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	146013	A. BUILDING _____ B. WING _____	C 11/09/2012

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F 371	Continued From page 19 would be used from left to right: wash, rinse, sanitize. E9 stated he did not mention the work needed to the vendor until 10/26/12 at a routine maintenance visit. E9 did not have a work order or date set for the work to be done. The rework of the hoses was completed on 11/1/12 at 12:45 PM. On 10/18/12 at 11:55 AM, two resident servings of food, including potato salad, were plated for tray service before the temperature of the potato salad was checked. The temperature reading was 70.2. [All temperature readings reported herein represent degrees Fahrenheit taken with a digital thermometer, calibration confirmed in ice bath.] Per E 11, Cook, the potato salad was prepared that morning at approximately 9:45 AM. The plated food was discarded and efforts began for rapid cooling of the potato salad prior to serving. Efforts included placing the 5-6 inch deep pan on another pan of ice with a bag of ice over the plastic wrap covering the potato salad, briefly placed in the freezer. The resulting temperature was 63.9 at 12:10 PM. The potato salad was divided into shallow pans and ice/freezer cooling continued. A final temperature of 40.8 was achieved at 12:30 PM. The Facility Data Sheet completed by E1, Administrator on 9/21/12 indicated there were 62 residents in the facility at the time of the survey.	F 371		
F9999	FINAL OBSERVATIONS Licensure Violations 300.610a) 300.1210b) 300.1220b)3) 300.3240a)	F9999		

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F9999	Continued From page 20 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 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including:	F9999		

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F9999	Continued From page 21 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. 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 requirements are not met as evidenced by: Based on observation, interview and record review, the facility failed to revise care plans, update fall assessments and follow policy for monitoring residents after falls, for residents with multiple falls. This was for 2 of 4 residents (R6, R7) reviewed for falls in a sample of 8. These failures resulted in R6 sustaining bilateral rib fractures and R7 sustaining a laceration requiring sutures as a result of falls. Findings include: 1.) R6's Fall Risk Assessment dated 1/7/12 indicated R6 was at risk for falls. According to Nurses Notes dated 6/7/12 to 9/10/12, R6 has a fall history as follows:	F9999		

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F9999	Continued From page 22 6/7/12 at 7:00AM - R6 found face down in his room attempting to go to the bathroom. Laceration to right eyebrow. 6/9/12 - R6 fell in his room. 6/26/12 at 2:10AM - R6 found face down in his room attempting to go to the bathroom. 6/30/12 at 7:00AM - R6 found on floor in his room. 7/28/12 at 2:00AM - R6 found on floor in his room. Laceration to right elbow. 8/13/12 at 3:30AM - R6 found on floor in his room attempting to go to the bathroom. R6 complained of pain in ribs and legs. 9/10/12 at 6:30AM - R6 found on the floor in his room. Laceration to left eyebrow. R6's Nurse's Note dated 9/10/12 documents that he was sent out to the hospital after his fall. R6 was admitted to the hospital with the diagnosis of bilateral rib fractures. R6's Physician Order Sheet dated 9/10/12 indicates to transfer the resident due to fall incident. On 10/18/12 at 3:40PM, E7-Licensed Practical Nurse (LPN) stated, "(R6) was sent to the hospital after the fall and readmitted to us on 9/19/12 with the diagnosis of bilateral rib fractures." On 10/18/12 at 10:55AM, E7-LPN was asked, "What is done when a resident falls?" E7 stated, in part, that if a resident hits their head or if it is unknown then neuro checks are started and post fall assessments for 72 hours. E7 also stated that fall risk assessment and interventions on care plans are updated. On 11/1/12 at 11:25AM, E2-Director of Nursing (DON) stated, " Neuro checks are performed for 72 hours after the fall if the resident is suspected to hit head."	F9999		

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F9999	Continued From page 23 An undated facility document with the heading "All Incidents" directs nursing staff of steps to be taken following every incident. Step 5 indicates "Fall risk care plan...The intervention that was put in place must be written on the careplan with date." Step 7 "Document! For 72 hours. Suspicion of head bumping object must do neuro checks." The facility Occurrence Report dated 9/10/12 related to R6's 9/10/12 fall indicates in section marked Personal Alarm, that no alarm is to be used. A section marked Care Plan intervention added or modified related to occurrence is marked "Yes" but the area to "specify" is left blank with no new interventions listed. R6's plan of care related to falls is dated 5/9/12 with review date of 8/9/12. There are multiple interventions, to include a bed alarm, with no dates documented alongside the interventions to indicate when interventions were put in place and that the care plan was updated with each fall. According to the Nurses Notes, all of R6's falls were unwitnessed. It could not be ruled out if R6 hit his head. On 3 occasions, R6 did hit his head. There were no documented neurological checks noted after the falls. R6's Fall Risk Assessment was inaccurately updated. On 9/19/12 it is documented that R6 had 1-2 falls in the past 3 months. R6 had 7 falls between 6/7/12 to 9/10/12. On 10/18/12 at 10:00AM, 12:45PM and 2:15PM and on 11/1/12 at 9:30AM, 12:30PM and 2:55PM, R6 was observed in bed without a bed alarm in place. R6's Care Plan dated 8/9/12 indicates that he should have a bed alarm in place. 2.) R7's Nurses Notes indicate that she was admitted to the facility on 8/29/12. The Nurses	F9999		

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F9999	Continued From page 24 Notes document that she is alert and oriented to person, place and sometimes time. R7 has slurred speech but able to communicate her needs. R7 has a history of right Subdural Hematoma and has right sided weakness. R7's fall history per Nurse's notes is as follows: 8/29/12 at 11:00PM - R7 was found on floor in her room laying on right side. 8/31/12 at 8:00AM - R7 was found on floor in her room laying on right side. 9/6/12 at 11:00AM - R7 was found on floor in her room sitting upright. 9/9/12 at 12:55PM - R7 was found in the prone position on floor in her room. Laceration to right eyelid. Sent to hospital. R7's Nurses Notes dated 9/9/12 indicate that she was sent to the hospital after the fall. According to R7's Nurses Notes dated 9/9/12, R7 returned to the facility at 8:00PM with 3 sutures on the right eyelid as a result of the fall incident. 9/17/12 at 5:00PM - R7 was found on the floor in her room. According to R7's Nurse's Notes, all of R7's falls were unwitnessed. There were no documented neurological checks noted after the falls. According to the facility's final summary for R7's 9/9/12 fall the facility will "reassess the resident's risk factors for falls and modify the care plan." R7's current Care Plan dated 8/30/12 contains multiple interventions but does not indicate when interventions were put in place or revised. There are no dates documented alongside the interventions. R7's Fall Assessment is dated 8/29/12 and has not been updated. The facility failed to accurately code R7 for falls on the Minimum Data Set (MDS) Assessment. According to R7's Minimum Data Set (MDS)	F9999		

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F9999	Continued From page 25 dated 10/24/12, R7 is coded for zero falls since admission. R7 had 5 falls from 8/29/12 to 9/17/12. On 11/1/12 at 12:15PM, R7 was observed sitting in a wheelchair in the hallway. There was no chair alarm affixed to her. According to R7's current Care Plan, R7 should have a chair alarm in place. (B)	F9999		