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	145197	A. BUILDING _____ B. WING _____	C 03/19/2013

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CONCORD NURSING & REHAB CENTER	**9401 SOUTH RIDGELAND AVENUE OAK LAWN, IL 60453**

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F 323	Continued From page 7 performed after any fall incident; safety interventions will be implemented for each resident identified at risk. 2). On 2/23/13 at 10:45am, R12 was in bed, mats were not on the floor on either side of the bed. R12's Fall Care Plan includes an updated intervention on 2/8/13 for "floor mats in place to prevent injury for falls." Fall Incident Report 2/7/13 documents R12 slid out of bed and was found on the floor. The last Fall Risk Assessment completed on 12/26/12 scores R12 as a high risk for falls. There is no Fall Risk Assessment completed after the fall on 2/7/13. 3). Fall Incident Reports document the following: 12/1/12 R8 was observed on the floor, 12/13/12 R8 found on mat on right side of bed, and 12/22/12 R8 was found lying on stomach on the floor at the side of bed with safety mat covering him. On 3/5/13 at 11am and 2:45pm, R8 was in bed, mats were not on the floor and an alarm was not on the bed. Fall Care Plan for R8 documents interventions on 2/17/13 are "floor mat" "bed alarm" because R8 "does intentionally try to crawl out of bed onto mats."	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION: 300.610a) 300.1210a) 300.1210b) 300.1210d)6) 300.1220b)3) 300.3240a)	F9999		

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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

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 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

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F9999	Continued From page 9 applicable. (Section 3-202.2a of the Act) 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. 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 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	F9999		

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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 regulation were not met as evidenced by the following:

Based on observation, interview and record review the facility failed to assess fall risk and implement fall interventions for 3 of 5 residents (R1, R8, R12) reviewed for falls in the sample of 12. This failure resulted in R1 falling out of bed and sustaining a right shoulder fracture requiring hospitalization.

Findings include:

1). On 3/5/13 at 2:20pm, E11(Nurse Aide) stated that on 2/14/13 day shift, she was assigned to weigh patients. "I was going into (R1)'s room to weigh the roommate and saw (R1) on the floor. I didn't hear any alarms sounding and there weren't mats on the floor on either side of the bed." E11 stated "I told both the day and night nurse right away that morning that (R1) fell out of bed. When I returned to work I learned that (R1) went to the hospital because she broke her arm. That's when I told (E2)(Director of Nursing)." E11 stated that E12(Nurse Aide) came into the room, lifted R1 up under the arms and placed R1 back into bed

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F9999	Continued From page 11 before a nurse came to assess her. On 3/6/13 at 2:30pm, Z1 (Physician) stated "I didn't know about (R1)'s second fall." Z1 stated the staff called him on 2/14/13 because R1 was complaining of right arm pain. "(R1) had a fall the day before on 2/13/13, they never mentioned that (R1) fell on 2/14/13. I understood the right arm pain was from the fall the day before." Z1 stated the bed alarm would have alerted the staff to check on R1 before she fell, and the floor mats could have cushioned her fall. "Because these interventions were not in place, that contributed to the fall and fracture. She would not have fallen if she was monitored. If she didn't fall, she would not have broken the arm." On 3/19/13 at 9:25am E14(Kitchen Staff) stated she witnessed R1's fall in the dining room on 2/13/13. "(R1) kept getting up from the wheelchair during lunch, the aide kept putting her back in the wheelchair. No one was directly around (R1) when she got up, started walking and fell. I called for help right away, we waited for the nurse to come, the nurse has to check the resident before moving them." E14 stated R1 did not have an alarm clipped to her clothing. "Some of the residents have the alarm that is attached to them, their clothing. (R1) did not have one on. There was no alarm sounding when she got up." Nurse Note 2/21/13 by E2(Director of Nursing) documents that he was made aware by E11 on 2/21/13 that R1 had fallen out of bed on 2/14/13 about 7:30am. Incident Report 2/22/13 documents that on 2/14/13 R1 was "noted laying on the floor next to bed at approximately 7:15am."	F9999		

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Incident Investigation 2/21/13 of R1's fall on 2/14/13 documents E12 picked up R1 and put her back into bed. E13 (Nurse) came into the room to do an assessment, so E12 left the room.

Nurse Note 2/14/13 9:22am documents R1's right arm was "bruised with a lot of pain, resident was screaming and hollering due to the increase of pain with movement." A call was made for a stat xray to right arm and shoulder areas. R1 was laid back in bed and given pain medication. Nurse Note 2/14/13 4:31pm documents R1 sustained a "right head humerus fracture." R1 was medicated for pain and an ambulance was called to transport R1 to the hospital.

On 2/23/13 at 9:50am, E3(Assistant Director of Nursing) stated a Fall Risk Assessment is completed on admission, quarterly, and after each fall. E3 stated the primary nurse must complete the fall investigation after a resident falls, updates the care plan with new interventions to prevent further falls, and notifies the physician and family of the fall. The resident is not to be moved after the fall until assessed by the nurse. E3 stated it is not known why a fall risk assessment was not done, why the fall care plan was not updated after the fall on 2/14/13, or why the interventions were not followed.

Xray Report 2/14/13 documents "findings suspicious for nondisplaced subcapital humeral head fracture."

Fall Care Plan was initiated on 1/30/13 and lists interventions as "W/C (wheelchair) alarm", which was not in place on 2/13/13 according to E14's interview, and "bed alarm" and "floor mat", which

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were not in place on 2/14/13 according to E11's interview. The Fall Care Plan is not updated after the fall on 2/14/13.

The last Fall Risk Assessment is dated 1/30/13 and scores R1 as high risk for falls. An intervention is for R1 to be on the Falls Prevention Program. A Fall Risk Assessment is not completed after the 2 falls on 2/13/13 and 2/14/13.

The Fall Prevention Program includes the following components: notification of physician, family/legal representative; care plan incorporates addressing each fall, interventions are changed with every fall, as appropriate; preventative measures; Fall Risk Assessment will be performed after any fall incident; safety interventions will be implemented for each resident identified at risk.

2). On 2/23/13 at 10:45am, R12 was in bed, mats were not on the floor on either side of the bed. R12's Fall Care Plan includes an updated intervention on 2/8/13 for "floor mats in place to prevent injury for falls." Fall Incident Report 2/7/13 documents R12 slid out of bed and was found on the floor. The last Fall Risk Assessment completed on 12/26/12 scores R12 as a high risk for falls. There is no Fall Risk Assessment completed after the fall on 2/7/13.

3). Fall Incident Reports document the following: 12/1/12 R8 was observed on the floor, 12/13/12 R8 found on mat on right side of bed, and 12/22/12 R8 was found lying on stomach on the floor at the side of bed with safety mat covering him.

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F9999	Continued From page 14 On 3/5/13 at 11am and 2:45pm, R8 was in bed, mats were not on the floor and an alarm was not on the bed. Fall Care Plan for R8 documents interventions on 2/17/13 are "floor mat" "bed alarm" because R8 "does intentionally try to crawl out of bed onto mats." B	F9999		