STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145752	A. BUILDING ______ B. WING ______	C 02/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST VIEW REHAB & NURSING CENTER	**535 SOUTH ELM ITASCA, IL 60143**

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F 323	Continued From page 6 prevent him from falling forward. But, E8 said that the CNA on 10/26/2012 did not ensure that the leg rest was used as required on 10/26/2012.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210b) 300.1210c) 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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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 WERE NOT MET AS EVIDENCED BY:	F9999		

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F9999	Continued From page 7 Based on observations, interviews and record reviews, the facility failed to provide supervision to two residents (R2 and R3) that were identified as at risk for falls, and failed to assess, analyze the circumstances, develop interventions, and re-evaluate for the effectiveness of interventions after each residents (R2 and R3) experienced falls in the facility. This applies to two residents (R2 and R3) in a sample of three residents, who are at high risk for falls. This failure resulted in R2 who sustained a cut to his upper lip which required evaluation and treatment at the local hospital and R3 sustained a laceration to the back of her head requiring 5 staples to close the wound at a local hospital. Findings include: 1. R3 was interviewed in her room on 1/31/2012. R3 was alert and anxious about her health. R3 stated that she recently fell in the facility. R3 said, "I needed 5 stables to close the wound to the back of my head." The nurse (E6), who took care of R3 on 1/25/2013, was interviewed by phone on 2/05/2013 at 11:40 AM. E6 indicated that staff did not witness R3's fall. E6 stated that she was on the second floor (R3 resides on the first floor) with a nurse, who was in orientation. E6 reported that the night nurse has to also take care of residents on the first and second floor. But, E11 was in room, providing care to another resident. E6 said E11 called her and told her to come down to the first floor. E6 stated: "We went down	F9999		

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because we got the idea something happened. When we got there she (R3) was on the floor. E6 told me she (E11) was helping someone in another room. She (E11) came out and R3 was screaming. (E6 reported that R3 had a habit of not using her call light and usually yell for staff assistance.) E11 went to her (R3) room and found her on the floor. R3 had turned herself in bed and fell on the floor." E6 reported that R3 was not at risk for falls. E6 indicated she knew this because R3 had no fall prevention measures in place. E6 said, "If someone is at risk for falls, they have chair and bed alarms and mats on the floor. R3 had nothing (no preventive measures in place.)." E6 described R3 as being unable to walk and stand by herself. E6 also described R3 as often having severe drops in her blood sugar level usually at night.

The restorative nurse (E12) was interviewed on 2/05/2013 at 2:35 PM. E12 stated that R3 was assessed at risk for falls when she was admitted to the facility.

The facility MDS coordinator (E8) was interviewed on 2/05/2013 at 2:09 PM. E8 reported that no fall prevention measures were put in place for R3 until after she (R3) fell on 1/25/2013. E8 said that R3 had a star placed on her (R3's) door name tag to alert staff that R3 was at risk for falling, and attached to her wheel chair. E8 was observed to go to R3's room to look for the star. But, no star was observed attached to R3's door name tag or wheel chair. E8 stated that she could not explain why the alert to staff was not in place for R3.

On 2/05/2013, E9 (acting director of nursing) was interviewed. E9 reported that the previous

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F9999	Continued From page 9 director of nursing did not complete a comprehensive fall assessment with an analysis for R3. Review of the Facility Admission/Readmission Departmental Notification Assessment, dated 12/28/2012, documented that R3 was admitted to the facility with the following diagnosis: Status Post Fall with Injury (Fracture Ribs and Arm), Diabetes, uncontrolled with Renal Manifestation. R3 is a 71 year old female. In the area " Special Risk Precaution and Equipment/Program needs upon Admission/Readmission *Nursing Department ", R3 was documented at high Risk for fall. However, the area for "Requires the following interventions " was left blank. No interventions were identified to address R3's risk for falls. R3's MDS (Minimum Data Set) Assessment, dated 1/10/2013, documented that R3 had a fall with fracture in the last three months and was at risk for falls. The Care Area Assessment (CAAR) for R3 documented that R3 triggered for risk to fall. R3 was assessed to have multiple factors that could cause her to fall; such as: unsteady gait, position change/transition-balance difficulty, balance problems, uncontrolled diabetes, and loss of arm and leg movements. R3's CAAR documented the need for R3 to have: "fall precautions in place to prevent future injury" The CAAR also directed staff to develop and "continue with care plan" for R3's fall. Review of R3's care plan had documentation that on 1/07/2013, R3's risk for fall was a focus of concern in her care. However, R3's care plan lacks specific staff interventions or use of safety	F9999		

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F9999	Continued From page 10 devices to prevent R3 from falling. R3's MDS identify factors that put her at risk for falls, but the care plan had no interventions/approaches addressing these factors. One of the approaches was not appropriate for R3, and directed staff to have R3 uses her call light. But, staff reported that R3 would yell to call staff and did not use her call light. Review of the facility's Incident Reports were difficult because on 1/31/2013, the administrator (E1) stated that the director of nursing (E2) had taken them (6 months of the facility's incident reports) home along with the Accident/Incident Tracking record. When the records became available, the tracking record was not complete. There was an incident report documenting that R3 had fallen in the facility. Review of this Incident Report, dated 1/25/2013, documents the following: 1/25/2012 at 4 AM, "Resident (R3) was on the floor in supine position in her room." A review of R3's Comprehensive Assessment, date 1/25/2013, was not completed. The following areas were left blank: "Root Cause as why the fall incident happened. Previous Interventions put in Place. Were the previous interventions effective?" The follow up to R3's fall on 1/25/2013, or the "Follow-Up Meeting" Form had no documentation of an interdisciplinary team getting together to analyze and develop a plan of care to address R3's fall. Review of the facility's Fall Program Guidelines had documentation instructing staff to do the following:	F9999		

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"5. Resident identified to be a fall risk will have an identified symbol placed on the doorway by the resident name, on the wheelchair (If applicable), and on the mobility assistive device (if applicable).
6. Resident's identified as fall risk will have an individualized care plan to address the contributing factors that place them at risk, goals to prevent falls/injury, and interventions/approaches to promote safety of the residents ... ." This policy was not being followed in the care of R3.

Review of the facility Accident/Incident Reporting Policy documented the following instruction for staff:
"12. A more extensive investigation procedure is required for the following occurrences: ...Fall with injury." But, this was not done after R3's fall occurrence on 1/25/2013.

2. Review of the facility's Accident and Incident Report, dated 10/26/2012 at 2:40 PM, documented the following:
"Nurse heard an alarm and also resident calling for help immediately went to that room and resident is on the floor ..." R2 cut his lip on a garbage can that was near him. R2 was sent to the hospital for evaluation and treatment.

Review of R2's Admission Face Sheet document that R2 is a 88 year old male with diagnosis including: Hemiplegic.

Review of R2's plan of care documented that R2 is at risk for fall and this is a focus in his care. One of the nursing care approaches was

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F9999	Continued From page 12 documented as: "8/10/2012 Educate wife to leave armrest and footrest of wheel chair up for safety. 8/10/2012 Staff to check resident for all safety appliances after wife leaves resident in the room." However, staff failed to ensure safety device was applied appropriately when the resident fell on 10/26/012. The nurse working the day that R2 fell was interviewed on 2/05/2013. E7 stated, "During the day at 2:45 PM, I was at the nursing station and heard an alarm. R2 was on the floor on his left side with facial bleeding on the upper lip." E7 reported that R2 was sent to the hospital for evaluation and treatment. The MDS coordinator (E8) was interviewed on 2/05/2013. E8 stated that R2 had been on fall precautions for a long time. E8 said that R2 needs the use of his arm rest and foot rest to prevent him from falling forward. But, E8 said that the CNA on 10/26/2012 did not ensure that the leg rest was used as required on 10/26/2012. (B)	F9999		