STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E253	A. BUILDING _____ B. WING _____	01/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN N H-KNOXVILLE	407 NORTH HEBARD STREET KNOXVILLE, IL 61448

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F 332	Continued From page 11 to R4. R4 was sitting in a chair in the dayroom bent forward with his head almost on his knees. E3 was having difficulty getting R4 to take this medication and E1 (Administrator and Registered Nurse) had R4 taken into the dining room and administered the medication to him. The Physician's Order form dated January 2012 instructs nurses to administer Haldol 0.5 milligrams 1/2 tablet (0.25 milligrams), Artane 2 milligrams and Tramadol 50 milligrams to R4 at 12 p.m. daily. On 01/05/12 at 9:45 a.m., E1 confirmed that she had administered the medication set up by E3 to R4 on 01/03/12 and verified that R4 should have received Haldol 0.25 milligrams not Haldol 0.5 milligrams. 2. On 01/03/12 at 11:30 a.m., E3(Licensed Practical Nurse) administered Clonazepam 1 milligram to R9. E3 looked through the medication cart for R9's Cogentin, but stated that there was none available. E3 stated that she would have to call the pharmacy to bring R9's Cogentin. The Physician Order form dated January 2012 instructs nurses to administer Cogentin 0.5 milligrams three times daily at 7:00 a.m., 12:00 p.m. and 8:00 p.m. At 2:00 p.m., on 01/03/12, E3 stated that the pharmacy will deliver R9's Cogentin 0.5 milligrams with the normal drug delivery at 8:00 p.m., so R9 will not receive his noon dose of Cogentin.	F 332		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.1210b) 300.1210d)6) 300.3240a) Section 300.1210 General Requirements for	F9999		

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F9999	Continued From page 12 Nursing and Personal Care b) The facility shall 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 resident care plan. 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: d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2- 07 of the Act) These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to critically analyze fall investigations for circumstances of falls, identify trends and patterns, revise care plans, implement interventions to minimize the risks for falls and injuries for two of five residents at risk for falls (R2, R4) in the sample of eight. R2 was found	F9999		

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on the floor and sustained a fracture to the right orbital and displaced nasal bone. The facility failed to develop and implement interventions after R4 fell four times in eight days. The facility nurse failed to conduct physical assessment of R4 after a fall. R4 fell on 01/04/12 and sustained a brain contusion and concussion. The facility failed to develop and implement any interventions after this fall and R4 fell again twenty five hours later, sustaining a head laceration requiring staples.

Findings Include:

1. According to the admission forms R4 was admitted to the facility on 12/5/2011. The Hospital Psychiatric Evaluation dated 11/20/2011 states that R4 has diagnoses including dementia related to alcohol abuse and dependency, and Wernicke - Korsakoff encephalopathy. This evaluation states that R4 had severe increased agitation and aggression.

According to the January 2012 Physician's order form R4's medication regime includes medications: Fentanyl 25 mcg(micrograms) / hour patch every three days, Depakote 125 milligram sprinkle three capsules (375 milligrams) every 12 hours, Haldol 0.5 milligram 1/2 tablet (0.25 milligrams) four times daily, Ultram 50 milligrams every six hours, Zyprexa 5 milligrams at bedtime, Trazodone 100 milligrams at bedtime. These medication may place R4 at an increased fall risk.

The Fall Risk Assessment dated 12/16/11 rates R4 at 16 with a score of over 10 considered high risk.

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Nurses notes from 12/06/11 to 12/27/11 document at least 23 episodes where R4 was combative, uncooperative, wandering, and /or roaming about facility in and out of other residents room. Nurses notes dated 12/27/11 at 3:30 a.m., document that R4 rolled out of bed onto floor.

Nurses notes dated 01/02/12 at 1:15 p.m., document that R4 was found on the floor in his room with no apparent injuries. Nurses notes dated 01/02/12, 2- 10 p.m. state that R4 is "very unsteady et (and) running into everything." and that R4 is " very busy in et out of there residents' rooms."

On 01/03/12 at 9:45 a.m., R4 wandered into room 145. R4's gait is unsteady and shuffling and R4's posture is bent forward with his head looking downward. R4 stood in the doorway of room 145, started to loose his balance, and banged his head against the door.

On 01/03/12 at 11:35 a.m., R4 was sitting in the dayroom with his head bent over nearly to the floor. R4 straightened partway and stood up. R4 shuffled about the dayroom with his head bent down. R4 shuffled right up to other residents' wheelchairs and up next to the wall. R4 began shuffling down the ramp with his shoe laces untied. E5 (Certified Nurse Aide) assisted R4 back to a chair and tied his shoe laces. About two minutes later, R4 fell to the floor in the day room. E3 (Licensed Practical Nurse) was present when R4 fell and went to assist R4 up. E3 could not get down to assist R4 and left to get an aide to help. During this time, R4 got himself back up to his feet. E3 did not perform any type of assessment

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for injury or evaluation of R4's condition.

Nurses notes dated 01/03/12 at 8:30 a.m., document another fall, stating that R4 was "on the floor next to a wall (no witnesses) sitting, could have slid off side of bed. No apparent injuries."

Nurses notes dated 01/04/12 document that at 7:00 a.m., R4 fell in the dining room , striking the right side of his head above his ear on another resident's wheelchair pedal. Nurse documents that R4 was sent to the local emergency room for evaluation and treatment.

Nurses notes dated 01/04/12 at 10:30 a.m., document that R4 returned from the hospital, had been sedated for a CT (computerized tomography) scan, and was sleeping. E2 (Director of Nursing) documented that the Emergency Room nurse had stated that R4 had a contusion, and brain concussion.

The CT scan report dated 01/04/12 states that R4 has brain ischemia and a right parietal scalp contusion.

On 01/04/12, 2-10 nurse documents that R4 "has a very unsteady gait" and "unable to hold a drinking glass."

On 01/04/12 at 3:30 p.m., E1 (Administrator) verified that R4 is a fall risk and has had numerous recent falls. E1 verified that she reviews R4's falls and updates the care plan. E1 verified that R4 has had five falls since 12/27/11, but no interventions or approaches have been developed or implemented to prevent R4 from

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continuing to fall. According to R4's clinical record and care plan, the facility did not develop any plan to increase supervision or monitoring of R4.

On 01/05/12 at 8:00 a.m., both certified nurse aides and the nurse (E2) were in the dining room area. R4 was ambulating in his shuffling gait wandering room to room unsupervised by facility staff. R4 wandered into another resident's room. A loud crash sounded and R4 was found on the floor. E2 responded to the crash and called for assistance. R4 had a laceration on right side of the back of his head.

Nurses notes dated 01/05/12 at 8:00 a.m., state that R4 fell in a peer's room, hitting the occipital area of his skull on the corner of a wastebasket causing a "L" shaped laceration that bled freely. R4 was sent into the local emergency room for an evaluation and treatment and returned at 12:30 p.m. with seven staples to his occipital laceration.

On 01/05/12 at 9:00 a.m., E5 (Certified Nurse aide) stated that R4 wanders constantly in an unsteady gait and does not sit down to rest and sleeps very little. E5 stated that R4 really needs constant supervision one to one.

2. The current physicians order sheet dated 1/1/12 through 1/31/12 documents that R2 is 92-years-old and has diagnosis of Alzheimer's disease. The Minimum Data Set dated 10/11/11 documents that R2's cognition is severely impaired, needs assistance with all activities of daily living, is transported by staff in a wheelchair with a lap cushion to and from meals. R2 is

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identified as high risk for falls.

The accident/incident reports from 1/1/11 through 12/31/11 document that R2 has fallen sixteen times during this time period. Out of these sixteen falls, eleven have happened when he was alone in his room unsupervised. The fall investigation report of 8/15/11 documents that R2 was found on the floor of his room. R2 was sent to the hospital where he was found to have a fracture of the Right orbital, two fractured ribs and a displaced nasal bone fracture. The other fall investigations document minor injuries of skin tears, bruises and scratches.

The care plan dated 4/29/10 through target date of 1/9/12 documents the falls with basic interventions of keeping the room free of clutter, well lighted and observe for weakness, etc. On 9/29/11 a lap cushion and a break away alarm was added as a new intervention to prevent further falls after a fall on 9/28/11. There are no other new interventions after the other falls. There is no documentation to indicate that a pattern was identified when 11 of the 16 falls happened when R2 was alone in his room seated in his wheelchair and no increased supervision was provided.

On 1/3/11 from 8:30 AM until 11:30 AM, R2 was seated in his wheelchair with lap cushion and break away alarm alone in his room with television playing. At 11:30 AM, R2 was transported by wheelchair to the dining room for lunch. After lunch, R2 was transported back to his room and left alone with the television playing. This routine was observed daily from 1/3/11 through 1/5/11. On 1/4/11 at 12:30 PM, R2's

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F9999	Continued From page 18 break away alarm was sounding. R2 was observed ambulating across the room to the bathroom by himself. E4(Certified Nurse Assistant) ran to assist him to the toilet, but had to leave him alone in the bathroom to go down the hall to a room and get a adult incontinence pad. E4 returned and assisted R2 back to the wheelchair, connected alarmed belt and lap cushion and left him alone in his room. E4 stated that he gets up and out of the wheelchair before she can get to him. (B)	F9999		