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| **RENAISSANCE AT 87TH STREET,THE** | **2940 WEST 87TH STREET CHICAGO, IL 60652** |

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| F 323 | Continued From page 6<br>could not recall the interventions implemented for R7.<br><br>On 12/5/12 at 1:23pm, E12 (therapy program manager) stated that all residents are screened post fall. E12 was asked to provide all assessments/screens for R7. E12 then stated that " all therapy screens are online with a different company and we don't have access to them." E12 then returned at 1:38 p.m. and stated that the screens are actually done on paper and placed in the resident ' s medical records. E12 provided a blank form titled "Fall Screen" and stated this is the form that is supposed to be in the chart. E12 was presented with R7's medical records and asked to locate the fall screen. E12 looked through the medical records and stated "I don ' t see any." E12 exited and returned at 3:01 p.m. and presented a computerized physical and occupational evaluation for R7 dated 7/8/12 (1 month after the initial fall).<br><br>On 12/6/12 at 3:30pm, Z2 (Physician) stated "the fall contributed to the fracture, but he has mushy bones."<br><br>The facility's "Fall Prevention Program" policy documents: "Notify therapy department after a fall. In addition to other interventions, therapy department will screen the resident and determine additional interventions if appropriate course of treatment. Therapy department will screen the resident and determine appropriate course of treatment." | F 323 | | |
| F9999 | FINAL OBSERVATIONS<br><br>LICENSURE VIOLATIONS: | F9999 | | |

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| F9999 | Continued From page 7<br><br>300.610a)<br>300.1210a)<br>300.1210b)<br>300.1210c)<br>300.1210d)3)6)<br>300.1220b)2)3)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br>a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which | F9999 | | |

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| F9999 | Continued From page 8<br>allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)<br>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:<br>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.<br>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:<br>3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.<br>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 | F9999 | | |

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| F9999 | Continued From page 9<br>and assistance to prevent accidents.<br><br>Section 300.1220 Supervision of Nursing Services<br>b) The DON shall supervise and oversee the nursing services of the facility, including:<br>2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.<br>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<br><br>Section 300.3240 Abuse and Neglect<br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.<br><br>These requirements were not met as evidence by:<br><br>Based on record review and interview, the facility failed to implement timely and appropriate fall | F9999 | | |

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interventions for 2 (R5, R7) of 5 residents reviewed for falls in a sample of 13. These failures resulted in R5 being hospitalized for a subdural hematoma, and R7 being hospitalized for C5 and T1 fractures of the spine.

Findings include:

1. R5 was admitted to the facility on 10/3/12. R5's Physician's History and Physical form documents the following diagnoses: subarachnoid hematoma, and orbit fractures. R5's Minimum Data Set (MDS) documents: Cognition: Moderately impaired cognitive skills, inattention, disorganized thinking, altered level of consciousness, and psychomotor retardation. Transfers: Extensive assistance with self performance (resident involved in activity, staff provide weight-bearing support) and two person physical assist for support. Locomotion on and off unit: Total dependence for self-performance (full staff performance) and one person physical assistance. Balance during transitions and walking: Not steady, only able to stabilize with staff assistance when moving from seated to standing position, moving on and off toilet, and surface-to-surface transfer (transfer between bed and chair or wheelchair). Mobility device: Wheelchair.

R5's physician (Z5) Physician Progress Notes dated 10/1/12 from the hospital document that R5 had fallen down stairs and sustained an (ICH) intercranial hemorrhage. R5's medical record also documents that R5 had a subarachnoid hemorrhage, forehead laceration, orbital fractures, and subdural hematoma.

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The facility's Fall Event report and nursing progress notes for R5 documents the following falls:
10/16/12, 6:07pm: Noted to have attempted to stand and tripped on leg rest, hit bottom on the floor.
10/16/12, 10:35pm: Tipped himself over in chair.
10/18/12, 4:13pm: Sitting in his wheel chair (w/c), rocked to the side and tipped over.
10/24/12, 2:22pm: Sitting on floor in dining room, unable to verbalize what happened.
10/27/12, 1:48am: C.N.A (Certified Nursing Assistant) alerted writer that R5 had fallen, while still seated in wheel chair, noted lying on right side.

R5's medical records contained no immediate interventions after the falls occurred. There were also no interventions located in R5's medical record related the fall R5 sustained on 10/16/12 at 6:07pm. R5 sustained a second fall the same day as he tipped over in the wheel chair. R5's care plan documents that anti-tippers were ordered the next day 10/17/12 for R5 ' s wheel chair. R5 sustained three more falls from his wheelchair within a two week period, two of which involved tipping the chair over/falling on his side (10/18/12 and 10/27/12). After R5 sustained a fall at 1:48 a.m. on 10/27/12, R5's nursing notes document that R5 was transferred to the hospital at 8:23 a.m. (7 hours later).

On 12/6/12 at 12:48 p.m., E7 (Quality Assurance/Falls Coordinator) stated that she ordered anti-tippers to be placed on the sides of R5's wheel chair. E7 stated that the manufacturing supply company informed her that

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there were no side anti-tippers, and the order was not filled. E7 stated she did not add alternate interventions for R5. When inquiry was made about interventions correlating with R5 standing and tripping over the chair leg rest on 10/16/12, E7 stated she added no interventions. As a result of the fall on 10/27/12, R5 was transported to the local hospital where he was diagnosed with a subdural hematoma.

On 12/6/12 at 3:30pm, Z2 (Physician) stated that the subdural hematoma R5 sustained at the facility was non-life threatening. However, per Z2, it was not the same hematoma documented in R5's hospital records prior to admission the facility.

On 12/7/12 at 9:29am, E7 stated she knew R5's admitting diagnoses and that he was at increased risks for falls.

On 12/7/12 at 2:00pm E23 (C.N.A) stated he left R5 alone on 10/27/12, to put another resident to bed. E23 stated he then heard R5's chair alarm sounding as R5 was falling. E23 added that R5 keeps rocking in his wheel chair and always tips the chair over.

On 12/7/12 at approximately 2:30pm (phone conversation) E24 (LPN) stated she was the nurse on duty when R5 sustained a fall on 10/27/12 at 1:48am. E24 stated that E23 had left R5 alone knowing that R5 needed monitoring. E24 stated that R5 was not to be left alone. E24 added that R5 had a scrape on the side of his head with some bleeding. E24 stated she did not transfer R5 to the local hospital until 8:23am. E24 stated that the facility's policy for emergency

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transfer to the hospital is for the staff to call the primary physician and dial 911 concurrently. E24 stated that for non-emergent situations, the policy is to notify the Primary Care Physician. E24 stated that if the primary physician does not respond to a page within 15 minutes to try again two times. E24 stated if no response after 3 pages, the policy is to call the facility ' s Medical Director. E24 added that she did call the Medical Director, and was not aware of the facility ' s policy on 10/27/12.

On 12/7/12 at 3:30pm, E2 (Director of Nursing) stated the facility's policy in non-emergent medical situations is to page the primary physician. According to E2 if the physician does not return the call within 15 minutes, the staff is to page him again. E2 added that if there is no return call after the second page, the Medical Director is to be paged.

R5's Physician Progress Note from the local hospital prior to admission to the facility (dated 10/1/12) documents: subdural hemorrhage along the right temporal lobe.
R5's radiology report from the local hospital after facility transfer (dated 10/27/12) documents: small extra-axial bleed along the right parietal lobe.

The facility's policy for fall intervention and documentation reads:
"Anytime a resident sustains a fall an intervention must be immediately put into place and documented in the medical record. The intervention must be related to the reason for the fall."

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2. R7 was admitted to the facility with the following diagnoses: Tracheostomy, hyperlipidemia, hypertension, atrial fibrillation, congestive heart failure, abdominal pain, BPH, muscle weakness, and head/neck/laryngeal cancer.
The facility's incident report dated 6/10/12 documents that R7 sustained a fall and was unable to state exactly what happened. The summary of investigation report documented by E7 (RN/falls coordinator) documents that the staff observed R7 on the floor, complaining that he was in unbearable pain; when he rolled over on his side he was too close to the edge and rolled on the floor.
R7's care plan approached dated 11/10/11 documents the following approaches: avoid clutter; maintain bed in lowest position, call light in reach, maintain needed items within reach, non-slid footwear, and toilet per resident ' s needs.
However, R7's falls care plan dated 6/10/12 documented the following post fall interventions: "Give pain medication per resident's request, and bed alarm-refused. There were no further documented safety interventions upon R7's refusal of the bed alarm". R7 sustained a second fall on 6/14/12 and was subsequently sent to the hospital. R7's CT (Computed Tomography) scan from the local hospital dated 6/14/12 documents: Impression- There is evidence of lytic metastasis to the C5 and T1 vertebral bodies with compression fractures.

On 11/9/12 at 1:15pm, E7 stated that R7 sustained a fall on 6/10/12 because he misjudged his distance related to pain. E7 added that the facility implemented a bed alarm in which R7

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refused. E7 stated she also informed the staff that if they walk down the hall to "stick their heads" in R7's room. E7 stated there was no documented frequency of how often the staff should check on R7. E7 Stated he should have had a therapy screen after the fall on 6/10/12. E7 added that if the residents refuse interventions, the facility should try alternate interventions.

On 11/9/12 at 2:30pm, via phone conversation, E8 (LPN) stated she was the nurse on duty when R7 sustained the fall on 6/14/12. E8 stated she could not recall the interventions implemented for R7.

On 12/5/12 at 1:23pm, E12 (therapy program manager) stated that all residents are screened post fall. E12 was asked to provide all assessments/screens for R7. E12 then stated that " all therapy screens are online with a different company and we don't have access to them." E12 then returned at 1:38 p.m. and stated that the screens are actually done on paper and placed in the resident ' s medical records. E12 provided a blank form titled "Fall Screen" and stated this is the form that is supposed to be in the chart. E12 was presented with R7's medical records and asked to locate the fall screen. E12 looked through the medical records and stated "I don ' t see any." E12 exited and returned at 3:01 p.m. and presented a computerized physical and occupational evaluation for R7 dated 7/8/12 (1 month after the initial fall).

On 12/6/12 at 3:30pm, Z2 (Physician) stated "the fall contributed to the fracture, but he has mushy bones."

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| F9999 | Continued From page 16<br><br>The facility's "Fall Prevention Program" policy documents: "Notify therapy department after a fall. In addition to other interventions, therapy department will screen the resident and determine additional interventions if appropriate course of treatment. Therapy department will screen the resident and determine appropriate course of treatment." (B) | F9999 | | |