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	14E888	A. BUILDING _____ B. WING _____	C 05/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HEALTH CARE WILLOWS	3520 NORTH ROCHELLE PEORIA, IL 61604

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F 323	Continued From page 4 better." On 5/6/13 at 3:10 p.m. E2 DON (Director of Nursing) stated new interventions were not put in place for R1's fall on 4/27/13 at 4:00 a.m. E2 confirmed no new interventions were put in place for any of R1's falls that occurred on 4/27/13 until 4/29/13. On 5/6/13 at 2:20 p.m. E3 (Care Plan Coordinator) stated a new intervention should be put in place after each fall. E3 provided an example, if a fall occurs at 10:00 p.m. at night an intervention for that fall is not decided until the next day at the daily fall meeting that takes place. E3 stated R1's falls that occurred on 4/27/13 were not addressed with new interventions by the fall committee until 4/29/13. On 5/7/13 at 12:10 p.m.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.610a) 300.1210a) 300.1210b)5) 300.1210d)3)6) 300.1220b)2)3) 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	F9999		

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F9999	Continued From page 5 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 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. Restorative measures shall include, at a minimum, the following procedures:	F9999		

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F9999	Continued From page 6 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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: 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. 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: 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. 3) Developing an up-to-date resident care plan for each resident based on the resident's	F9999		

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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.

These requirements were not met as evidence by:

Based on interview and record review the facility failed to operationalize their Safety policy by assessing fall risk upon admission and failed to implement new interventions with each fall for one of three residents (R1) in a sample of three. R1 sustained a fractured cervical spine and nose after three consecutive falls.

Findings include:

Facility Admission Data Base documents that R1 was admitted to the facility on 4/18/13 with the following diagnoses: Chronic Lymphoid leukemia, Dementia, and Paralysis Agitans (Parkinson's Disease).

The Facility's undated Resident Accident/Incident Safety Policy documents "all residents will have

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an assessment done at the time of admission." "Those individuals identified as high risk for falls will be identified for staff to monitor closely." "On a daily basis incidents/accidents will be reviewed by the facility administrative staff. Necessary changes in the resident's plan of care will be implemented."

The Facility's undated Incident/Accident Reporting and Investigation Policy documents: "For residents with persistent problems, list on their care plan, with measures taken to correct."

R1's Fall Risk Assessment dated 4/24/13, six days after admission documented R1 had a total score of 11 which indicated a high fall risk.

E6 (Restorative Nurse) confirmed R1's Fall Risk Assessment was not completed until 4/24/13, 6 days after admission.

R1's Interim Care Plan (Care Card) dated 4/18/13 documents under the section High Risk Program, "fall." Interventions were not listed to specifically address R1's fall potential.

The Facility's Incident log documents R1 had falls on 4/21/13 at 12:05 p.m., 4/25/13 at 10:00 p.m. and 4/27/13 at 4:00 a.m., 10:33 a.m. and 10:50 a.m.

R1's Incident Report dated 4/21/13 at 12:05 p.m. documents R1 was found on the floor. R1 was "lying on his right side and noted with blood on the Left side of his face and hands." The report documents R1 had a "2 cm (Centimeter) laceration to medial bridge of nose. Nose noted with swelling." On R1's Incident Form under the

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section titled "Actions Taken" it documents the doctor was notified and sent to the hospital for evaluation and treatment. R1's History and Physical from the Hospital dated 4/21/13 documents under Admission diagnosis: Status post fall with closed head injury/facial trauma. The Hospital's Diagnostic Imaging Report documents "Comminuted, Depressed Nasal bone Fracture.

R1's Incident Report Dated 4/25/13 documents R1 was found Lying face down in his room with no injuries noted. The section titled Actions taken documented: assisted back to bed. R1's Incident Report Investigation documents recommendation for action: Hospice referral and Side rails for bed mobility.

R1's Care Plan dated 4/26/13 documents as a problem for R1: risk for falls. The Care plan also documents under problem: resident noted with 2 falls in his room, siderails ordered for bed. Individual interventions were not indicated or dated for the fall that occurred 4/21/13.

R1's Incident Report dated 4/27/13 documents at 4:00 a.m. R1 was found lying on his left side with no injuries noted. Under the section titled description of incident it documents "nose laceration open." The Section on the Incident Form titled action taken is blank. On the same day at 10:33 a.m. R1's Incident Form documents R1 fell on the floor. The section titled Description of Incident documents R1 sustained a small laceration to the left elbow with active bleeding and altered skin with bruises to face "from previous incident." R1's Incident Report dated the same day, 4/27/13 at 10:50 a.m. documents R1

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"was on the floor again." On R1's Incident Report under Action Taken it is documented to send to hospital.

R1's History and Physical dated 4/27/13 at 11:45 a.m. documents facial contusion (bruising), neck pain and possible acute fracture of C5 and C6 Vertebrae in the neck. The section titled Chief Complaint on the Hospital History and Physical documents weakness, frequent falls and altered mental status. The Assessment and Plan section of R1's History and Physical documents a cervical spine fracture. R1's Hospital Diagnostic Imaging report dated 4/27/13 documents under the section titled Impression: "Hematoma (Collectin of blood outside of a blood vessel) over right side of forehead and nose with mildly depressed fracture of anterior Nasal bones Bilaterally. Cannot exclude Fracture of an anterior Osteophyte (bony projection) at C5 C6."

R1's care plan dated 4/26/13 documents a problem for R1 as a risk for falls. The Fall care plan contains undated interventions with the only intervention dated being on 4/29/13. The Care Plan does not include interventions for R1's falls on 4/21/13 or 4/27/13 at 4:00 a.m. and 10:33 a.m..

On 5/7/13 at 12:20 p.m. E5 (Assistant Administrator) stated an Interim Care Plan (Care Card) is used for residents for the 1st 14 days after admission. E5 stated after R1 fell on 4/21/13 a full Care Plan should have been initiated to direct the staff with cares. E5 stated R1's Interim Care Plan did not direct staff with interventions for R1's falls. E5 confirmed that R1's care plan nor

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F9999	Continued From page 11 Incident Report documented an intervention for R1's falls on 4/21/13 and 4/27/13 at 4:00 a.m. and 10:33. E5 stated "we should have done better." On 5/6/13 at 3:10 p.m. E2 DON (Director of Nursing) stated new interventions were not put in place for R1's fall on 4/27/13 at 4:00 a.m. E2 confirmed no new interventions were put in place for any of R1's falls that occurred on 4/27/13 until 4/29/13. On 5/6/13 at 2:20 p.m. E3 (Care Plan Coordinator) stated a new intervention should be put in place after each fall. E3 provided an example, if a fall occurs at 10:00 p.m. at night an intervention for that fall is not decided until the next day at the daily fall meeting that takes place. E3 stated R1's falls that occurred on 4/27/13 were not addressed with new interventions by the fall committee until 4/29/13. On 5/7/13 at 12:10 p.m. (B)	F9999		