STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145696	A. BUILDING _____ B. WING _____	C 05/01/2009

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F 309	Continued From page 12 for falls using a "star" on the name plate and an updated list of identified residents in the nursing assistant documentation book. Care plans are updated for those residents that has an incident related to a fall. 6. The Director of Nursing or designee will audit daily all incident/falls until the next monthly Quality Assurance meeting. The review includes monitoring for all components/steps of the Incident/Accident,Change of Condition, and Notification of the Medical Doctor policy. Corrected action will be taken for deficient practice. Completion date of 4-30-09 for all of the above interventions.	F 309		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1010h) 300.1210a) 300.1210b)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be	F9999		

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F9999	Continued From page 13 followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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	F9999		

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F9999	Continued From page 14 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 are not met, as evicenced by the following: Based on interviews and record reviews, the facility failed to assess and monitor 1 of 4 sampled resident (R2) after a fall with a suspected head injury. The facility neglected to notify the physician of the fall and obtain timely physician's orders for treatment. The facility failed to follow the established policy and procedure for monitoring a resident after a fall that included hitting the head. This failure resulted in R2 having a seven and half hour delay in treatment. Findings include the following: R2 is an 78 year old resident with diagnosis including A-fibrillation, Paranoid Schizophrenia, Hypertension, Degenerative Joint Disease and Cerebral Vascular Accident. R2's medications include Coumadin therapy, therefore putting resident is at risk for bleeding. R2's assessment dated 3/7/09 indicates that R2 is nonambulatory resident requiring assistance with transfers and mobility. R2's assessment also describes the resident as needing total care for all ADLs (Activities of Daily Living) and as having moderate cognitive impairment. Care-Plan states resident is high risk for falls. No evidence of updated care-plan related to falls. Last dated fall	F9999		

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F9999	Continued From page 15 care-plan dated November 2008. According to the facility's incident report dated April 20, 2009, R2 was found on the floor. Nursing Notes state:on 4-20-09 at 3:00 AM, staff heard a "noise" coming from the room of R2. Resident was found lying on the floor in a supine position. Initial assessment indicates "discoloration" noted back of the head. Ice applied, vital-signs taken. R2 verbally complained of "head/neck" discomfort. Acetaminophen 650 mili-grams given for pain. Resident transferred into bed. No neurological assessment initiated. The attending Physician was not notified. At 6:00 AM, resident was "resting quietly." At 7:15 AM, resident was "sleeping." At 8:15 AM, resident was still "sleeping" and breathing appeared to be " labored." At 9:00 AM, resident was "non-arousable." At 10:00 AM, resident was examined by Z2 (Advanced Practice Nurse). After examination, Z2 instructed facility to activate Emergency Medical Services. The Emergency Medical Services paramedics arrived for transport to the local hospital. Prior to transfer, Z1 (Attending Physician) was not notified. Z1 interviewed on 4-29-09 at 3:00PM per telephone stated that the resident sustained a "head injury" from the fall. Z1 stated that he should have been notified immediately. Z1 stated that if he was notified at the time of the fall, the patient would have been sent to the hospital immediately. Z2 interviewed on 4-29-09 per telephone at 2:45PM stated that she was asked to assess the resident by E8 (Registered Nurse). R2 was non-responsive and with labored breathing. Gave order to activate Emergency Medical Services. Stated that the attending	F9999		

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F9999	Continued From page 16 physician should have been notified immediately after the fall. E3 (Assistant Director of Nursing) interviewed on 4-29-09 at 11:00AM stated that resident was a fall risk and that she called for Emergency Medical Services. E3 stated that R2's last fall occurred on 1-15-09 without an injury. E6 (Registered Nurse) interviewed on 4-29-09 at 1:00PM stated that on 4-20-09 at 3:00AM, she entered the room of the resident and found the resident lying on the floor in a supine position. She stated that the patient showed no injuries, and she notified the nurse assigned to R2 to follow up. E6 stated on the incident report that resident had a "bruise" on the back of the head and ice was applied. E6 confirmed during the interview that a Neurological assessment was not done on R2. E5 (Registered Nurse) interviewed on 4-29-09 at 1:15PM stated that when the resident fell, she was on her break. Upon return from the break, received report that the resident fell. Stated that she did not call the physician because the condition was not an "emergency." E5 stated that neurological assessments were not done on the resident. She stated she informed the day shift nurse to call the doctor. E7 (Registered Nurse) interviewed on 4-29-09 at 12:45PM stated that on 4-20-09 at 10:15 AM, she informed the attending physician and the family of the condition of the resident. E8 (Registered Nurse) interviewed on 4-29-09 at 1:30PM stated that on 4-20-09 at 7:00 AM, received report from E5 that the resident fell	F9999		

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F9999	Continued From page 17 earlier on the night shift. Stated that between 7-7:30 AM, resident was "sleeping." At 8:00AM, resident was still "sleeping." At 8:30 AM, resident was still "sleeping." At 10:00 AM, the resident was non-responsive. She stated that between 7:00 AM and 10:00 AM , the physician was not notified and that neurological assessments were not done. E2 (Director of Nursing) interviewed on 4-29-09 at 10:30AM stated that E5 did not inform Z1 of the fall. She stated that E5 did not follow the facility policy related to physician notification. E5 was terminated from employment. Policy review is as follows: Falling Star Program is defined to provide a visual cue to the staff to alert them that specified residents have a high risk of falling. Last care-plan related to fall risk dated November 2008. Neurological Assessments is defined "will be completed related to any un-witnessed fall and any incident when the resident has a bruise to the head." The schedule for the assessments are as follows: 1st hour-every 15 minutes, 2nd to 3rd hour-every 30 minutes, 4th to 8th hour every hour, 8th to 16th hour every 2 hours. If at any time the assessment changes, the Physician is to be notified of the specific changes and orders obtained if needed." No evidence indicates that neurological assessments were done on 4-20-09 from 3:00 AM thru 10:00 AM. Change In Residents Condition is defined as "alerting the physician and residents responsible party of a change in condition."	F9999		

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F9999	Continued From page 18 Incident Report Protocol is defined as "any unusual occurrence." The attending physician and family will be notified within "1 hour" of the incident. Accidents/Incidents policy includes "notify the medical director or the attending physician of the accident/incident." The facility's policy on abuse and neglect states, "The facility will continue to ensure that each resident has the right to be free of mistreatment, neglect and misappropriation of property." Hospital Records were reviewed on 4/30/09. R2 was brought to the local hospital Emergency Room at 11:00 AM via the Fire department. The resident had been intubated in the field because the resident was unresponsive. In the emergency room, the resident was found to have a large Subdural Hematoma. The resident expired at 4:00PM. (A)	F9999		