STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145926	A. BUILDING ______ B. WING ______	C 06/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERMILION MANOR NURSING HOME	**14792 CATLIN TILTON ROAD** **DANVILLE, IL 61834**

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F 323 — Continued From page 5 — F 323

"Ensure Tab Alarm is in place when in wheelchair or bed and Pressure Sensitive alarm to bed and wheelchair."

E3, RN ADON (Registered Nurse, Assistant Director of Nurses) on 5/31/12 at 4:25 PM could not confirm that the tab alarm or the sensitive alarm were in place when R1 fell on 5/3/12 and 5/8/12. E3 did confirm that R1 did receive sutures to both lacerations from the falls of 5/3/12 and 5/8/12 and that R1 was up and wandering around the building per self without assistance before the fall on 5/3/12.

F9999 — FINAL OBSERVATIONS — F9999

LICENSURE VIOLATIONS:

300.610a)
300.1210b)
300.1210d)6)
300.3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by

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F9999	Continued From page 6 written, signed and dated minutes of such a meeting. 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. 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 2-107 of the Act)	F9999		

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F9999	Continued From page 7	F9999		

These requirements were not met as evidenced by:

Based on record review and interview the facility failed to conduct a complete root cause analysis and implement appropriate interventions for falls for R1. Failure to complete the root cause analysis for R1's first fall resulted in R1 having another fall five days later. R1 sustained lacerations requiring sutures from both falls.

Findings include:

The Physician's Order Sheet (POS) dated May 2012 lists the following diagnoses for R1: Dementia with Delirium and Agitation. The Minimum Data Set (MDS) dated 5/14/12 states R1 is cognitively severely impaired in making daily decisions, requires extensive assistance with transfers and ambulation. The same MDS states R1's balance is unsteady and is only able to stabilize with assistance. The Fall Risk Assessments dated 4/20/12 and 5/10/12 reads R1 is at High Risk for falls. The facility's Accident and Incident Log dated May 2012 shows R1 had a total of 4 falls, 5/3/12, 5/8,12, 5/9/12 and 5/20/12.

Incident Accident Report dated 5/3/12 describes R1 was found lying on his left side in the Exam Room on C section with a large laceration above R1's left eye with profuse bleeding at 10 PM on 5/3/12. R1 was transferred to the emergency

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F9999	Continued From page 8 room of the local hospital for evaluation and treatment. Nurses note dated 5/4/12 at 4 AM states R1 returned to the facility with sutures to the left side of the forehead. Emergency Room report dated 5/3/12 titled After Care Emergency lists the following diagnoses for R1: Forehead Laceration, Closed Head Injury and Frequent Falls. The facility's report titled "Final Report-Incident" regarding incident date of 5/3/12 states the root cause analysis of the fall was "Dementia and Delirium and agitated behaviors. The approach/intervention was, "Weight room locked after 4 PM when decrease in staff and floor alarm while in bed." The Nurses Notes for R1 dated 5/5/12 thru 5/7/12 describes R1 to be up and wandering throughout the facility, wandering in and out other residents rooms per self. The facility's Incident and Accident Report dated 5/8/12 describes R1 was yelling and found on the floor beside his bed wrapped in blankets lying on R1's right side with a laceration above R1's right eye brow approximately 3.5 centimeters (cm) long. The report continues to state R1 was transferred to the Emergency Room of the local hospital for evaluation and treatment. The hospital Progress Record dated 5/9/12 states R1 was seen by the Emergency Room doctor for laceration due to the fall and possible elevated cardiac enzymes. The Nurses Notes dated 5/9/12 at 11:45 AM states R1 was returned to the facility with four sutures to the right side of the face. The facility's "Final Report -Incident" dated	F9999		

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F9999	Continued From page 9 5/12/12 states the root cause analysis for this fall was "Dementia and agitated behaviors". Interventions /Approach put into place was "low bed with bed alarms and medication review." The facility's Incident/Accident Report dated 5/9/12 states R1 was found sitting on the floor at 3:30 PM in his room, no injuries noted. The root cause analysis for this fall states: unsteady gait /balance with poor safety awareness. Approach/intervention is to do medication review. Facility's Incident/Accident report dated 5/20/12 describes R1's fall as "(R1) fell to floor from chair at desk (R1) on bottom with head against water cooler....Alarm pad placed under (R1) after assisted to feet with two staff and gait belt.." The root cause analysis again states "Unsteady gait /balance and weakness. Approach/intervention : Pad alarm at Nurses Station and gait belt on at all times when out of bed." The Care Plan for R1 dated 3/30/12 under "Falls" list the following interventions/approaches, "Ensure Tab Alarm is in place when in wheelchair or bed and Pressure Sensitive alarm to bed and wheelchair." E3, RN ADON (Registered Nurse, Assistant Director of Nurses) on 5/31/12 at 4:25 PM could not confirm that the tab alarm or the sensitive alarm were in place when R1 fell on 5/3/12 and 5/8/12. E3 did confirm that R1 did receive sutures to both lacerations from the falls of 5/3/12 and 5/8/12 and that R1 was up and wandering around the building per self without assistance before the fall on 5/3/12. (B)	F9999		