999	Continued From page 18 common to all: none. These interventions were checked that applied to R1 or none were handwritten that were specific for the prevention of R1's falling. Some of the interventions that were in the care plan: "to monitor for dizziness, vertigo, syncope, postural hypotension, stay within staff vision." These interventions were not implemented nor was R1 monitored on 6/23/08 the day when R1 fell. It was documented in R1's daily Medicare ADLs that he needed extensive support of self and two or more person physical assistance to transfer on 6/18, 6/19, and 6/23/08. On 6/20, 6/21, and 6/22/08 R1 needed extensive support of self and one person physical assistance to transfer. There was no documentation to show which of the decline or improvement of R1's physical functional status warranted to have one staff or two staff assistance to transfer. On 7/7/08 at 1:00 p.m. E4 demonstrated the incident of R1 falling on 6/23/08 in the bathroom (Room 316) when he was taking R1 to bathroom. E4 indicated that on 6/23/08 at 7:30 a.m. he noticed R1 crying in his room when was going to answer a call light for another resident in another room. R1 told him he wanted to go to bathroom. E4 left R1's room saying he will be back after he is done answering the other resident's call light. E4 returned after 15 minutes and transferred R1 from bed to his wheelchair and wheeled the resident to bathroom. In the bathroom E4 stood R1 up facing the bathroom wall by holding the grab bar in front of him by himself. E4 then turned and stood	F9999		

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F9999	Continued From page 19	F9999		

between the sink and R1's back of left side to push the wheelchair out of the bathroom. E4 felt he could not push the chair out because the bed of the other resident was blocking the door and the chair to push out of the room.

E4 then turned his view away from R1. At this time he spontaneously noticed R1 had fallen backwards. R1's right posterior head hit the metal part of the wheelchair arm rest. His neck and back hit the other metal parts of the wheelchair then landed on the floor. E4 stated he tried to hold R1 from falling or to ease him to the floor, but it was too late and also he could not contain him because R1 was too tall and heavy a man.

E4 also stated that he just went by his feeling to transfer R1 by himself, because he transferred R1 in the same way the day before and thought it would be fine. E4 did not know R1 was having any blood pressure, dizziness problems, or how many staff he has to have to transfer R1. In general the CNA's do not get direction as to how many staff they have to use to transfer residents. The CNA's assignments are simply by room numbers.

On 7/7/08 E5 (the Nurse on 6/23/08 morning shift) stated that she is not the one who develops the care plan or tells the CNA's how many staff to use to transfer a resident. On 6/23/08 E4 informed E5 of R1 falling, and she evaluated R1 who was unresponsive, and sent him to the hospital. E5 denied being aware of any evaluation of R1's orthostatic hypotension.

On 7/8/08 Z1 (the attending physician) was interviewed over the telephone. Z1 stated that on 6/18/08 R1 was sent to the facility from the

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F9999	Continued From page 20 hospital status post Quadruple CABG. Within four days after R1's admission to the facility Z1 heard from the Hospital and R1's family that R1 was sent to the hospital after his falling at the facility. At the hospital Z1 took care of R1 in the Critical Care Unit for Hypotension. A CT scan was positive for Subdural Hematoma. R1 had to undergo a Craniotomy to release pressure from Subdural Hematoma. R1 later developed Respiratory Arrest due to his immobility from Craniotomy and Muscle Weakness and expired. Later Z1 learned from the facility that R1 had fallen when a CNA has taken him to bathroom. Due to R1's status post CABG, DJD, Muscle Weakness, Pain related to Arthritis in his legs and neck, Anemia and Hypertension, he would have been unsteady to stand on his legs which put him at risk for falling and required close staff supervision. On 7/8/08 Z2 in the Coroners office was interviewed over the telephone. Z2 stated their office responded to R1's death at the hospital and followed the body to the Funeral Home where multiple pictures of the injuries on R1's body were taklen. Z2, from the information he gathered so far, was sure that R1 died of Subdural Hematoma. Z2 stated he is in the process of receiving information from pertinent sources and will have his report ready for review in a couple weeks. On 7/7/08 facility incident reports for the month of June 2008 were reviewed. There were 24 accidents and incidents in the month of June 2008, of which 22 incidents involved residents being found on the floor unwitnessed by the staff	F9999		

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F9999	Continued From page 21 and sustaining bruises, skin tears, and lacerations. These incidents of residents found on floor and sustaining injuries were not investigated thoroughly to determine the cause and to change interventions to prevent residents from falling again. The facility's current system of post incident follow up (Interdisciplinary Post Fall Assessment) is thorough to include staff and other witness interviews. The physical limitations noted in the post fall follow-up are short, one worded and vague. The examples are unsteady gait, osteoporosis, dementia, blank spaces, should be up with assistance only. The Care Plan Decision section in post-fall follow-up was left blank. There was system to evaluate environmental hazards that could cause potential harm. E1 (the facility Administrator) stated that the facility currently does not have a Director of Nurses since December 2007. E2 (the Acting Director of Nurses) and E3 (the designated falls investigator) are supposed to investigate the incidents, but E3 quit her job at the facility a couple weeks ago. The facility policy and procedures for fall was reviewed. The policy and procedure was developed in 1991, signed by the Administrator and Director of Nurses as updated in 2007. The Policy and Procedure does not include details of assessment and investigation of incidents. The facility Medical Director was not part of the team for the development of policy and procedure. The Administrator stated he will consult with the Medical Director to revise the Policy and Procedure. (A)	F9999		