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	145494	A. BUILDING _____ B. WING _____	06/07/2012

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F 325	Continued From page 31 R7's Nurses Notes for the month of April 2012 did not show documentation where the Physician or family was notified of R7's weight loss for the month of April. The facility's undated policy titled"Weight Gain/Weight Loss Policy" states "...The ward clerk reviews weights every Friday and notifies the physician of any weight gain/loss of 5% in one month, 7.5% in three months or 10% in six months....." On 6/4/12 at 11:37 AM R7 ate approximately 25 to 50% of her meal, on 6/5/12 at 9:20 AM R7 did not eat any of her meal and on 6/5/12 at 1:35 PM R7 did not eat any of her meal.	F 325		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.1210b)4)5) 300.1210d)6) 300.3240a) 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	F9999		

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care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.
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 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. (A, B) (Section 2-107 of the Act)

Based on observation, interview, and record review, the facility failed to conduct complete

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investigations, root cause analysis and identify/ implement interventions to prevent falls for 4 of 11 residents(R13,R20,R15,R9) reviewed for falls, in the sample of 24. The facility failed to provide supervision during toileting to prevent falls for two residents(R13,R20) resulting in a fracture for R13 and a laceration with sutures for R20.

Findings include:

1. R13's Physician's Order Sheet dated 6/01/12 lists diagnoses of Dementia, Diabetes Mellitus, Lower Extremity Diabetic Neuropathy, and Agitation with Behaviors. The Care Plan dated 3/23/12 also lists a right humeral head fracture and a fracture to the radial head which occurred on 5/22/12. R13's quarterly Minimum Data Set dated 3/15/12 identified R13 had severe cognitive impairment, requiring supervision of one for transfers.

The Nurse's Notes dated 5/11/12, 7:30 am document R13 was being toileted at 4:55 am and as the Certified Nurse Aide (CNA) turned her back R13 stood, lost her balance, fell backwards and landed on her back with her head hitting the floor. R13 received a scrape to knee.

CNA E8 stated on 6/06/12 at 10:30 am that she had R13 on the toilet (on 5/11/12). E8 stated R13 can be very "antsy". E8 said she was by the sink in the bathroom getting a piece of clothing off the towel rack, with her back to R13. E8 stated "I didn't see it, cause my back was turned, I think she stood up, started falling and grabbed on the the wheelchair that was in front of her." E8 stated R13 and the wheelchair tipped over.

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The Incident/Accident report dated 5/11/12 lists the root cause analysis as "Residents dementia keeps her from being able to move safely in her surroundings." There was no documented intervention suggested on the report to prevent a future fall during care.

Nurse's Notes dated 5/24/12 at 1:55 pm document CNAs had taken R13 to her room to take her to the bathroom. After the lap cushion was removed R13 stood up, got her feet tangled, lost her balance and fell to the floor landing on her right hip and shoulder. The Nurses Notes document R13 could move all extremities as usual except would not move her right arm and shoulder. R13 was taken by ambulance to the emergency room and returned to the facility with her arm in an immobilizer and orders for pain medicine. The Care Plan dated 6/1/12 states R13 had a fall on 5/24/12 resulting in a Fractured Right Humerus.

CNA E16 stated on 6/04/12 at 3:20 pm that she was assisting R13 when R13 fell and broke her arm on 5/24/12. E16 stated she and E20 were working in the room with R13 and her roommate. E20 was with the roommate in the bathroom. E16 was helping undress R13, who was seated in the wheelchair with the lap cushion removed and the personal alarm turned off. E16 stated she was standing in front of R13 and turned around to get some clothing off a table when R13 stood up quickly and tipped over.

Nurse E19 stated on 6/05/12 at 10:20 am that she had been working on 5/24/12 when R13 fell and fractured her arm. E19 stated she spoke with the CNAs E16 and E20. E19 stated staff were

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getting ready to change R13, R13 was seated in the wheelchair with her pants down, and when E16 went to get an incontinent brief R13 stood up and fell and they couldn't catch her. E19 stated that R13's movements are quick.

The facility Incident/Accident report dated 5/24/12 documented by Nurse E19 stated the personal alarm had been removed to give care and a gait belt was on. The report listed two CNAs as witnesses (E16, E20). The facility Investigation-Response Report dated 5/24/12 listed the Root Cause Analysis as "Due to decreased cognitive level and resident trying to get up independently despite lap buddy being used in wc (wheelchair). CNAs were by her but couldn't catch her before she fell. There were no recommendations for interventions to prevent future falls on the report.

The Care Plan dated 6/1/12 documented the fall with fracture however there were no interventions added to the care plan to address R13's need for close supervision with care when she does not have the lap cushion in place because she will impulsively stand up. The care plan also had not been updated to address R13's previous falls in May 2012. This included another fall while being assisted by staff on 5/11/12.

On 6/05/12 at 2:40 pm Director of Nurse's E2 stated that she had talked to both of the CNAs about the 5/24/12 incident but had not documented anything. E2 stated we don't take statements unless there is important information. The root cause analysis had not identified any supervision issues related to R14's falls or any recommendations of any new interventions to

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prevent falls during care.

2. R20's quarterly MDS dated 3/29/12 identifies R20 as cognitively alert, requiring limited assistance of one for ambulation, having unsteady balance requiring physical assistance to steady.

On 6/05/12 at 12:15 pm R20 was noted to have two fading black eyes,a bruise to her jaw, and a very bloodshot right eye. R20 was seated in a wheelchair with a personal body alarm. R20 stated she fell when she stood up to get off the toilet. R20 stated she thought she could do it herself and she fell.

The Nurse's Notes dated 5/13/12 at 3:00 am document the nursing staff heard a loud crash and moan and found resident lying half on her abdomen and half on her left side laying on top of her walker. R20 left forehead had swelling and bruising with an open area that was bleeding. The swelling measured 7.5 centimeters (cm) long by 4 cm wide. R20 was sent to the emergency room and returned to the facility with 6-7 stitches to her forehead.

Director of Nurse's E2 stated on 6/06/12 at 11:55 am that E2 was told that E8 stepped from the bathroom out to grab a towel and the resident fell.

The facility Incident/Accident report dated 5/13/12 documented that there was no actual witness to the incident. The assigned care giver was Certified Nurse Aid (CNA) E8. The "Investigation-Response" report dated 5/13/12 documents the resident was on the toilet, got up with out help with walker and fell outside of the

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bathroom, face down with the walker under the resident. The Root Cause Analysis documented "Should not have been left unattended on the toilet. Resident has personal alarm on bed and wheelchair."

On 6/06/12 at 12:30 pm. CNA E8 stated that she had walked R20 to the bathroom and had left her seated on the toilet while she left the bathroom to get an incontinent brief out of the drawer in the bedroom and also went out into the hall to retrieve towels from the hall linen cart. E20 stated there were other call lights going off and she went into the hallway to take a peek at what other lights were on, grabbed the towels and when she came back into the room R20 had already gotten up and had fallen. When asked why she left R20 alone on the toilet, E20 responded that usually she takes what supplies she needs with her into the toilet room and R20 usually stays seated on the toilet.

R20's Care Plan dated 3/28/12 stated "At Risk for falls, injury D/T (due to) weakness of her legs which causes unsteadiness. The approaches include assist with one or two persons for stand pivot transfer, remind not to stand with out wheeled walker, encourage not to rush when she is transferring, personal alarm to bed and wc (wheelchair) prn to alert staff to mobility. The Care Plan did not address R20's 5/13/12 fall, nor any intervention for supervision for toileting.

3. R15's Physician's Order Sheet (POS) dated June 2012 documents the following diagnoses: Blindness, Osteoarthritis, Osteoporosis, Dementia, Depression/Anxiety, and Auditory Hallucinations. The POS documents the medical

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symptoms for use of the soft waist restraint as "poor balance and anterior listing."

R15's Minimum Data Set (MDS) dated 04/26/12 documents that R15 is severely cognitively impaired and requires the extensive assistance of one person for transferring and ambulating in her room.

R15's Fall Risk Assessment dated 04/26/12 shows R15 is at high risk for falls.

On 06/05/12 at 8:40am, R15 slid off of her wheelchair and was held in the wheelchair (while buttocks and thighs were off of the wheelchair seat) by a soft waist restraint. The soft waist restraint (which was secured to the bars on the lower back of the wheelchair) had slipped up under R15's right and left axilla and across her upper chest, forcing R15's bent arms upward to shoulder height. E5, Licensed Practical Nurse (LPN), E6, Certified Nursing Assistant (CNA), and E7, CNA, picked up R15 and placed her back in the wheelchair, replaced the soft waist restraint, and secured the restraint to the bars on the lower back of the wheelchair. R15 then sat in the wheelchair in the hall near the nurse's station.

On 06/05/12 at 8:45am E5, E6, and E7, stated that R15 had previous occurrences of sliding down in her wheelchair with the soft waist restraint in place.

On 06/06/12 at 10:10am, E11, LPN, stated that R15 had previous occurrences of sliding down in her wheelchair with the soft waist restraint in place.

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On 06/06/12 at 10:15am, E12, CNA, stated that R15 had previous occurrences of sliding down in her wheelchair with the soft waist restraint in place.

On 06/06/12 at 9:15am, 9:55am, 11:18am, 1:00pm, and 4:00pm, R15 was sitting in her wheelchair with the soft waist restraint in place.

On 06/07/12 at 11:00am, E18, Registered Nurse (RN) and Care Plan Coordinator, stated that an Incident/Accident Report was not completed for the 06/05/12 incident. E18 also stated that an investigation determining root cause analysis for the 06/05/12 incident was not completed, and no interventions or other action was taken. E18 also stated that there was no documentation in the Nurse's Notes regarding the 06/05/12 incident of R15 sliding down in the wheelchair with the soft waist restraint in place.

R15's Care Plan dated 04/26/12 and 05/02/12 directs staff to "Assess (R15) for safety alternative" and "Lap (cushion) on wheelchair." There was no direction to use a soft waist restraint. E18's Care Plan contained no interventions for the 06/05/12 incident.

On 06/06/12 at 11:15am, E13, Certified Occupational Therapy Assistant (COTA), stated that he has not evaluated R15 for positioning and restraint use.

The Facility's Fall Prevention Policy and Procedure (revised 04/21/11) defined a fall as unintentionally coming to rest on the ground, floor, or other lower level" and "an episode that occurs...when a resident would have fallen, if not

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for staff intervention, is also considered a fall." The Policy directs staff to complete an Incident Investigation Report, analyze each incident, determine a root cause analysis, and determine the response or action that should be taken. The Policy directs Physical and Occupational Therapists to "Conduct assessments for fall-risk patient referrals", and "(Help) develop an intervention program...to reduce fall risk." The Policy also directs staff to "Update resident care plans appropriately to ensure proper interventions are in place."

4. R9's POS dated June 2012 documents the following diagnoses: Dementia with Behavioral Symptoms, Chronic Back Pain, and Incontinence. R9's POS also documents "Soft waist (restraint) in wheelchair as necessary due to poor balance and unsteady gait."

R9's Fall Risk Assessment score dated 12/08/11 and 3/09/12 assess R9 at high risk for falls.

R9's MDS dated 12/15/11 and 03/08/12 document that R9 is severely cognitively impaired and requires limited assistance with one staff person for bed mobility, transferring, and ambulation. R9's MDS documents that R9's balance is not steady, but that he is able to stabilize without human assistance.

On 06/04/12 at 12:10pm R9 sat in the hall in his wheelchair with a soft waist belt on. The soft waist belt was secured to the bars on the lower back of the wheelchair.

On 06/05/12 at 8:45am, 10:15am, 11:45am, 12:20pm, and 3:45pm, R9 sat in the hall in his

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F9999	Continued From page 41 wheelchair with a soft waist belt in place and secured to the bars on the lower back of the wheelchair. The wheelchair did not have anti-tip bars in place. On O6/06/12 at 9:00am, 1:00pm, and 4:00pm, R9 sat in the hall in his wheelchair with a soft waist belt on. The waist belt was secured to the bars on the lower back of the wheelchair. The wheelchair did not have anti-tip bars in place. The Facility's Incident and Accident Report dated 02/02/12 at 8:00pm documents that R9 was found lying on the floor of his room on his left side while still in the wheelchair with the soft waist restraint still in place and secured to the bars on the lower back side of the wheelchair. R9's personal alarm was still attached to the resident's clothing and did not alarm. The Facility's Incident and Accident Report dated 02/08/12 at 7:30pm documents that R9 was found sitting on the floor of his room next to his bed with his back against the dresser, with his lower legs caught inside the wheelchair and inside the soft waist restraint. The Facility's Incident and Accident Report dated 02/09/12 at 5:30pm documents that R9 was found on his hands and knees on the floor of his room with the wheelchair strapped to his back by the soft waist restraint which remained secured to the bars on the lower back side of the wheelchair. (B)	F9999		