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	145016	A. BUILDING ______ B. WING ______	C 06/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR-BLOOMINGTON	700 EAST WALNUT BLOOMINGTON, IL 61701

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evaluation and treatment. This was noted on the copy of facility provided transcript describing (R1's) 05/15/10 incident.

2. Effective on 05/17/10, the facility provided In-Service training that instructed that wheelchairs are to be used for transport at all times, not seated walkers, to the two Certified Nurses Aides (CNAs), E4 and E5, involved in the incident of (R1's) 05/15/10 fall. All other facility staff were also given this same In-Service on 05/17/10, 05/19/10, 05/24/10, and 05/25/10. Copies of In-Service documents were provided on 05/25/10 at 1:30 P.M. and reviewed.

3. Effective on 05/15/10 both CNAs were "counseled on safety."

4. Effective on 05/17/10, unused wheelchairs were to be kept in the "Bird Room" adjacent to the facility's front door for quick access. It was noted on 05/26/10 at 12:10 P.M. that there were two wheelchairs in the "Bird Room" and again on 05/26/10 at 8:20 A.M.

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FINAL OBSERVATIONS

LICENSURE VIOLATIONS

300.1210a)
300.3240a)

Section 300.1210 General Requirements for Nursing and Personal Care

a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with

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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.

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 interview, observation and record review, the facility failed to provide the correct transportation equipment for one of three residents (R1) requiring assistance with transporting in a sample of three. R1 was transported while sitting on a wheeled walker seat, fell over backwards and sustained a head injury. R1 subsequently died from complications directly related to the head injury.

Findings include:

Z6, R1's spouse, on 05/24/10 at 10:55 A.M., stated that Z6 and R1 had been at the facility on Friday, 05/14/10, and "(R1) was admitted ...and I (Z6) brought (R1) in on Saturday (05/15/10) the next day. Well, we did the paper work Friday (05/14/10) and they (the facility) told me it was o.k. to bring (R1) in on Saturday (05/15/10) because that was more convenient for us (Z6 and R1)." Z6 also stated that a "$5,000" check for "down payment" had been given to the facility on 05/14/10.

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Z6 also stated that on Saturday, 05/15/10, a Certified Nurses Aide (CNA) who Z6 could not identify, put R1 into the flip-down seat of the wheeled walker brought to the facility by Z6 and then tried to push (R1) in that walker. Z6 stated that R1 "went up a ramp, hit a crack and fell over backwards and (R1) hit his head." While Z6 was unable to name which CNA had been pushing the walker with R1 seated on it, Z6 did give a brief physical description.

On 05/24/10 at 2:00 P.M., Z6 verbally confirmed that R1's fall had occurred at the facility at "A quarter after 2:00 P.M."

E1, Administrator, provided three months (March 1st through May 24th, 2010) of daily staffing assignments on 05/24/10, as requested, to determine which staff were present in the facility on 05/15/10 at 2:15 P.M., the day and time Z6 had stated R1 had fallen. E1 verbally confirmed that staffing sheets were accurate and reflected any staffing changes that may have occurred on those days. Upon review of these staffing sheets it was noted that the actual hours worked for each shift were not listed.

E2, Director of Nursing (DON), verbally explained the staffing hours on 05/25/10 at 10:40 A.M. Upon request, E2 described that "first shift" staff worked from 6:00 A.M. to 2:00 P.M. but were expected to be giving "report" to on-coming second shift staff between 2:00 and 2:30 P.M. E2 clarified that the first shift nurses would definitely not leave work until 2:30 P.M. but the CNAs might leave, "A little earlier. They (CNAs) do a walk-around report that's not as long as the nurses'." From this information it was determined, and verbally confirmed by E2, that

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on 05/15/10, there were eight nurses and sixteen CNAs scheduled from both first and second shifts.

E1 also provided, on 05/24/10 at 1:00 P.M., the requested admission/discharge list dated from 2/24/10 to 05/24/10. R1 was not listed on any of these documents.

On 05/24/10, also at 1:00 P.M., E1 provided requested "Occurrence Report" forms dated from 02/23/10 through 05/24/10. R1 was not identified on any of these forms either.

The most current census sheet, dated 05/23/10, requested on 05/24/10 and received from E1 on this same date, also did not have R1 listed.

E1, Administrator, on 05/25/10 at 10:40 A.M., was informed that all occurrences noted on the previously provided "Occurrence Reports" had happened within the facility and was questioned whether there had been any incidents, accidents or occurrences outside on the grounds. E1 stated, "Yes," that there had been an occurrence this month (May, 2010) when a "guest" had fallen outside and had to be taken to the hospital. At this time E1 was asked to provide all reports, incident forms and any communication or memos related to the incident involving R1 falling.

In the same time period noted in the previous paragraph, E1 stated that a male "guest" (R1) had arrived in the facility parking lot to be admitted. E1 stated that while a housekeeper (E6) was inside the facility trying to find a wheelchair to use as transport for the "guest," (R1), (E4), the CNA assisting him (R1), decided to use the "guest's" (R1's) seated, wheeled

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walker to transport (R1) under the eaves of the facility rather than wait for the wheelchair to arrive because, "it was chilly and raining at the time." During this transport (R1's) seated, wheeled walker's arms "folded together" and he, (R1), fell backwards and hit (R1's) head on the sidewalk. E1, when asked, stated that during this occurrence with R1 there were only two CNAs present with R1 and Z6, R1's spouse. E1 stated that E5, the other CNA present, had been assisting with carrying the "guest's" (R1's) belongings.

At 11:00 A.M. on 05/25/10 E1, Administrator (with E3, Field Nurse, present per E1's request for a witness) stated, "He (R1) was not admitted to the facility when the occurrence happened. We (facility) considered (R1) as a guest and treated and delivered care as a good Samaritan." At 11:10 A.M., upon E1 learning that (R1) would be part of the investigated sample, E1 stated that the facility did not agree with the assignation of "R1" as the "R" implied "resident." E1 reiterated that the facility considered R1 as a "guest."

On 05/25/10, this investigation continued at a local hospital from 8:30 A.M. to 10:30 A.M., due to the only data provided by E1 on 5/24/10 at 11:10 A.M. in regards to (R1's) fall was an untitled, two page transcript describing "Guest," "Employees involved," "Weather Conditions," "Location," "Time of Occurrence," "Equipment," "Narrative," and "Action Taken To Prevent an Occurrence of This Nature Again." This transcript describes the incident of R1's fall on 05/15/10 under the "Narrative" titled section and is consistent with E1's statement about R1's fall as previously noted. There is noted the detail that, "CNA, (E4), was assisting resident out of

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F9999	Continued From page 16 car when he (R1) sat down on the seated walker. Z6, who was (sic) also accompanied (R1) into the facility asked (R1) if (R1) didn't want to walk. (R1) responded, 'No.'" This contradicts Z6's statement that R1 was placed in seated, wheeled walker by E4, CNA, as noted in first paragraph above. This document also indicates that E5, CNA, was present and witnessed (R1's) fall while E5 was carrying R1's belongings. All copies of (R1's) local hospital records were provided by Z5, Director of Health Information Services, on 05/25/10 at 9:40 A.M. (R1's) History and Physical from local hospital medical records, dated 05/15/10 and dictated by Z3, medical resident for Z2, R1's neurosurgeon, at 4:57 P.M., indicates "Chief complaint: Subdural hematoma (a pocket or pooling of blood under the protective tissue barrier surrounding the brain) ...Social History: ...resides in a nursing home ...HEENT (Head, Eyes, Ears, Nose and Throat): There is an abrasion on the posterior (back) aspect of the scalp which appears to have stopped bleeding at this point." Another document dictated by Z2 on the same day but six hours and 10 minutes later indicates a "Preoperative Diagnosis: Large right frontal temporal (Side of brain beneath the temples) parietal (side of brain above the ears) acute subdural hematoma." This same document also indicates that "all bleeding points (in the brain) were controlled" during a surgical process involving opening (R1's) skull on that same day. (R1's) EEG (electroencephalogram, a test to read brain activity through the electrical impulses produced by the brain), done at the local hospital was interpreted and a report was dictated on 5/20/10 indicating, "History: ... (R1) is currently	F9999		

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F9999	Continued From page 17 unresponsive on ventilator (a machine that artificially maintains breathing)...EEG was done at bedside to look for ...the cause of (R1's) unresponsiveness. Impression: This is an abnormal EEG ...diffuse generalized brain dysfunction and focal abnormalities due to underlying hematomas consistent with (R1's) clinical history ((R1's) subdural hematomas that developed after the fall on 05/15/10 caused widespread but thinly scattered damage throughout the brain causing the brain to not function properly. There were also some specific areas that were not producing electrical activity in a normal fashion)." "Preliminary Radiology Reports" from the local hospital dated 05/15/10 indicate that at 3:23 P.M. R1 had two subdural hematomas identified by taking a computerized tomography (CT) of R1's head. One hematoma at the parasagittal (roughly around the front portion of the back end of the brain) area of (R1's) brain measured 17 millimeters at its maximum thickness. The other hematoma located in (R1's) frontal region of the brain measured 4 millimeters. Three hours and thirty-eight minutes later at 7:04 P.M., in response to (R1) becoming non-responsive, another CT was done on (R1's) head. At this time (R1's) frontal hematoma measured two centimeters (20 millimeters) and now was producing a "herniation" (swelling protrusion) within the brain. This "Moderate acute enlargement" was now causing "swelling and compression (squashing) of the right cerebral cortex (the right side of (R1's) brain)." (R1's) "Emergency Physician Record" from the local hospital, dated 05/15/10 at 3:00 P.M., indicates under the "Clinical Impression:	F9999		

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Post-Concussion (blow) Syndrome: Intercranial Hemorrhage (abbreviated as ICH, which indicates bleeding inside the skull where the brain is located)."

Z1, County Coroner, was interviewed by phone on 05/25/10 at 9:50 A.M. after noting that local hospital document titled, "Section I Record of Death" for (R1) dated 05/23/10 at 3:35 P.M. did not include a cause of death for R1, but did indicate the coroner had been notified. Z1 stated awareness of (R1's) case and was following along with the Deputy County Coroner to whom Z1 had assigned (R1's) case upon being informed by the local hospital of (R1's) death. Z1 stated no other knowledge of (R1's) fall than what had been provided by Z6, (R1's) spouse, when Z1 spoke with Z6. This information was consistent with information this writer had received from Z6. In regards to (R1's) cause of death, Z1 stated that it was required for the Coroner's office to review all available medical records before assigning a cause of death, and (R1's) records had not been received. Z1 did state that on information already known about R1's case the cause of R1's death would probably be attributed to (R1's) fall, "But I (Z1) can't be 100% until I (Z1) review his (R1's) medical records." At the time of this writing Z1 has not yet called in (R1's) cause of death. Z1 had explained it could be "days or even a week or more" before all of (R1's) data was received, reviewed and deliberated upon.

Z2, (R1's) neurosurgeon, stated on 05/25/10 at 3:45 P.M. that Z2 had no knowledge of the details regarding (R1's) fall. Z2 stated he thought that (R1) was "from the nursing home." Z2 stated that (R1's) death was due to a physical

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"systems failure" related to the brain injury caused by the ICH that had occurred due to (R1) falling and striking (R1's) head. Z2 added that (R1) had gotten a surgical intervention to relieve the pressure on (R1's) brain and to stop the bleeding, "The surgery was successful but (R1) never recovered consciousness after that." Z2 stated that Z6 had made an informed decision to remove all life support equipment when R1 remained comatose, allowing care measures, but R1 expired in the "next few days." Z2 explained (R1's) death was primarily due to respiratory (breathing) failure but that all of R1 ' s systems were shutting down or in the process of shutting down. When asked directly if Z2 was saying that (R1's) fall on 05/15/10 was responsible for (R1's) death, because the fall had led to an ICH, causing brain injury that resulted in (R1's) physical systems to shut down, Z2 replied, "That's what I've been saying."

E5, CNA, was interviewed on 05/25/10 at 11:45 A.M. with E1, Administrator, present as witness per E1's request. E5 acknowledged E5's presence when (R1) fell on 05/15/10. E5 stated that Z6 set up walker and (R1) sat down on the folding seat in the walker. E5 stated that E4, CNA, started pulling from the front of the walker with (R1) seated, i.e., E4 was facing (R1). E5 physically demonstrated how this looked. E5 then continued stating that E4 pulled (R1) to the back of the car that brought R1 to the facility. E4 then was able to turn, still facing (R1) seated. At this time E5 was asked to show this writer exactly where (R1's) incident had occurred. E1 and E5 walked to the front of the building outside and E5 pointed that (R1's) and Z6's car had been parked in the area directly to the left of the handicapped parking space, just directly to the right of where

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F9999	Continued From page 20 the black asphalt of the parking lot meets the concrete of the sidewalk that leads to the facility's front entrance. E5 pointed out that (R1's) fall had occurred at the area where the parking lot meets the sidewalk. This writer measured the lip of the concrete sidewalk and measured that the sidewalk was anywhere from ¼ inch to ¾ inches higher than the parking lot asphalt. During this measuring, E1 stated to E5 that (R1's) walker had not caught its wheels at this measured juncture but (R1's) fall had occurred at the same spot while E4 was pushing (R1) while (R1) sat on the seated, wheeled walker. E1 stated, "The walker's arms folded together." E5 agreed with E1 that that had been the case. E5 completed telling about the incident by stating that from that point, when the walker's arms had folded, (R1) had tipped over backwards. E5 added that E5 could not exactly remember seeing (R1) fall because E5 had been more focused on E4's efforts of trying to pull (R1) up from falling. E5 stated that after (R1) fell to the ground E5 dropped (R1's) belongings E5 had been carrying and "Ran inside to tell the nurses." When E5 was asked why had E4 decided to use a seated, wheeled walker to transport (R1) instead of waiting for the wheelchair that the housekeeper, E6, was retrieving, E5 began the gesture of shrugging shoulders when E1 stated that it had been "raining and chilly out that day." E5 agreed and verbally repeated that they (E4 and E5) wanted to get (R1) and Z6 out of the rain and under the eaves of the facility that overhang the sidewalk. When directly asked if E5 had awareness of the facility's standards for transporting residents, E5 replied that staff are expected to use wheelchairs for residents unable to walk.	F9999		

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In response to a request, made in the same time frame as the preceding paragraph, for any facility policy or procedure that specifically addresses how staff are to transport anyone with impaired ambulation, E1 stated there was none, that it was "understood" and part of staffs' initial orientation training.

E3, Field Nurse, on 05/25/10 at 12:35 P.M. stated there was no policy specifically addressing seated walker usage.

E1 informed this writer on 05/25/10 that E4, CNA, was in California and not expected back in the facility until the following week; therefore, no interview with E4 was conducted as of this writing. On 05/26/10 at 10:25 A.M., E1 stated there were statements made by E4 and E5 during the facility's investigation of R1's fall on 05/15/10 and provided copies as requested. These statements were not signed, but E1 verbally confirmed them as accurate. Both statements do not deviate from the interview received from E5 and both are less detailed.

On 05/26/10 at 1:40 P.M. E10, Facility Regional Supervisor, provided requested copies of contract and down payment check that Z6 had stated were done with the facility on 05/14/10, the day before (R1's) fall. E10 stated that these items had been with the facility's lawyers and had been faxed to the facility after this writer's request. The "Contract between Resident and Heritage Manor Bloomington, LLC" is dated "May/15/2010." This contract indicates under section "I, III, Term (Automatic Renewal). The initial term of this contract shall commence on May 15, 2010 and shall continue ..." This contract was signed by "responsible party" Z6,