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ADDOLORATA VILLA	**555 MCHENRY ROAD WHEELING, IL 60090**

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F 309	Continued From page 21 "Incidents" to include directive to revise resident care plan as appropriate after incidents. 4. Renamed policy entitled "Change in Resident's Condition or Status" to "Physician Notification - Change in Resident Condition or Status." 5. Facility has identified recent falls with injury within the last 7 days and assessed resident for change in condition. Identified resident care plans have been updated initially 5/4/09 and will be completed 5/5/09 by Nurse manager. This will be ongoing as necessary. 6. Quality Assurance: the Director of Nursing, or her designee, will review each incident report involving resident injury for the next three months to ensure that: 1. Comprehensive assessment completed by Licensed Nurse. 2. In case of head injury, appropriate completion of Neurological checks. 3. Physician notified as appropriate; thorough follow through to physician orders. 4. Results of these audits will be identified and reviewed on a case-by-case basis as they occur. Monthly, the issue will be reviewed and discussed in the facility Performance Improvement Committee meeting.	F 309		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)3) 300.3240a)	F9999		

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F9999	Continued From page 22 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: 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. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on record reviews and interviews the facility neglected to adequately assesst (R1) after a fall incident on 3/24/09. The facility neglected to notify the physician of R1's neurological	F9999		

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F9999	Continued From page 23	F9999		

decline and failed to follow the policy regarding change in resident's condition. R1 showed a change in the neurological status and change in the condition of the injured left eye. This failure resulted in R1 having a 33-hour delay in medical treatment and needing hospital care.

R1's left eye swelling and bruising progressed to the extent that the staff was unable to open the left eye to check for eye and pupil response within 24 hours post fall. R1 was sent to the hospital on 3/26/09 due to mental status change. R1 was admitted to the hospital with diagnoses of Cervical fracture and Brain bleed.

Findings include:

R1 is an 83 year old resident with multiple diagnoses including Dementia with agitation, difficulty in walking and acute MI (myocardial infarction). Review of R1's quarterly assessment dated 2/22/09 showed that the resident is severely impaired with cognition, and required limited assistance x 1 person physical assist for bed mobility, transfers and ambulation. R1's assessment also showed that the resident had a problem with standing balance and the wheelchair was the resident's primary mode of locomotion.

Review of the facility incident report dated 3/24/09 (10:15 PM) showed, "Description of Incident: Resident was sitting across from nurses' station. Nurse was working at the desk. She heard the chair alarm go off and when she looked up, resident was on the floor on her left side."

"Resolution/Final Resident Outcome: Resident

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F9999	Continued From page 24 initially assessed at time on incident and found with laceration to lateral orbit and some facial swelling and bruising starting. Assessed resident back to a recliner chair and first aid administered. On 3/25/09, resident was responding, and eating, with negative neuro checks. On the morning of 3/26/09, resident was noted to be more lethargic and sent to NWCH ER for evaluation. resident was admitted with a brain bleed and cervical fracture." Review of R1's neurological assessment showed the following documentation: - 3/24/09 (11 PM) - left pupil, "Sl." Eye response, open spontaneously- checked. - 3/25/09 (12:05 PM) - left pupil, "Sl." Eye response, open spontaneously- checked. - 3/25/09 (1 AM) - left pupil, "*." Eye response, open spontaneously- checked. - 3/25/09 (2 AM) - left pupil, "*." Eye response, open spontaneously- checked. - 3/25/09 (3 AM) - left pupil, "*." Eye response, open spontaneously- checked. - 3/25/09 (4 AM) - left pupil, "*." Eye response, open spontaneously- checked. - 3/25/09 (6 AM) - left pupil, "*." Eye response, open spontaneously- checked. - 3/25/09 (10 AM) - left pupil, "C." Eye response, open spontaneously- checked "R." - 3/25/09 (2 PM) - left pupil, "C." Eye response, open spontaneously- not marked. - 3/25/09 (6:15 PM) - left pupil, "*.) Eye response, open spontaneously- checked. - "Comments: Left pupil sluggish, after 1 AM unable to check due to swelling." Based on this neurological assessment documentation, the facility assessed R1, 45 minutes post fall, then every hour for 5 hours and	F9999		

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F9999	Continued From page 25 then two to fours hours thereafter. The facility assessed R1's neurological status 10 times within 19 hours post fall. Review of R1's computerized nurses' notes showed the following documentation: - 3/25/09 (3:21:26 AM), "Res. with normal restless behaviors, attempting to get out of bed, Taken to toilet several times with success and taken to TV lounge, reclining chair for closer observation at 12:20 am. Res. denies pain, swelling continues into left eye area with left eye unable to open for pupil response by 1am. res. continues to refuse to keep cold ice pack over left forehead. At 2 am tylenol ES one tablet given even though res. denies pain, is restless and grimaces at times when repositioning self in chair." - 3/25/09 (6:15:59 AM), "Res. restless all night, another tylenol ES given at 4am (order is for 1-2 tabs, one tab given at 2am) res. attempting to get out reclining chair, out of w/c (wheelchair), returned to bed for HHN treatment and attempted to get out of bed. Res. gives no requests, toileted, given fluids, needing 1:1 care, did not give ativan the normal med for these behaviors due to fall and could mask any symptoms. Res. with normal vitals, bruising continues to spread over left forehead, left eye and now noted on left shoulder-normal ROM with no pain noted." - 3/25/09 (10:59:45 PM) showed a late entry documentation stating, "On 3/24/2009 at 11:31 PM return call recd (received), from Z1 with no new orders noted. Except for Neuro check per protocol and monitor closely. In case of any abnormal findings call Z1. Report informed to on duty nurse of 11 - 7 shift and informed by her that	F9999		

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F9999	Continued From page 26 she already talked with Z1." Review of R1's POS (Physician order sheet) showed, "(Late entry 3/25/09) Neuro check per protocol & monitor closely. In case of any abnormal findings. Call Z1." Review of R1's POS dated 3/1/09 through 3/31/09 showed orders for Aspirin 81 mg, 1 tablet daily and Plavix 75 mg, 1 tablet daily. During interviews held inside the first floor sitting room on 4/30/09 from 2:35 PM through 3:10 PM, E5 (nurse) stated that on 3/24/09 at 10:15 PM, she heard a wheelchair alarm go off while she was in the nursing station doing computer charting. E5 stated that she immediately went around the nursing station and saw R1 on the floor in front of the nursing station, on a left side laying position. Upon assessment, E5 stated that she noted a bump on R1's forehead (left side) and scrape skin without bleeding on the resident's left forearm. Per E5, there was no redness or eye swelling noted, R1's extremities were within normal range and the resident was able to walk and go back to the wheelchair with assistance from the staff. E5 stated that she attempted to call Z1 (physician) twice without response and on the 3rd call at around 11:30 PM on 3/24/09, Z1 responded. Per E5, she informed Z1 of R1's fall incident and the bump that was observed on the resident's left forehead area. Z1 told E5 to monitor and continue neuro checks and to call the physician (Z1) for anything abnormal. E5 stated that at the time she talked to Z1, R1 did not have any left eye injury, bruising or swelling. Per E5 she informed E4 (incoming nurse) about the fall incident and about Z1 being aware of the incident and the order to do neuro checks, monitor for behavior and to call the	F9999		

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F9999	Continued From page 27 physician for any abnormal findings/assessment per neurological assessment. E5 informed the surveyor that she made late entry documentation on R1's nurses' notes on 3/25/09, because she (E5) was leaving when Z1 returned her call on 3/24/09 (post R1 incident). E5 stated that she called E4 after talking to Z1 on 3/24/09 and informed E4 about Z1's order to do neurological assessment per facility protocol for R1 and to call the physician for any abnormal findings/assessment. During a phone interview held on 4/30/09 from 12:16 PM through 12:42 PM, E4 stated that she worked on 3/24/09 from 10:30 PM through 7:00 PM and was the nurse assigned for R1. E4 stated that on 3/24/09, she arrived in the unit early at around 10:15 PM. Per E4, she was informed by out going nurse (E5) that R1 fell, sustained abrasion on the left forehead and an ice pack was applied. Per E4, she was informed by E5 that R1's ROM (range of motion) on all extremities were within normal limits. Per E4, she was informed by E5 that Z1 was called several times to report the incident but without response. E4 stated that after E5 left the unit, she (E4) called Z1 to inform him of R1's incident, but was informed by Z1 that he already spoke with the nurse and was informed of the incident. E4 stated that Z1 told her to continue monitoring R1. During the same interview, E4 stated that sometime during her shift on 3/24/09 (10:30 PM - 7:00 PM), E5 called and informed her that she (E5) spoke with Z1 prior to leaving the facility on 3/24/09. E5 informed E4 that Z1 did not make any orders for R1. Further interview of E4 stated that she first saw R1 on 3/24/09 at around 10:30 PM, R1 was in bed awake and the ice pack was off because the resident refused to have it on .	F9999		

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Per E4, she saw R1 with swelling and redness on the left side of the forehead towards the left eye. Per E4, during this observation, R1 was still able to open both eyes. E4 stated that R1's left pupil was sluggish at the time of observation on 3/24/09 at 11:00 PM (which was 45 minutes post fall incident) and on 3/25/09 at 12:05 AM as documented in the neurological assessment written as "Sl." Per E4, she was not able to check R1's left eye pupil for response to complete the neurological assessment on 3/25/09 at 1:00 AM, because the resident's left eye was closed and swollen. E4 told the surveyor that the "*" documented on the neurological assessment dated 3/25/09 at 1:00 AM, 2:00 AM, 3:00 AM, 4:00 AM and 6:00 AM, meant not able to check the left pupil due to swelling of the eye. E4 acknowledged that the neurological assessment of R1 was not complete because the resident's left pupil response was not assessed. E4 also stated that she did not call Z1 to inform the physician of R1's sluggish left pupil response. E4 further acknowledged that she did not call Z1 when R1 showed signs and symptoms of pain (grimacing) when repositioning self in the chair and when R1's bruise spread over the resident's left forehead, left eye and left shoulder.

During interviews held inside the first floor sitting room on 4/30/09 from 11:10 AM through 11:40 AM, E3 (nurse) stated that she worked on 3/25/09 during the 6:30 AM through 3:00 PM and was the nurse assigned to take care of R1. E3 reviewed R1's neurological assessment sheet and confirmed that on 3/25/09 at 10:00 AM, R1's left eyelid was swollen, therefore was not able to see the left eye pupil. E3 stated, "I did not open the left eye lid because of the swelling. I was

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F9999	Continued From page 29 afraid to open it to worsen the condition of the left eye." E3 told the surveyor that she did not do the test for R1's left pupil response because the eyelid was closed due to swelling. Per E3 she documented this observation on the neurological assessment sheet under left pupil response as "C" indicating the eye lid was closed. During the same interview, E3 acknowledged that she did not call R1's physician to inform him that a complete/comprehensive neurological assessment could not be performed due to the worsening condition of the resident's left eye. During another interview held on 5/7/09 at 10:46 AM via phone, E3 stated that she paged Z1 on 3/26/09 at around 8:45 AM to inform the physician of R1's mental status change. Per E3, Z2 (covering physician) responded on 3/26/09 at around 9:00 AM and gave the order to send the resident to the hospital for evaluation. Review of the facility policy regarding Change in a resident's condition or status showed, "Policy Statement - Our facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's condition and/or status." "Policy Interpretation and Implementation - 1. The nurse Supervisor will notify the resident's attending physician when: b. There is a significant change in the resident's physical, mental or psychosocial status." During interviews held inside the first floor sitting room on 4/30/09 at 2:00 PM, E2 (Director of Nursing) stated that the facility uses a standardized form to perform neurological assessment of residents post fall. Review of the standardized neurological assessment form used by the facility for R1 (post fall incident) showed,	F9999		

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"Instructions: Complete form and describe any neurological problems in comments. Frequency per facility policy." E2 was asked regarding the facility policy for frequency of monitoring residents post fall. E2 responded that the facility does not have any policy and or protocol in place regarding frequency of neurological assessment monitoring. E2 stated that the standard nursing practice and the expected neurological assessment frequency are as follows: every 15 minutes for 1 hour post fall incident, every 30 minutes for 2 hours and every hour thereafter for the first 24 hours and then every shift until 3 days or 72 hours post fall. E2 stated that this frequency of neurological monitoring should have been followed by the nurses.

During interview held inside the first floor sitting room on 3/30/09 from 3:20 PM through 3:35 PM, Z1 stated that he received a call from the facility on the night of 3/24/09, informing him of R1's fall. Z1 stated that he was notified that R1 hit her head, but the resident was alert, oriented to name and with no visible injury. Per Z1 he ordered to continue neurological check and to call him if there was any change in R1's neurological status. Z1 stated that the facility did not call him when R1's neurological status changed as evidenced by sluggish left pupil. Per Z1, he would have ordered to immediately send R1 to the hospital for evaluation and treatment if the facility called and informed him that R1's left pupil response was sluggish after hitting her head post fall incident. Z1 stated that R1 was receiving Aspirin and Plavix while in the facility, and the combination of these medications have the tendency to increase bleeding. Z1 who is also the facility's Medical Director acknowledged that the facility does not have a policy in place to

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F9999	Continued From page 31 address the neurological monitoring frequency of residents post fall. Z1 stated that the expected neurological assessment frequency are every 15 minutes for 1 hour post fall incident, every 30 minutes for 2 hours and every hour thereafter for the first 24 hours and then every shift until 3 days or 72 hours post fall. Z1 stated that R1 was diagnosed with Sub-arachnoid hemorrhage in the hospital ER and was immediately transferred from the ER to another hospital for further evaluation and treatment. This failure to provide timely, frequent and comprehensive neurological assessment, and failure to notify the physician in a timely manner for a change in neurological status resulted in a 33 hour delay of medical treatment for R1. (A)	F9999		