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MAPLE CREST CARE CENTRE	4452 SQUAW PRAIRIE ROAD BELVIDERE, IL 61008

(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 323	Continued From page 8 R11's Minimum Data Set (MDS) Assessment of 2/6/12 showed R11 required extensive assistance of two staff for transferring, toileting and bed mobility. R11 had range of motion impairments of both upper and lower extremities. R11 was assessed as occasionally incontinent of bowel. The test for balance showed R11 was not steady moving on and off the toilet and required physical help to stabilize. The ADL (Activities of Daily Living) care plan documented, R11 has self care deficit related to having a Stroke. The interventions initiated on 12/9/11 showed , "R11 requires extensive assist of two for toilet use. R11 has left side neglect. Needs extensive assist with the left side of his body." The facility's Unusual Occurrence Report for R11 dated 2/23/12 at 6:40 PM showed, Resident fell when sitting on the toilet and slipped to the floor landing on his buttocks. "R11 had been alone in the bathroom." Report further documented, "Do not leave R11 on the toilet by himself. Staff to stay with him at all times[when he is] on the toilet . Certified Nursing Assistant (CNA) had not been in the bathroom with him. On 4/24/12 at 3:05 PM, E4 (Restorative RN) said R11 should not have been left alone on the toilet.	F 323		
F9999	FINAL OBSERVATIONS Surveyor: Simerly, Juli Licensure Violations	F9999		

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F9999	Continued From page 9 300.690b) 300.1210b) 300.1210b)5) 300.1210d)6) 300.3240a) Section 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident Section 300.1210 General Requirements for 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. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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	F9999		

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F9999	Continued From page 10 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. These regulations are not met as evidenced by: Based on observation, interview and record review the facility failed to supervise a confused and agitated resident while the resident was sitting on the edge of the bed. This failure resulted in R8 lunging forward and sustaining a large hematoma to her left forehead, a telescoping fracture of the left femur and a compression fracture of the left tibia on 4/8/12. The facility also failed to monitor R11, R12 while on the toilet/bedside commode to prevent the resident from falling off and sustaining an injury, failed to ensure that R4 who requires 2 assist for transfers was transferred from the bed to the bedside commode by 2 staff members to avoid injury to the resident's leg and failed to ensure that R10, R4 were wearing non-skid footwear during transfers to prevent slipping on the floor and falling. The facility also failed to report a serious injury of a resident to the Department of Public Health (R8). This applies to 5 of 9 residents (R8, R12, R4,	F9999		

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R11, R10) reviewed for falls/injuries in a sample of 13.

The findings include:

1. The Physician's Order Sheet dated April 2012 shows that R8 has diagnoses including Senile Dementia and Depressive Disorder.

The Unusual Occurrence Report dated 4/8/12 at 5:30 AM states, "CNA (E9) reported that when dressing (R8), they bumped heads- (R8) had a 2 cm x 2.5 cm hematoma on left forehead approximately the size of an apricot, cold pack applied immediately, red lines noted superiorly and inferiorly on hematoma but no open areas, bruising was faint at first then darkened as noted at 6:30 AM and hematoma became flatter a little and spread over left forehead from hairline to eyebrow with only red line noted superiorly- remained alert, talking, smiling, laughing. Denied pain at 5:30 AM, then stated it hurt later."

The Minimum Data Set of 3/28/12 shows that R8 requires extensive assist of 2 staff for transfers and toilet use. This same document shows that R8 is not steady and is only able to stabilize with human assistance when transferring from surface to surface

R8's Fall Risk Assessment dated 3/28/12 shows that R8 scored a 16= High Risk.

R8's careplan revised and initiated on 4/23/12 (resident expired 4/12/12) states, "(R8) is high risk for falls related to unaware of safety need, Deconditioning." One of the interventions listed states, "All care of (R8). should be done with two

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assists at all times. This same care plan states, "Behaviors- combative behaviors during personal care." One intervention listed for this problem states, "When (R8) is agitated, make sure she is safe and secure, give her 5-10 minutes to calm down. Upon returning thank her for waiting for you, give explanation of task intended showing visual aids, tell her you would like to help... Use 2 CNAs if needed."

The facility Department of Public Health Reporting Form dated 4/9/12 states, " Approximately 5:00 AM on 4/8/12, resident was being assisted with AM care. Aide summoned nurse because R8 had struck head with the CNA and was getting a bump. Nurse(E10- LPN) noted and egg sized bump raising on the left side of patients forehead. The aide stated she was bumped on the right side of her head behind her ear... POA refused recommended CT scan. 30 minutes later resident agreeable to getting up for breakfast. C/O leg pain upon movement. Resident remained in bed and x-rays were obtained which revealed a telescoping fracture of the left femur/hip and a slight compression fracture of the tibial shelf. Pt apparently struck left knee on the floor when she lunged/fell to the side. Hospital recommended. POA refused, requesting pain control/comfort care. Pt is on hospice for end stage dementia." R8 expired on 4/12/12.

The Radiology Report of R8's left hip dated 4/8/12 states, " There is an acute fracture through the left femoral neck with telescoping." A Radiology Report of R8's left knee also dated 4/8/12 states, "Due to overlap, the lateral tibial plateau is not well-seen, however, findings are very suspicious for a compression type fracture of

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F9999	Continued From page 13 the lateral tibial plateau of indeterminate age." The facility form entitled, Follow-up Investigation of Injury states, "I spoke with (E9-CNA) on Sunday, April 8, 2012 at 10:24 AM. I asked her to tell me exactly what happened the (R8). (E9) said (R8) was doing fine with her. She had washed her, put on her diaper. (R8) started hitting at (E9). (E9) says she pushed (R8's) arms away from her face. (R8) wouldn't put her arms up. (E9) put her upper clothes on her. (E9) says she was holding (R8) up in the bed with 1 arm. (E9) says she was reaching to end table to get (R8's) glasses and (R8) threw her head into the back of (E9's) head. (E9) said she stared crying and laid (R8) down. Went and told (E10-LPN) . (E9)says (E10) came in the room, another aide came with her, (E9) did not know her name. (E10) iced (R8's) head and left her in bed. (E9) says she kept checking on (R8). I asked her why she was checking on (R8) and (E9) said to make sure the ice was still on her head. (E9) told me this happened between 5:15 AM and 5:30 AM. I asked (E9) if (R8) had fallen out of the bed and she said no. (E9) said she didn't fall out of bed." On 4/24/12 at 10:45, Z1 (R8's Physician) stated, "About 4-6 months ago the family had had a really good experience with hospice and wanted her to be on hospice too. I wouldn't sign the paper because I didn't think she was going to die in 6 months. She would sit in the hallway and talk and smile. If she didn't want to be messed with she would push you away. I saw her a couple days after the incident and she looked terrible. She had a bump on her forehead, that raccoon look around her eyes and an open area between between her eyes. They (facility) said her	F9999		

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daughter didn't want anything done. I was told she had head bumped someone. If she was a non-hospice pt she would have had a CT of the brain. I am sure she had a subdural bleed or something catastrophic happened to her brain." Z1 was asked if he felt that the head injury led to R8's death. Z1 stated, "I think so. Something terrible happened to her brain. When I saw her she was definitely post trauma unresponsive. I think without the fall she would have lasted quite a while. I was told about the leg trauma later and was told that the daughter didn't want to do anything with that either. I reviewed the X-rays. I think she had a femur fracture and a tibia fracture."

On 4/25/12 at 1:25 PM E2 (DON) stated, "I know she hit something harder than the CNAs head. Looking at her injury, I'm sure she hit the bedside table- she had 2 lines- one on the top and one on the bottom of the bump. The telescoping fracture- she had a white area on her left knee with an ecchymotic area around it. She had to have hit her knee on the floor. That had to be the mechanism of injury- it just fits. We interviewed E9 for 3 hours. I came to the conclusion that either she really didn't know what happened and was incompetent or she does know what happened and she is being deceitful. Either way I couldn't trust her with another resident."

The facility Department of Public Health Reporting Form dated 4/9/12 states, " Approximately 5:00 AM on 4/8/12, resident was being assisted with AM care. Aide summoned nurse because R8 had struck head with the CNA and was getting a bump. Nurse(E10- LPN) noted and egg sized bump raising on the left side of pts

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F9999	Continued From page 15 forehead. The aide stated she was bumped on the right side of her head behind her ear... POA refused recommended CT scan. 30 minutes later resident agreeable to getting up for breakfast. C/O leg pain upon movement. Resident remained in bed and x-rays were obtained which revealed a telescoping fracture of the left femur/hip and a slight compression fracture of the tibial shelf. Pt apparently struck left knee on the floor when she lunged/fell to the side. Hospital recommended. POA refused requesting pain control/comfort care. Pt was on hospice for end stage dementia." On 4/25/12 at 3:00 PM, E1 (Administrator) stated, "We talked about it but didn't fax it because she didn't go out (to the hospital). It was just poor judgement on our part." 2. The Physician's Order Sheet dated April 2012 shows that R12 has diagnoses including Dementia and Anxiety. R12's Fall Risk Assessment dated 12/20/11 shows that R12 scored a 28= High Risk. The Minimum Data Set of 3/21/12 shows that R12 requires extensive assist of 2 staff for transfers and toilet use. This same document shows that R12 is not steady and only able to stabilize with human assistance when moving on and off the toilet. The Unusual Occurrence Report dated 3/8/12 at 4:40 AM states, "CNA reported left resident on the Bedside Commode to go get the (mechanical lift), observed resident lying on floor on her left	F9999		

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side, holding head up and talking, but speech unclear, disorganized, able to move all extremities as condition allows. Skin tear noted on left forearm near elbow and no head trauma noted to head until 7:15 AM. Then has bump and bruise on left forehead approximately size of a large egg."

R12's care plan initiated on 9/27/10 states, "(R12) is high risk for falls related to unaware of safety needs, deconditioning and psychoactive drug use." One of the interventions listed for this problem states, "Monitor (R12) while she is in the bathroom and transfer with assist of 2 people and gait belt."

On 4/24/12 at 3:05 PM, E4 (Restorative Nurse) stated, "(R12) should not have been left alone on the commode. That was the intervention we added to the care plan."

3. The Physician's Order Sheet printed 4/24/12 shows that R4 has diagnoses including Dementia with Behavioral Disturbances and Parkinson's Disease.

R4's Minimum Data Set of 1/24/12 shows that R4 requires extensive assist of 2 staff for transfers.

The Unusual Occurrence Report dated 4/6/12 states, "While transferring (R4) from the bed to the bedside commode (R4) started to slide feet forward, right buttocks coming off of the bed. This writer (E8- RN) put knees in squat position against resident to keep resident from sliding off bed. Skin tear to left shin noted from writer's right

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knee. Size 2.0 x 0.5 cm. It is also shown that R4 was "barefoot" during the transfer. An intervention listed on this same form states, "TX per protocol :Always use 2 staff to transfer (R4)."

On 4/24/12 at 3:11 PM, E4 stated, "If it were me I would have transferred (R4) with 2 people."

R4's care plan initiated 11/9/10 states,"Restorative, toileting, transfer: (R4) has an ADL Self Care Performance deficit related to/ Parkinson's Disease;s and Osteoarthritis." An intervention for this problem states, "Transfer:(R4) requires extensive assist of two staff participation with transfers. At times needing a mechanical device."

Surveyor: White, Jacqueline
4. The April 2012 Physician's Order Sheet documents that R10's diagnoses include: Scoliosis, Osteoporosis and Edema.

R10's Minimum Data Set (MDS) Assessment of 1/23/12 shows R10 has severe cognitive impairment and long and short-term memory loss. R10 requires extensive assistance of one staff for transferring, toileting and bed mobility. R10 has range of motion impairment of both lower extremities. R10 is frequently incontinent of bowel and bladder.

The facility's Unusual Occurrence Report for R10 dated 2/1/12 at 2:45 PM showed, "CNA responded to the call light, observed patient sitting on her bottom on the floor with her back resting up against the bed. The report documented R10 had on slippery socks in the

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F9999	Continued From page 18 bed which caused her to slide down the side of the bed." R10's falls care plan dated 4/9/12 showed an approach that was added on 2/2/12 which documented, "Remove socks when in bed. If feet are cold, apply non-skid slipper socks so R10 does not slide out of bed." The facility's Unusual Occurrence Report for R10 dated 2/14/12 at 1:30 PM showed, "Resident was observed found on the floor by the bed in her room. The report documented R10 was wearing slippery socks in bed." The report further documented that staff were again advised to follow the intervention mentioned in R10's care plan to prevent falls. On 4/24/12 at 3:00 PM, E4 (Restorative RN) stated, [Before R10 fell out of bed the second time], "I told them [staff] to put non-skid socks on her if her feet are cold or no socks when she's in bed." 5. The January 2012 Physician's Order Sheet documents that R11 was readmitted to the facility on 1/8/12 with diagnoses include: Seizures, Acute Anxiety State and Cerebral Vascular Accident with Left-Sided Hemiplegia. The Physical Therapy Note of 1/9/12 showed R11 was recently hospitalized for seizure activity. The note documented, "R11 had left sided weakness and left upper extremity flaccidity and decreased mobility for functional transfers. Patient has increased falls."	F9999		

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F9999	Continued From page 19 R11's Minimum Data Set (MDS) Assessment of 2/6/12 showed R11 required extensive assistance of two staff for transferring, toileting and bed mobility. R11 had range of motion impairments of both upper and lower extremities. R11 was assessed as occasionally incontinent of bowel. The test for balance showed R11 was not steady moving on and off the toilet and required physical help to stabilize. The ADL (Activities of Daily Living) care plan documented, R11 has self care deficit related to having a Stroke. The interventions initiated on 12/9/11 showed , "R11 requires extensive assist of two for toilet use. R11 has left side neglect. Needs extensive assist with the left side of his body." The facility's Unusual Occurrence Report for R11 dated 2/23/12 at 6:40 PM showed, Resident fell when sitting on the toilet and slipped to the floor landing on his buttocks. "R11 had been alone in the bathroom." Report further documented, "Do not leave R11 on the toilet by himself. Staff to stay with him at all times[when he is] on the toilet . Certified Nursing Assistant (CNA) had not been in the bathroom with him. On 4/24/12 at 3:05 PM, E4 (Restorative RN) said R11 should not have been left alone on the toilet. (B)	F9999		