STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145736	A. BUILDING _____ B. WING _____	C 03/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	**6120 WEST OGDEN CICERO, IL 60804**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Investigation 1091011/IL46391 An extended survey was conducted.	F 000		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to: -asses a severely injured resident on the floor after a fall , -follow facility policy for resident's with head injuries; - assess, develop interventions, re-evaluate the effectiveness of interventions, attempt alternative interventions, supervise, after previous falls, for 1 resident (R3). . These failures resulted in R3 falling from bed and sustaining a head and neck injury which then resulted in Cardio-Pulmonary Arrest. The resident (R3) was moved post fall by the facility staff from the floor into bed without stabilization with proper emergency equipment. The resident expired after being transferred to the hospital.	F 323		4/1/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 323	Continued From page 1 These failures resulted in an Immediate Jeopardy, has potential to effect all 183 residents in the facility who are at risk for falls. The Immediate Jeopardy was determine to have begun on 03/6/10. Immediate jeopardy was called on 03/15/10 at 3:00pm., The Administrator, Assistant Administrator, Regional Nurse and Director of Operation were notified on 03/15/10 at 3:00 pm. The Immediate Jeopardy was removed on 03/16/10 at 5:00pm but the facility remains out of compliance at severity level 2. Finding Include: R3 was a 83 year old black female with diagnosis Diabetes Mellitus, Anemia, Cellulitis Right Big Toe, Coronary Artery Disease, Congestive Heart Failure, Arthritis, Gout, Glaucoma, Hypertension, Chronic Renal Failure, Old Cerebral Vascular Accident, Dementia Behavior, Renal Insufficiency, Degenerative Joint Disease and Gastro Esophagus Regurgitate Disease. The Minimum Data Set dated 12/19/10 denoted in Section B. (4). Cognitive Skill For Daily Decision-Making denoted R3 was moderately impaired -- decisions poor; cues/supervision required. Section G: (a). Bed Mobility (How resident moves to and from from lying positions, turns side to side, and position body while in bed) was score 3/2 (Extensive assistance/one person physical assist). Continued Review of the Minimum Data Set denoted in Section J. (4). Accidents (b). Fell in past 31- 180 days was marked with a X.	F 323		

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F 323	Continued From page 2 The Fall Risk Assessment Quarterly dated 02/19/10 denoted R3 was score 12 - high risk. The Nurses Notes state on the following dates: 11/20/09 7:00 pm - Resident while in dining room stood up, lost balance, tried to sit back on wheelchair. Resident missed the chair landing on buttock. No injury noted. Will continue monitor. 11/29/09 - 9:00 am - As housekeeping staff entered a resident room she observed resident sitting on floor next to wheelchair. She notified nurse and Certified Nurse Aide. No physical injuries noted. Resident currently in room with other resident and staff present will continue to monitor. 03/06/10 Approximately 7:10 pm Staff heard noise while nurse's station. Upon rounds noted resident on the floor in bedroom in a prone position. E2 (Nurse) called down the hallway for additional help. Approximately 7:15 pm Resident was rolled over to assess injuries. Noted a 21/2 laceration to left forehead that angle up over residents left brow. Neuro checks initiated, eyes were fixed at this time. Resident was unresponsive to verbal and physical stimuli. Pulse palpable 96 and Respiration Rate 22. 911 was called. Oxygen was applied per nasal canula at oxygen 2 liter. Pressure applied to forehead. 7:20 pm Resident remain unresponsive. Unable to detect pulse. Nurse initiated Cardiac Pulmonary Resuscitation compression due to resident being a full code. 7:25 pm Paramedics Arrive. They immediately transferred her to the Emergency room at for evaluation. 7:30 pm Medical Doctor notified.	F 323		

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F 323	Continued From page 3 10:00 pm Called to receive a status on resident. They stated that resident is still being evaluated. 03/07/10 1:00 am Verified at hospital regarding resident status, Emergency Room Nurse reported resident expired at 10:20 pm on 03/06/10 with Diagnosis Cardiac Arrest, Blunt Trauma, Intracranial and Subarachnoid Hemorrhage. The Z3 (fire department) Patient Care Report dated 03/06/10 stated," 19:17 - Unresponsive - Patient not breathing, some gastric fluids in back of airway. Head Laceration - Large vertical jagged laceration to right side forehead with mild bleeding . 19:32 - Primary Impression - Trauma Arrest secondary to fall. Trauma description - Fall of 1-6 feet." The Z3 Narratives report on 03/06/10 stated," Crew called to the facility for a fall victim. Upon arrival crew walked into room and saw a female elderly victim lying supine on the bed and not moving. Crew asked facility staff what happen, they responded that patient had fallen. Crew noted 6- 7 staff in room initially when we walked in. Crew noted 83 year old female lying supine in facility bed, Unresponsive to all stimuli and appearing to be apneic. Crew asked how the patient got into her bed. We were told that they the staff, put here back in there. The details of the fall were never made clear to the crew. We asked 3 different times. The only answer we were given was that staff heard a thud, came into the room and found the patient lying on the floor with a head wound. Crew did note a large jagged laceration to the patient's forehead, light bleeding. Wound about 1 inches length with the skull visible. Crew also noted blood coming from	F 323		

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F 323	Continued From page 4 both of the patients nares. Blood appear dried. Patient was "No Spinal Precaution" taken by staff prior to arrival. Crew then noted that patient was in fact apneic and pulseless. Staff expressed disbelief, but obviously did not notice that the patient was in Cardiac Arrest prior to arrival. Crew immediately began CPR and spinally immobilized patient. Patient intubated, Crew noted fluid in patient airway, suctioned what appears to be gastric contents out. Patient stayed in Asystole until transport, converted to ventricular tachycardia with no pulse." Hospital report dated 3/06/10 stated," Chief Complaints: Status Post fall with head trauma and cardiac arrest. History and Physical - Patient arrived after having sustained a cardiac arrest. Arrest was witnessed and downtime was an unknown period. History at time of arrival: Patient was found on the floor at nursing home staff after heard a thud. Patient was found face down on the floor. She had laceration to mid forehead. She was put back in bed by the staff. She was noted to be unresponsive and Emergency medical treatment was called. Patient Status and Presentation: Unconsciousness, intubated. There is a C shape 3 laceration on the mid fore head. Pupil (s) the right and the left are nonreactive. Diagnosis Cardiac Arrest, Blunt Trauma: Intracranial injury and Subarachnoid Hemorrhage with a loss of unconsciousness of unknown duration. Patient was pronounced dead at 10:22 pm." The CT Scan of the head and Cervical Scan Report dated 03/06/10 Stated," Mild extra clavicle soft tissue swelling in the frontal region is seen. However, I do not appreciate any acute calvarial fracture. There is a subtle area of high	F 323		

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F 323	Continued From page 5 attenuation along the free convexity of the left parietal lobe which was not seen on the previous examination compatible with a subtle Subdural or Subarachnoid hemorrhage. Evaluation of the cervical spine demonstrates a fracture of the base of the Odontoid Process. There is a minimal posterior displacement of the tip of the Odontoid process with respect to the base of the C2 vertebral body. Impression - A Subtle Subarachnoid or Subdural Hemorrhage along the free convexity of the left parietal lobe. In addition there is fracture at the base of the Odontoid process compatible with a Type II fracture." s E3 (Nurse) on 03/11/10 at 10:10 am in conference room stated," It was about 7:00 pm. E2 (Acting Director of Nurse) and I was standing at medication cart in the medication room. We were talking about things, I wanted to do. She said did you hear that noise. I said no, I did not heard noise. E4 (Certified Nurse Aide -CNA) was sitting at nurse station in chair. She said E3, I bumped in chair. E2 said "No", I heard a thud. So E2 left at that time and started making rounds. She went toward the room. She looked in all rooms. So,when she got room 313 she started yelling for help. E4 and I ran into the room. E7 (Nurse) came into the room. R3 was lying on the floor face down. E7 called her name. She (R3) responded and roll her eyes, then they appeared to be fixed. My first impression was that she does not have a pulse. When E7 went to palpate a pulse, she had a pulse. It was rapid and she was breathing. By then I am yelling to get a ice pack. I saw the blood on the floor. E7 and I tried to stabilized her neck to see where the blood was coming from. It was a laceration on the left side of forehead. Ice packed was applied with	F 323		

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F 323	Continued From page 6	F 323		

pressure. Someone yelled to call 911 and check chart for what status she was. Someone came in with oxygen tank. E2 was standing at the foot of the bed and she said we got to get her up. So, we rolled her on a blanket and got here up in bed. I was still applying pressure with a ice pack to forehead. The paramedics came in and E2 talked to them."

Surveyor asked E3 what did they use to stabilize the head and neck before putting R3 in bed, and who told them put R3 in bed.
E3 stated," None," She was told by E2 that she (E2) realized they should not have moved her off the floor

E4 (CNA) on 03/11/10 at 10:35 am in the conference room stated," About 7:00 pm I was at nursing station. I was during restorative book. I got ready to get up out of the chair. My chair bumped the nurse's station desk. E2 said did you heard that? I explained to E2 that it was my chair bumping the desk. E2 was persistent she heard something, and began to walk down hall. When she got down to end of hall she was screaming my name E4! E4! E4! I and E3 proceeded down to R3's room. When I approached the room R3 was lying face down on the floor. E2 was across R3. R3 was lying in a pool of blood that had extended out from the body. It was large amount of blood. Her bed wall was shaped like a V. Her head was in the corner of the V shape. She was face down in the V shape with her head touching the wall. E2 told me to check to see if she was a "Do Not Resuscitate". E3 checked and got a pulse. They had to turn her on the her back. E3 was cleaning the head to see what was going on. E2 told us we had to clean her up. I and E5 (CNA) attempted to clean her bottom on the floor.

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F 323	Continued From page 7 She had saturated with urine and stool. When E5 went to get the towel, so we could clean her. E2 said "you can not clean her from down there". I told E2 she was dirty needed to be clean before the ambulance come. She (E2) said "No!" We got to get her up!". I told E2 we could not move her. E2 said we have to get her back to bed and stabilized her. E2 said we have to get her into the bed. I said we had inservice to leave the resident on the floor. E2 was persistent in putting her back to bed. They (E5, E8, E4 and E3) was going to pick her up with arms and legs. Two at the top and two at the bottom. I said stop. I would go get a sheet to lift her. I took the sheet and put it under her body. We held the side of the sheet to lift her in bed. I don't know if anyone held her head. I did not want to lift this women off the floor. E2 persistence on lifting her in bed. E3 and I said look like her neck was broken. They put ice pack on the head. her neck was very loose like a noodle. E3 said," I think her neck is broken". E2 said "Do you think we should put her back down on the floor?". I Said NO! He-- No! I am not putting her back on the floor. The paramedic asked what happened and who moved her. The paramedics were very angry at the staff. He said we should not have moved her. We had a inservice that a resident with head injury should not to be moved." E5 on 03/11/10 at 11:00 am in the conference room stated," The tray came up at 5:00 pm. We passed trays 5:00 pm - 5:30 pm. We have to feed residents in the dining room. I got through feeding residents in dining room at 6:30 pm. The head of the bed was in a sitting position for R3. R3 was lying face down on the floor when she was found. I was putting another resident to bed. I helped put R3 back to bed. It was I, E4, E8 and	F 323		

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F 323	Continued From page 8 E3 that put her in bed. We lifted her up and put her in bed. We put a blanket under the legs and other two others were holding the shoulders. I did not see the blanket under shoulder or head. She was covered with blood. She was between the bed and cabinet with her head on the wall. I don't know how she fell. When we put her back in bed. E3 said we are not put her in bed. E3 said we are not to put her back in bed because she fell. When a person fall on the floor we are not supposed to move them. We had inservice on head injury and we are not suppose to touch or move residents when on the floor. We have to wait until resident is assessed. E2 told us to put her in bed. We put her in bed because E2 told us. After we put her in bed. E2 said we should not have put her in bed. She said we should put her on the floor. The staff refused to put her back on the floor." E2 on 03/11/10 at 11:40 am in the conference room stated," I was in nursing station talking to nurse E3. Then I heard a thud. I ask did you heard that?. They reply was no one that. E4 said it was from her chair getting up. I said did not sound like a chair. I said we should make rounds. I started from the nurse station going room to room. When I got to room 313, I saw legs and yelled out for help. All the nurses came. I went into room, observed R3 in the prone position on the floor. I checked for pulse; I did not feel a pulse. The nurse and CNA was in the room. I left the room. I looked at the chart to see if there was a DNR and got oxygen. I came back to room. I thought she had expired. We put a blanket under her and with E3 at head, rolled her up from the floor to the bed. We checked the pulse. There was no pulse. I did the three compressions and the ambulance people took over. We checked the laceration of the head. We applied ice pack.	F 323		

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F 323	Continued From page 9 We moved her off the floor. I thought she had expired that why we moved her off the floor." Surveyor ask why did moved off the floor. E2 stated," I thought she was dead. E3 made a comment "if people have a head or spinal injury then we don't move them." E7, (Nurse) on 03/11/10 at 12:15 pm per telephone stated," I heard E2 nurse yelling. We all went down hall. We went into the room. She (R3) was lying face down on the floor. There was a pool of blood around her head. E3 the nurse rolled her over to assess her. She had a pulse and pupils fixed. When I called her name, she had moved her head. She did not say anything verbally. I told E2 to check the chart for DNR and call 911. E3 applied pressure to the forehead and applied ice pack. At that point I ran out of the room for oxygen." Surveyor asked: "are you suppose to move resident with head or possible cervical injury"? E7 stated," We are not to move the resident with a head, neck or back injury. We had a inservice on head, neck and back injury. She had a pulse on the floor. She had not expired." E8 (CNA) on 03/11/10 at 3:35 pm in the conference room stated," I was working that day. E4 call ask me if I had towels on the cart, so I brought them towels to the room. When I was in the room, I saw R3 on the floor. I saw blood on the forehead. They ask me to help put R3 back into bed. I knew it was wrong to put her back in bed. We had inservice on if a resident on the floor do not touch or move from the floor. E2 told us to put her back in bed. I saw her eyes was open. She did not look dead. The inservice was	F 323		

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F 323	Continued From page 10 long time ago. But in school, you were told not to move someone on the floor whom had fallen out of bed." Surveyor asked E8 "who told you put resident in bed"? E8 stated," It was E2 who told us to put her on the bed. I told her there was inservice that we are not to move residents from the floor to bed if there injury. Z2, (Paramedic) on 03/15/10 at 9:00 am per telephone stated," Upon arrival found 5- 7 staff standing around the resident. Staff did nothing. Resident was in full cardiac arrest. I asked who put the resident in bed. The staff said they put her in bed. I asked did they immobilized the patient. They said did not immobilize her. They did not know if she had a fracture of her C2 spine. She was in cardiac arrest. They were not during anything for her. She had arrest X 3 in the hospital. She had diagnosis Cardiac Arrest, Cervical Spinal Injury and Multi Brain Injury. I also saw a large jagged laceration on the patient's forehead, light bleeding, wound about 1 inch length with the skull visible. This patient was critical injury and was in full code cardiac arrest when we arrival. We were very angry that they put the patient in bed with no immobilized equipment under her to put in bed. A CNA said they had used a blanket to put her in the bed." The Head Injuries Nursing Policy and Procedures Date 03/09 denoted: 3). Determine baseline condition of the resident. a). Conduct neurological assessment. c). Evaluate pupil size and reaction to light. e). measure blood pressure, pulse and respiration.	F 323		

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F 323	Continued From page 11 g). Assess for injuries to other organ systems. 8). Document emergency measure taken. The Neurological Assessment Nursing Policy and Procedure dated 03/09 denoted: 2). Observe, assess and document the resident's level of consciousness, speech, pupils, hand grasp and vitals signs. Review of the care plan denoted there was no updated revisions after the first two falls; interventions or approaches were not changed to prevent resident from any additional falls. No additional fall assessments were found either to address the residents previous falls The facility submitted the following plan for F323: The facility submitted the following plan to remove the Immediacy for F323: > An action plan was imitated by the Administration on 03/06/10 addressing supervison and head injuries. > The interim Director of Nurses and four nurses were reassessed all residents in the facility and have identified those residents that are High Risk for Fall/Falling Star Program. The initial list was completed by 3/12/10 and will be updated on ongoing basis via the daily AIMMs meeting. Care Plan were updated and intervention were implemented. > All staff in all departments including dietary, housekeeping, laundry, activities, nursing, maintenance and all department heads were inserviced on supervision and Falling Star Program as 3/12/10. Staff who are on vacation or otherwise not on duty, and new staff, will be in-serviced before they go on duty. > The facility held mandatory, directed inservices	F 323		

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F 323	Continued From page 12 for all nursing staff including nurses and CNAs starting 03/06/10 and reviewed the Policies and Procedures on Head Injuries, (11 Notifications, First Aid, MD Notification of a change in condition, a fall or other injury and neurological assessment. Staff who are on vacation or otherwise not on duty, and new staff, will be in-serviced before they go on duty. > A QA/QI meeting was held on 03/13/10 to discuss the result of the action plan and to prevent further incident. The DON and/or designee conducted and presented the audits at the meeting. > All results of audits and additional findings will be provided to the QA?QI committee quarterly thereafter. The DON and/or designee will conducted and present the audits at the meeting.	F 323		
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the administration failed to provide necessary care and service to promote health, safety and welfare for a resident R3 in the facility. These failures resulted in R3 falling from bed and sustaining a head and neck injury which then resulted in Cardio-Pulmonary Arrest. The resident (R3) was moved post fall by the facility staff from the floor into bed without stabilization with proper emergency equipment. The resident expired after	F 490		4/1/10

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	145736	A. BUILDING _____ B. WING _____	C 03/30/2010

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F 490	Continued From page 13 being transferred to the hospital. These failures resulted in an Immediate Jeopardy, has potential to effect all 183 residents in the facility who are at risk for falls. The Immediate Jeopardy was determine to began on 03/06/10. The Administrator, Assistant Administrator, Regional Nurse and Director of Operation were notified on 03/15/10 at 3:00 pm. The Immediate Jeopardy was removed on 03/16/10 at 5:00pm but the facility remains out of compliance at severity level 2. Findings Includes: R3 was a 83 year old black female with diagnosis Diabetes Mellitus, Anemia, Cellulitis Right Big Toe, Coronary Artery Disease, Congestive Heart Failure, Arthritis, Gout, Glaucoma, Hypertension, Chronic Renal Failure, Old Cerebral Vascular Accident, Dementia Behavior, Renal Insufficiency, Degenerative Joint Disease and Gastro Esophagus Regurgitate Diseases. E3 (Nurse) on 03/11/10 at 10:10 am in conference room stated," It was about 7:00 pm. E2 (Acting Director of Nurse) and I was standing at medication cart in the medication room. We were talking about things, I wanted to do. She said did you hear that noise. I said no, I did not heard noise. E4 (Certified Nurse Aide -CNA) was sitting at nurse station in chair. She said E3, I bumped in chair. E2 said "No", I heard a thud. So E2 left at that time and started making rounds. She went toward the room. She looked in all rooms. So,when she got room 313 she started	F 490		

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F 490	Continued From page 14 yelling for help. E4 and I ran into the room. E7 (Nurse) came into the room. R3 was lying on the floor face down. E7 called her name. She (R3) responded and roll her eyes, then they appeared to be fixed. My first impression was that she does not have a pulse. When E7 went to palpate a pulse, she had a pulse. It was rapid and she was breathing. By then I am yelling to get a ice pack. I saw the blood on the floor. E7 and I tried to stabilized her neck to see where the blood was coming from. It was a laceration on the left side of forehead. Ice packed was applied with pressure. Someone yelled to call 911 and check chart for what status she was. Someone came in with oxygen tank. E2 was standing at the foot of the bed and she said we got to get her up. So, we rolled her on a blanket and got here up in bed. I was still applying pressure with a ice pack to forehead. The paramedics came in and E2 talked to them." Surveyor asked E3 what did they use to stabilize the head and neck before putting R3 in bed, and who told them put R3 in bed. E3 stated," None," She was told by E2 that she (E2) realized they should not have moved her off the floor E4 (CNA) on 03/11/10 at 10:35 am in the conference room stated," About 7:00 pm I was at nursing station. I was during restorative book. I got ready to get up out of the chair. My chair bumped the nurse's station desk. E2 said did you heard that? I explained to E2 that it was my chair bumping the desk. E2 was persistent she heard something, and began to walk down hall. When she got down to end of hall she was screaming my name E4! E4! E4! I and E3 proceeded down to R3's room. When I approached the room R3	F 490		

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F 490	Continued From page 15 was lying face down on the floor. E2 was across R3. R3 was lying in a pool of blood that had extended out from the body. It was large amount of blood. Her bed wall was shaped like a V. Her head was in the corner of the V shape. She was face down in the V shape with her head touching the wall. E2 told me to check to see if she was a "Do Not Resuscitate". E3 checked and got a pulse. They had to turn her on the her back. E3 was cleaning the head to see what was going on. E2 told us we had to clean her up. I and E5 (CNA) attempted to clean her bottom on the floor. She had saturated with urine and stool. When E5 went to get the towel, so we could clean her. E2 said "you can not clean her from down there". I told E2 she was dirty needed to be clean before the ambulance come. She (E2) said "No!" We got to get her up!". I told E2 we could not move her. E2 said we have to get her back to bed and stabilized her. E2 said we have to get her into the bed. I said we had inservice to leave the resident on the floor. E2 was persistent in putting her back to bed. They (E5, E8, E4 and E3) was going to pick her up with arms and legs. Two at the top and two at the bottom. I said stop. I would go get a sheet to lift her. I took the sheet and put it under her body. We held the side of the sheet to lift her in bed. I don't know if anyone held her head. I did not want to lift this women off the floor. E2 persistence on lifting her in bed. E3 and I said look like her neck was broken. They put ice pack on the head. her neck was very loose like a noodle. E3 said," I think her neck is broken". E2 said "Do you think we should put her back down on the floor?". I Said NO! He-- No! I am not putting her back on the floor. The paramedic asked what happened and who moved her. The paramedics were very angry at the staff. He said we should not have moved her. We had a	F 490		

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F 490	Continued From page 16 inservice that a resident with head injury should not to be moved." E5 on 03/11/10 at 11:00 am in the conference room stated," The tray came up at 5:00 pm. We passed trays 5:00 pm - 5:30 pm. We have to feed residents in the dining room. I got through feeding residents in dining room at 6:30 pm. The head of the bed was in a sitting position for R3. R3 was lying face down on the floor when she was found. I was putting another resident to bed. I helped put R3 back to bed. It was I, E4, E8 and E3 that put her in bed. We lifted her up and put her in bed. We put a blanket under the legs and other two others were holding the shoulders. I did not see the blanket under shoulder or head. She was covered with blood. She was between the bed and cabinet with her head on the wall. I don't know how she fell. When we put her back in bed. E3 said we are not put her in bed. E3 said we are not to put her back in bed because she fell. When a person fall on the floor we are not supposed to move them. We had inservice on head injury and we are not suppose to touch or move residents when on the floor. We have to wait until resident is assessed. E2 told us to put her in bed. We put her in bed because E2 told us. After we put her in bed. E2 said we should not have put her in bed. She said we should put her on the floor. The staff refused to put her back on the floor." E2 on 03/11/10 at 11:40 am in the conference room stated," I was in nursing station talking to nurse E3. Then I heard a thud. I ask did you heard that?. They reply was no one that. E4 said it was from her chair getting up. I said did not sound like a chair. I said we should make rounds. I started from the nurse station going room to room. When I got to room 313, I saw legs and	F 490		

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F 490	Continued From page 17 yelled out for help. All the nurses came. I went into room, observed R3 in the prone position on the floor. I checked for pulse; I did not feel a pulse. The nurse and CNA was in the room. I left the room. I looked at the chart to see if there was a DNR and got oxygen. I came back to room. I thought she had expired. We put a blanket under her and with E3 at head, rolled her up from the floor to the bed. We checked the pulse. There was no pulse. I did the three compressions and the ambulance people took over. We checked the laceration of the head. We applied ice pack. We moved her off the floor. I thought she had expired that why we moved her off the floor." Surveyor ask why did moved off the floor. E2 stated," I thought she was dead. E3 made a comment "if people have a head or spinal injury then we don't move them." E7, (Nurse) on 03/11/10 at 12:15 pm per telephone stated," I heard E2 nurse yelling. We all went down hall. We went into the room. She (R3) was lying face down on the floor. There was a pool of blood around her head. E3 the nurse rolled her over to assess her. She had a pulse and pupils fixed. When I called her name, she had moved her head. She did not say anything verbally. I told E2 to check the chart for DNR and call 911. E3 applied pressure to the forehead and applied ice pack. At that point I ran out of the room for oxygen." Surveyor asked: "are you suppose to move resident with head or possible cervical injury"? E7 stated," We are not to move the resident with a head, neck or back injury. We had a inservice on head, neck and back injury. She had a pulse on the floor. She had not expired."	F 490		

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F 490	Continued From page 18 E8 (CNA) on 03/11/10 at 3:35 pm in the conference room stated," I was working that day. E4 call ask me if I had towels on the cart, so I brought them towels to the room. When I was in the room, I saw R3 on the floor. I saw blood on the forehead. They ask me to help put R3 back into bed. I knew it was wrong to put her back in bed. We had inservice on if a resident on the floor do not touch or move from the floor. E2 told us to put her back in bed. I saw her eyes was open. She did not look dead. The inservice was long time ago. But in school, you were told not to move someone on the floor whom had fallen out of bed." Surveyor asked E8 "who told you put resident in bed"? E8 stated," It was E2 who told us to put her on the bed. I told her there was inservice that we are not to move residents from the floor to bed if there injury. Z2, (Paramedic) on 03/15/10 at 9:00 am per telephone stated," Upon arrival found 5- 7 staff standing around the resident. Staff did nothing. Resident was in full cardiac arrest. I asked who put the resident in bed. The staff said they put her in bed. I asked did they immobilized the patient. They said did not immobilize her. They did not know if she had a fracture of her C2 spine. She was in cardiac arrest. They were not during anything for her. She had arrest X 3 in the hospital. She had diagnosis Cardiac Arrest, Cervical Spinal Injury and Multi Brain Injury. I also saw a large jagged laceration on the patient's forehead, light bleeding, wound about 1 inch length with the skull visible. This patient was critical injury and was in full code cardiac arrest	F 490		

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F 490	Continued From page 19 when we arrival. We were very angry that they put the patient in bed with no immobilized equipment under her to put in bed. A CNA said they had used a blanket to put her in the bed." The Head Injuries Nursing Policy and Procedures Date 03/09 denoted: 3). Determine baseline condition of the resident. a). Conduct neurological assessment. c). Evaluate pupil size and reaction to light. e). measure blood pressure, pulse and respiration. g). Assess for injuries to other organ systems. 8). Document emergency measure taken. The Neurological Assessment Nursing Policy and Procedure dated 03/09 denoted: 2). Observe, assess and document the resident's level of consciousness, speech, pupils, hand grasp and vitals signs. Review of the care plan denoted there was no updated revisions after the first two falls; interventions or approaches were not changed to prevent resident from any additional falls. No additional fall assessments were found either to address the residents previous falls The facility submitted the following plan for F323: The facility submitted the following plan to remove the Immediacy for F323: > An action plan was imitated by the Administration on 03/06/10 addressing supervison and head injuries. > The interim Director of Nurses and four nurses were reassessed all residents in the facility and have identified those residents that are High Risk for Fall/Falling Star Program. The initial list was	F 490		

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F 490	Continued From page 20 completed by 3/12/10 and will be updated on ongoing basis via the daily AIMMs meeting. Care Plan were updated and intervention were implemented. > All staff in all departments including dietary, housekeeping, laundry, activities, nursing, maintenance and all department heads were inserviced on supervision and Falling Star Program as 3/12/10. Staff who are on vacation or otherwise not on duty, and new staff, will be in-serviced before they go on duty. > The facility held mandatory, directed inservices for all nursing staff including nurses and CNAs starting 03/06/10 and reviewed the Policies and Procedures on Head Injuries, (11 Notifications, First Aid, MD Notification of a change in condition, a fall or other injury and neurological assessment. Staff who are on vacation or otherwise not on duty, and new staff, will be in-serviced before they go on duty. > A QA/QI meeting was held on 03/13/10 to discuss the result of the action plan and to prevent further incident. The DON and/or designee conducted and presented the audits at the meeting. > All results of audits and additional findings will be provided to the QA?QI committee quarterly thereafter. The DON and/or designee will conducted and present the audits at the meeting.	F 490		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1030a)1)2) 300.1210a) 300.1210b)6) 300.1220b)3) 300.3240a)	F9999		

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F9999	Continued From page 21 Section 300.1030 Medical Emergencies a) The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur from time to time in long-term care facilities. These medical emergencies include, but are not limited to, such things as: 1) Pulmonary emergencies (for example, airway obstruction, foreign body aspiration, and acute respiratory distress, failure, or arrest). 2) Cardiac emergencies (for example, ischemic pain, cardiac failure, or cardiac arrest). 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)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	F9999		

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F9999	Continued From page 22 Services b) The DON shall supervise and oversee the nursing services of the facility, including: 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. 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 Regulations were not met as evidenced by: Based on interview and record review, the facility failed to: - assess, develop interventions, re-evaluate the effectiveness of interventions, attempt alternative interventions and supervise after previous falls for 1 resident (R3). -asses a severely injured resident on the floor after a fall , -follow facility policy for resident's with head injuries	F9999		

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F9999	Continued From page 23 -perform CPR on the resident who went into Cardio-Pulmonary Arrest. . These failures resulted in R3 falling from bed and sustaining a head and neck injury which then resulted in Cardio-Pulmonary Arrest. The resident (R3) was moved post fall by the facility staff from the floor into bed without stabilization with proper emergency equipment. The resident expired after being transferred to the hospital. Finding Include: R3 was a 83 year old black female with diagnosis Diabetes Mellitus, Anemia, Cellulitis Right Big Toe, Coronary Artery Disease, Congestive Heart Failure, Arthritis, Gout, Glaucoma, Hypertension, Chronic Renal Failure, Old Cerebral Vascular Accident, Dementia Behavior, Renal Insufficiency, Degenerative Joint Disease and Gastro Esophagus Regurgitate Disease. The Minimum Data Set dated 12/19/10 denoted in Section B. (4). Cognitive Skill For Daily Decision-Making denoted R3 was moderately impaired -- decisions poor; cues/supervision required. Section G: (a). Bed Mobility (How resident moves to and from from lying positions, turns side to side, and position body while in bed) was score 3/2 (Extensive assistance/one person physical assist). Continued Review of the Minimum Data Set denoted in Section J. (4). Accidents (b). Fell in past 31- 180 days was marked with a X. The Fall Risk Assessment Quarterly dated 02/19/10 denoted R3 was score 12 - high risk.	F9999		

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F9999	Continued From page 24 The Nurses Notes state on the following dates: 11/20/09 7:00 pm - Resident while in dining room stood up, lost balance, tried to sit back on wheelchair. Resident missed the chair landing on buttock. No injury noted. Will continue monitor. 11/29/09 - 9:00 am - As housekeeping staff entered a resident room she observed resident sitting on floor next to wheelchair. She notified nurse and Certified Nurse Aide. No physical injuries noted. Resident currently in room with other resident and staff present will continue to monitor. Review of the care plan denoted there was no updated revisions after the first two falls; interventions or approaches were not changed to prevent resident from any additional falls. No additional fall assessments were found either to address the residents previous falls. 03/06/10 Approximately 7:10 pm Staff heard noise while nurse's station. Upon rounds noted resident on the floor in bedroom in a prone position. E2 (Nurse) called down the hallway for additional help. Approximately 7:15 pm Resident was rolled over to assess injuries. Noted a 21/2 laceration to left forehead that angle up over residents left brow. Neuro checks initiated, eyes were fixed at this time. Resident was unresponsive to verbal and physical stimuli. Pulse palpable 96 and Respiration Rate 22. 911 was called. Oxygen was applied per nasal canula at oxygen 2 liter. Pressure applied to forehead. 7:20 pm Resident remain unresponsive. Unable to detect pulse. Nurse initiated Cardiac Pulmonary Resuscitation compression due to resident being a full code.	F9999		

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ALDEN TOWN MANOR REHAB & HCC	**6120 WEST OGDEN CICERO, IL 60804**

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F9999	Continued From page 25 7:25 pm Paramedics Arrive. They immediately transferred her to the Emergency room at for evaluation. 7:30 pm Medical Doctor notified. 10:00 pm Called to receive a status on resident. They stated that resident is still being evaluated. 03/07/10 1:00 am Verified at hospital regarding resident status, Emergency Room Nurse reported resident expired at 10:20 pm on 03/06/10 with Diagnosis Cardiac Arrest, Blunt Trauma, Intracranial and Subarachnoid Hemorrhage. The Z3 (fire department) Patient Care Report dated 03/06/10 stated," 19:17 - Unresponsive - Patient not breathing, some gastric fluids in back of airway. Head Laceration - Large vertical jagged laceration to right side forehead with mild bleeding . 19:32 - Primary Impression - Trauma Arrest secondary to fall. Trauma description - Fall of 1-6 feet." The Z3 Narratives report on 03/06/10 stated," Crew called to the facility for a fall victim. Upon arrival crew walked into room and saw a female elderly victim lying supine on the bed and not moving. Crew asked facility staff what happen, they responded that patient had fallen. Crew noted 6- 7 staff in room initially when we walked in. Crew noted 83 year old female lying supine in facility bed, Unresponsive to all stimuli and appearing to be apneic. Crew asked how the patient got into her bed. We were told that they the staff, put here back in there. The details of the fall were never made clear to the crew. We asked 3 different times. The only answer we were given was that staff heard a thud, came into the room and found the patient lying on the floor with	F9999		

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F9999	Continued From page 26 a head wound. Crew did note a large jagged laceration to the patient's forehead, light bleeding. Wound about 1 inches length with the skull visible. Crew also noted blood coming from both of the patients nares. Blood appear dried. Patient was "No Spinal Precaution" taken by staff prior to arrival. Crew then noted that patient was in fact apneic and pulseless. Staff expressed disbelief, but obviously did not notice that the patient was in Cardiac Arrest prior to arrival. Crew immediately began CPR and spinally immobilized patient. Patient intubated, Crew noted fluid in patient airway, suctioned what appears to be gastric contents out. Patient stayed in Asystole until transport, converted to ventricular tachycardia with no pulse." Hospital report dated 3/06/10 stated," Chief Complaints: Status Post fall with head trauma and cardiac arrest. History and Physical - Patient arrived after having sustained a cardiac arrest. Arrest was witnessed and downtime was an unknown period. History at time of arrival: Patient was found on the floor at nursing home staff after heard a thud. Patient was found face down on the floor. She had laceration to mid forehead. She was put back in bed by the staff. She was noted to be unresponsive and Emergency medical treatment was called. Patient Status and Presentation: Unconsciousness, intubated. There is a C shape 3 laceration on the mid fore head. Pupil (s) the right and the left are nonreactive. Diagnosis Cardiac Arrest, Blunt Trauma: Intracranial injury and Subarachnoid Hemorrhage with a loss of unconsciousness of unknown duration. Patient was pronounced dead at 10:22 pm." The CT Scan of the head and Cervical Scan	F9999		

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F9999	Continued From page 27 Report dated 03/06/10 Stated," Mild extra clavicle soft tissue swelling in the frontal region is seen. However, I do not appreciate any acute calvarial fracture. There is a subtle area of high attenuation along the free convexity of the left parietal lobe which was not seen on the previous examination compatible with a subtle Subdural or Subarachnoid hemorrhage. Evaluation of the cervical spine demonstrates a fracture of the base of the Odontoid Process. There is a minimal posterior displacement of the tip of the Odontoid process with respect to the base of the C2 vertebral body. Impression - A Subtle Subarachnoid or Subdural Hemorrhage along the free convexity of the left parietal lobe. In addition there is fracture at the base of the Odontoid process compatible with a Type II fracture." E3 (Nurse) on 03/11/10 at 10:10 am in conference room stated," It was about 7:00 pm. E2 (Acting Director of Nurse) and I was standing at medication cart in the medication room. We were talking about things, I wanted to do. She said did you hear that noise. I said no, I did not heard noise. E4 (Certified Nurse Aide -CNA) was sitting at nurse station in chair. She said E3, I bumped in chair. E2 said "No", I heard a thud. So E2 left at that time and started making rounds. She went toward the room. She looked in all rooms. So,when she got room 313 she started yelling for help. E4 and I ran into the room. E7 (Nurse) came into the room. R3 was lying on the floor face down. E7 called her name. She (R3) responded and roll her eyes, then they appeared to be fixed. My first impression was that she does not have a pulse. When E7 went to palpate a pulse, she had a pulse. It was rapid and she was breathing. By then I am yelling to get a ice pack. I	F9999		

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F9999	Continued From page 28 saw the blood on the floor. E7 and I tried to stabilized her neck to see where the blood was coming from. It was a laceration on the left side of forehead. Ice packed was applied with pressure. Someone yelled to call 911 and check chart for what status she was. Someone came in with oxygen tank. E2 was standing at the foot of the bed and she said we got to get her up. So, we rolled her on a blanket and got here up in bed. I was still applying pressure with a ice pack to forehead. The paramedics came in and E2 talked to them." Surveyor asked E3 what did they use to stabilize the head and neck before putting R3 in bed, and who told them put R3 in bed. E3 stated," None," She was told by E2 that she (E2) realized they should not have moved her off the floor E4 (CNA) on 03/11/10 at 10:35 am in the conference room stated," About 7:00 pm I was at nursing station. I was during restorative book. I got ready to get up out of the chair. My chair bumped the nurse's station desk. E2 said did you heard that? I explained to E2 that it was my chair bumping the desk. E2 was persistent she heard something, and began to walk down hall. When she got down to end of hall she was screaming my name E4! E4! E4! I and E3 proceeded down to R3's room. When I approached the room R3 was lying face down on the floor. E2 was across R3. R3 was lying in a pool of blood that had extended out from the body. It was large amount of blood. Her bed wall was shaped like a V. Her head was in the corner of the V shape. She was face down in the V shape with her head touching the wall. E2 told me to check to see if she was a "Do Not Resuscitate". E3 checked and got a	F9999		

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F9999	Continued From page 29 pulse. They had to turn her on the her back. E3 was cleaning the head to see what was going on. E2 told us we had to clean her up. I and E5 (CNA) attempted to clean her bottom on the floor. She had saturated with urine and stool. When E5 went to get the towel, so we could clean her. E2 said "you can not clean her from down there". I told E2 she was dirty needed to be clean before the ambulance come. She (E2) said "No!" We got to get her up!". I told E2 we could not move her. E2 said we have to get her back to bed and stabilized her. E2 said we have to get her into the bed. I said we had inservice to leave the resident on the floor. E2 was persistent in putting her back to bed. They (E5, E8, E4 and E3) was going to pick her up with arms and legs. Two at the top and two at the bottom. I said stop. I would go get a sheet to lift her. I took the sheet and put it under her body. We held the side of the sheet to lift her in bed. I don't know if anyone held her head. I did not want to lift this women off the floor. E2 persistence on lifting her in bed. E3 and I said look like her neck was broken. They put ice pack on the head. her neck was very loose like a noodle. E3 said," I think her neck is broken". E2 said "Do you think we should put her back down on the floor?". I Said NO! He-- No! I am not putting her back on the floor. The paramedic asked what happened and who moved her. The paramedics were very angry at the staff. He said we should not have moved her. We had a inservice that a resident with head injury should not to be moved." E5 on 03/11/10 at 11:00 am in the conference room stated," The tray came up at 5:00 pm. We passed trays 5:00 pm - 5:30 pm. We have to feed residents in the dining room. I got through feeding residents in dining room at 6:30 pm. The	F9999		

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F9999	Continued From page 30 head of the bed was in a sitting position for R3. R3 was lying face down on the floor when she was found. I was putting another resident to bed. I helped put R3 back to bed. It was I, E4, E8 and E3 that put her in bed. We lifted her up and put her in bed. We put a blanket under the legs and other two others were holding the shoulders. I did not see the blanket under shoulder or head. She was covered with blood. She was between the bed and cabinet with her head on the wall. I don't know how she fell. When we put her back in bed. E3 said we are not put her in bed. E3 said we are not to put her back in bed because she fell. When a person fall on the floor we are not supposed to move them. We had inservice on head injury and we are not suppose to touch or move residents when on the floor. We have to wait until resident is assessed. E2 told us to put her in bed. We put her in bed because E2 told us. After we put her in bed. E2 said we should not have put her in bed. She said we should put her on the floor. The staff refused to put her back on the floor." E2 on 03/11/10 at 11:40 am in the conference room stated," I was in nursing station talking to nurse E3. Then I heard a thud. I ask did you heard that?. They reply was no one that. E4 said it was from her chair getting up. I said did not sound like a chair. I said we should make rounds. I started from the nurse station going room to room. When I got to room 313, I saw legs and yelled out for help. All the nurses came. I went into room, observed R3 in the prone position on the floor. I checked for pulse; I did not feel a pulse. The nurse and CNA was in the room. I left the room. I looked at the chart to see if there was a DNR and got oxygen. I came back to room. I thought she had expired. We put a blanket under her and with E3 at head, rolled her up from the	F9999		

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F9999	Continued From page 31	F9999		

floor to the bed. We checked the pulse. There was no pulse. I did the three compressions and the ambulance people took over. We checked the laceration of the head. We applied ice pack. We moved her off the floor. I thought she had expired that why we moved her off the floor."

Surveyor ask why did moved off the floor. E2 stated," I thought she was dead. E3 made a comment "if people have a head or spinal injury then we don't move them."

E7, (Nurse) on 03/11/10 at 12:15 pm per telephone stated," I heard E2 nurse yelling. We all went down hall. We went into the room. She (R3) was lying face down on the floor. There was a pool of blood around her head. E3 the nurse rolled her over to assess her. She had a pulse and pupils fixed. When I called her name, she had moved her head. She did not say anything verbally. I told E2 to check the chart for DNR and call 911. E3 applied pressure to the forehead and applied ice pack. At that point I ran out of the room for oxygen."

Surveyor asked: "are you suppose to move resident with head or possible cervical injury"? E7 stated," We are not to move the resident with a head, neck or back injury. We had a inservice on head, neck and back injury. She had a pulse on the floor. She had not expired."

E8 (CNA) on 03/11/10 at 3:35 pm in the conference room stated," I was working that day. E4 call ask me if I had towels on the cart, so I brought them towels to the room. When I was in the room, I saw R3 on the floor. I saw blood on the forehead. They ask me to help put R3 back into bed. I knew it was wrong to put her back in

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F9999	Continued From page 32	F9999		

bed. We had inservice on if a resident on the floor do not touch or move from the floor. E2 told us to put her back in bed. I saw her eyes was open. She did not look dead. The inservice was long time ago. But in school, you were told not to move someone on the floor whom had fallen out of bed."

Surveyor asked E8 "who told you put resident in bed"?
E8 stated," It was E2 who told us to put her on the bed. I told her there was inservice that we are not to move residents from the floor to bed if there injury.

Z2 (Paramedic) on 03/15/10 at 9:00 am per telephone stated," Upon arrival found 5- 7 staff standing around the resident. Staff did nothing. Resident was in full cardiac arrest. I asked who put the resident in bed. The staff said they put her in bed. I asked did they immobilized the patient. They said did not immobilize her. They did not know if she had a fracture of her C2 spine. She was in cardiac arrest. They were not doing anything for her. She had arrest X 3 in the hospital. She had diagnosis Cardiac Arrest, Cervical Spinal Injury and Multi Brain Injury. I also saw a large jagged laceration on the patient's forehead, light bleeding, wound about 1 inch length with the skull visible. This patient was critical injury and was in full code cardiac arrest when we arrival. We were very angry that they put the patient in bed with no immobilized equipment under her to put in bed. A CNA said they had used a blanket to put her in the bed."

The Head Injuries Nursing Policy and Procedures Date 03/09 denoted:
3). Determine baseline condition of the resident.

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F9999	Continued From page 33 a). Conduct neurological assessment. c). Evaluate pupil size and reaction to light. e). measure blood pressure, pulse and respiration. g). Assess for injuries to other organ systems. 8). Document emergency measure taken. The Neurological Assessment Nursing Policy and Procedure dated 03/09 denoted: 2). Observe, assess and document the resident's level of consciousness, speech, pupils, hand grasp and vitals signs. (A)	F9999		