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	145247	A. BUILDING _____ B. WING _____	03/07/2013

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DOCTORS NURSING AND REHAB CENTER	1201 HAWTHORN ROAD SALEM, IL 62881

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F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.610)a) 300.1210)a) 300.1210)b 300.1210)d)6) 300.1220b)2)3) 300.3240)a 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	F9999		

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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:

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

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F9999	Continued From page 24 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 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)	F9999		

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F9999	Continued From page 25 These Regulations were not met as evidenced by: Based on record review and interview, the Facility failed to thoroughly assess for contributing factors and implement interventions based on the identified contributing factors for 2 (R7, R11) resident's reviewed for incidents and accidents. This failure resulted in R7 falling out of her wheelchair and sustaining fractures involving the lateral aspect of the superior pubic rami and the medial aspect of the inferior pubic rami. Findings include: 1. A review of R7's Facility Incident Investigation documents the following: 9/24/12, 12:15 AM, "the nurse was sitting at the nurses station, heard a noise and then heard her yell for help. She went to the room to find R7 lying on the floor crying in pain. They kept her on the floor until the ambulance arrived. This resident is alert to herself. She is confused to time and place. She has Alzheimer's. She is independent with ambulation and going to the bathroom. She ambulates freely about the facility. She is Diabetic. She went to the hospital and was diagnosed with a fracture of her left hip. R7 was admitted for surgery". E2, Director of Nursing, stated during an interview on 3/6/13 at 1:50 PM that R7 was independent in her activities of daily living, ambulation and toileting prior to her fall on 9/24/12. E2 said that when R7 came back to the Facility following surgery and hospitalization for the left hip	F9999		

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fracture, she could no longer ambulate. E2 said that a pommel cushion to prevent abduction; an alarm to notify staff when R7 would gets out of bed; and a tabletop placed over her wheelchair; were all ordered on 10/17/12, upon R7's return from the hospital.

R7's Facility Incident Investigation documents that on 10/17/12, at 3:50 PM, "R7 was found lying on right side on floor, noted spilled water pitcher, had just returned from therapy. No injury". The investigation does not state when R7 was last observed, when she was last taken to the toilet, when she last had a drink, or if she was lying in her bed or sitting in her wheelchair prior to being found on the floor. The corrective action for this fall documents "resident to be sitting in hallway when up in chair unless with staff or family".

Facility Incident Investigation for R7, dated 10/20/13, at 4:15 PM, documents "Resident found on floor lying on right side. Shoes on, floor dry, complaining of left hip pain. Recent hip fracture, attending therapy at this time. Resident returned from therapy and set her in room without tabletop on wheelchair. No injury". The Investigation does not document when R7 was last seen prior to her fall, or when she was last toileted prior to the fall. The corrective action for this fall documents "to have personal alarm and lap tray on when not at nurses station, resting or in therapy".

R7's Facility Incident Investigation, dated 1/4/13 at 6:15, documents "Resident's husband took tray off of wheelchair for supper and left without putting tray back on, and resident got out of wheelchair and fell". The investigation does not

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document when R7 was last observed by staff or last toileted prior to her fall. This investigation documents that R7 sustained acute non-displaced fractures at the superior ramus of the right pubic bone, inferior ramus of the right pubic bone and medial aspect of the superior ramus of the left pubic bone. R7 was sent to the emergency room and returned a short time later with an order for Ultram 25 milligrams every 8 hours as needed. The corrective action for this fall documents "staff to take lap tray off for meals with supervision and to be put back on after eating".

Radiology Report for R7, dated 1/25/13, documents "Follow-up for fractures. Fractures are noted involving the lateral aspect of the superior pubic rami and the medial aspect of the inferior pubic rami".

Facility Incident Investigation for R7, dated 2/8/13 at 6:25, documents "resident found sitting on floor on buttocks with legs out in front, sitting by geriatric chair. No injuries noted. No injury noted" The investigation does not document when R7 was last observed by staff, when R7 was last toileted or if the lap tray was in place. The documented corrective action for this incident is "resident to be up in wheelchair with table top, release every 2 hours for 10 minutes with supervision".

E2 stated in an interview on 3/6/13 at 1:50 PM, that R7's fall on 2/8/13 occurred over a weekend. E2 said that R7 had an intravenous access site on her foot which infiltrated and caused edema. E2 said that nursing staff needed to elevate R7's foot so they placed her into a geriatric chair

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without the lap tray and she fell out.

R7's plan of care, with an original date of 10/9/12 documents a problem of "Potential for injury from falls related to minimal difficulty with hearing, usually understood, vision impaired, wears glasses, short and long term memory deficit, cognitive skills for daily decision making moderately impaired, inattention, disorganized". The Goal for this Problem documents "Resident will have no falls or injury related to falls". Approaches for this Problem include: "High back wheelchair with pommel cushion and table top, release every 2 hours for 10 minutes with supervision. Personal alarm in bed".

R7's Minimum Data Set (MDS), dated 12/27/12, documents that she has short and long term memory problems; requires the extensive assistance of 1 person for transfers; does not ambulate and is at high risk for falls.

2. A review of R11's current medical record and admission records indicate R11 was admitted to the facility on 8/22/12 with multiple diagnosis including: Chronic Obstructive Pulmonary Disease, Mental Status Change, Congestive Heart Failure, Atrial Fibrillation, Renal Failure, Delusions, Agitation and Post Suicidal Event. R11's Fall Risk Evaluation from 8/22/12 and 11/5/12 and an undated evaluation find R11 rated at High Risk for falls. Review of R11's incident reports indicate R11 has had 9 falls from 9/2/12 to 2/18/13. The incident reports for each fall were reviewed and found incomplete. The falls root cause was repeatedly "Due to resident action or internal risk factors", the interventions after falls on 9/26/12, 11/6/12, 12/4/12, 12/29/12

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F9999	Continued From page 29 and 2/18/13 were to remind the resident or council the resident. None of the interventions from the falls above were facility / staff actions or changes that could be made to assist R11 to reduce the risk to fall. There were no interventions gleaned from the facts ascertained from the investigations and/or incident report investigations. Interview with E2 (Director of Nursing) on 3/6/13 at 4:45pm found that the incident investigations did not lead to effective interventions. (B)	F9999		