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	146163	A. BUILDING _____ B. WING _____	C 08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYCAMORE HEALTHCARE CENTER	**720 SYCAMORE QUINCY, IL 62301**

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F 323	Continued From page 9 impairment. A Fall Risk Assessment dated 7/10/13 shows a score of 23 indicating R2 is at high risk for falls. On 7/29/13 at 2:20 p.m., E13 (CNA - Certified Nursing Assistant) demonstrated R2's alarm was working properly. E13 (CNA) stated, "... (R2) had (R2's) alarm on all the time in the chair and in the bed. (R2) don't ever have it off. We're suppose to make sure it's working every time we put it (R1's personal body alarm) on....". On 7/25/13 at 1:15 p.m., E1 (Administrator) verified staff are to check resident's personal alarms to ensure they are functioning properly prior to resident use.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.610a) 300.1210a) 300.1210b) 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. The written policies and procedures 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. The policies shall comply with the Act and this Part.	F9999		

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F9999	Continued From page 10 The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the 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. 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	F9999		

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F9999	Continued From page 11 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 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.	F9999		

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F9999	Continued From page 12 Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These requirements are not met as evidenced by: Based on record review, observation, and interview, the facility failed to assess and implement appropriate safety measures to prevent a fall after removing side rails for one of four residents (R1) reviewed for side rail use in the sample of seven. This failure resulted in R1 falling from the bed, receiving a head injury and subsequently dying from the fall. The facility also failed to ensure assistive devices were properly functioning for two of four residents (R2 and R4) reviewed for accidents in the sample of seven. Findings include: 1. R1's MDS (Minimum Data Set) dated 3/01/13 states R1 scored a three on a BIMS (Brief Interview for Mental Status) assessment indicating R1 had severe cognitive impairment. R1's Fall Risk Assessment dated 6/01/13 shows R1 was at high risk for falls. An Incident/Accident Report dated 6/01/13 at 1:00 p.m., states a dark purple bruise was found on the right side of R1's chin and on R1's left pointer finger. A Skin Tear/Bruise of Unknown Origin Investigation form dated 6/03/13 states, "Final Conclusion: (R1) is dependent on nursing staff for most ADL's (Activities of Daily Living). (R1) keeps head and chin to chest position and during transfers draws up legs/feet and does not bear weight resulting in bruises. Staff in-serviced on (R1) in two person transfer assist....".	F9999		

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A radiology report dated 6/03/13 shows R1's right foot and ankle were x-rayed and the x-ray showed diffuse soft tissue edema. On 7/25/13 at 1:15 p.m., E1 (Administrator) stated during the investigation of R1's injuries of unknown original noted on 6/01/13, E5 (CNA - Certified Nursing Assistant) reported R1's foot had been found in the side rail during care on the night shift. A hand written statement dated 6/03/13 and signed by E5 (CNA) states, "... Event occurred on 5/31/13. Went in at approximately 12:05 a.m. to do a check and change on (R1). Seen (R1's) foot was caught in the side rails. I removed (R1's) foot from the rails, straightened out (R1's) legs, finished the check and change on (R1) then told the nurse (E4 RN - Registered Nurse) of my findings. (E4 RN) went and looked over (R1) and said everything looked okay....".

On 7/29/13 at 11:10 a.m., E5 (CNA) stated, "...I went in (on 5/31/13) and both side rails were up. I was doing check and change and seen (R1's) foot was in the rail. I removed it. It was a little red and swollen so I told (E4 RN)... Later (E4 RN) checked on it and said I didn't have to fill out an incident report or anything because (E4 RN) didn't think it was hurt...". On 7/25/13 at 1:15 p.m., E1 (Administrator) verified neither E4 (RN) nor E5 (CNA) documented finding R1's foot in the side rail or assessing R1 for potential injury on 5/31/13.

A Side Rail Assessment form dated 6/07/13 and completed by E3 (RN) states, "... Unable to use side rails at this time to assist with bed mobility/repositioning... 6/07/13 bilateral full side rails discontinued...". On 7/25/13 at 1:50 p.m., E3 (RN) verified a side rail assessment was

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completed on R1 on 6/07/13 after staff on the night shift reported R1 had gotten (R1's) feet caught in the rail. E3 (RN) stated, "...We re-assessed and (R1) wasn't able to use the rails anymore. So that made them (side rails) a restraint. So we took them off...". E3 (RN) verified no other safety measures were put in place to evaluate R1's response to removal of (R1's) side rails. E3 (RN) verified R1 did not have a personal body alarm, a floor mat, or a low bed in use on 6/09/13 at 10:00 p.m. On 7/29/13 at 11:10 a.m., E5 (CNA) stated R1 did not use the side rails to turn in bed but R1 was able to roll in the bed. E5 (CNA) verified R1 was using a regular bed and not a low bed.

An Incident/Accident Report dated 6/09/13 at 10:00 p.m., states R1 was found lying on the floor next to (R1's) bed with a laceration to the forehead. The incident report indicates R1 was transferred to a local hospital by ambulance at 10:32 p.m. A CT (Computed Tomography) scan of R1's head completed on 6/09/13 at 11:14 p.m. states, "Impression: 1. Large intraparenchymal hemorrhage (bleeding into the main part of the brain) in the right parietal lobe with smaller adjacent hemorrhages and small amount of subarachnoid blood. 2. Right frontal scalp hematoma ...". An Emergency Physician Record dated 6/09/13 at 10:55 p.m. states, "... Head Injury... 5 by 3.4 (centimeter) Intraparenchymal hemorrhage right parietal lobe ... Discussed with (Z3 - R1's POA - Power of Attorney) patient is DNR (Do Not Resuscitate). Made aware of intraparenchymal hemorrhage and possible outcome. (Z3) does not want patient admitted or neurologist consulted. (Z3) wants patient sent back to nursing home for comfort care...".

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R1's nurses' note dated 6/10/13 at 1:17 a.m. states, "(R1) returned to facility via ambulance... (R1) non responsive ... 1:30 a.m. ...Neuros (neurological checks) initiated - deficit noted. Resident remains unresponsive. Pupils fixed...". A 72 Hour Charting form entry dated 6/10/13 at 3:00 p.m. documents "(R1) continues to be unresponsive... bruising to both eyes, left shoulder, and multiple bruising on arms and legs...". Nurses' notes dated 6/10/13 state R1 expired on 6/10/13 at 5:25 p.m.

A Fall Investigation dated 6/10/13 states, "(R1) is dependent on nursing staff for most ADLs (Activities of Daily Living). Transfers with assist of one for safety. (R1) was in bed when (R1) rolled to the floor resulting in a laceration to (R1's) forehead. (R1) was sent to (Emergency Room) and received sutures to laceration. Bilateral handrails and blue safety mat to bedside implemented at this time ..."

On 7/30/13 at 1:10 p.m., Z6 (R1's Attending Physician) stated, "A subdural hematoma (bleeding on the brain), that's probably going to be fatal if you don't take (R1) up to ICU (Intensive Care Unit), do a neurological consult and surgical intervention....". On 7/31/13 at 6:03 p.m., Z4 (Emergency Room Physician) stated, "... (R1) suffered a head injury where there was a bleed to the brain and in discussing it with (Z3 - R1's Power of Attorney) (Z3) didn't want (R1) admitted to ICU (Intensive Care Unit), a neurological consult, or surgery so (R1) was returned to the facility for comfort care. For someone of (R1's) age and condition we would probably not be doing surgical intervention anyway. We would have admitted (R1) to ICU and continued comfort

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F9999	Continued From page 16 measures. But definitely, left to run it's natural course, the injury would be fatal...". (A) 300.690c) 300.695b) Section 300.690 Incidents and Accidents c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. Section 300.695 Contacting Local Law Enforcement b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations: 1) Physical abuse involving physical injury inflicted on a resident by a staff member or visitor; 2) Physical abuse involving physical injury inflicted on a resident by another resident, except	F9999		

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F9999	Continued From page 17 in situations where the behavior is associated with dementia or developmental disability; 3) Sexual abuse of a resident by a staff member, another resident, or a visitor; 4) When a crime has been committed in a facility by a person other than a resident; or 5) When a resident death has occurred other than by disease processes. c) The facility shall develop and implement a policy concerning local law enforcement notification, including: 1) Ensuring the safety of residents in situations requiring local law enforcement notification; 2) Contacting local law enforcement in situations involving physical abuse of a resident by another resident; 3) Contacting police, fire, ambulance and rescue services in accordance with recommended procedure; 4) Seeking advice concerning preservation of a potential crime scene; 5) Facility investigation of the situation. These requirements are not met as evidenced by: Based on record review and interview, the facility failed to notify the state agency of an accident that resulted in the death of a resident for one of four residents, (R1) reviewed for accidents in a sample of seven. Findings include: An Incident/Accident Report dated 6/09/13 at 10:00 p.m., states R1 was found lying on the floor next to (R1's) bed with a laceration to the forehead. The incident report indicates R1 was transferred to a local hospital by ambulance at	F9999		

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10:32 p.m. A CT (Computed Tomography) scan of R1's head completed on 6/09/13 at 11:14 p.m. states, "Impression: 1. Large intraparenchymal hemorrhage (bleeding into the main part of the brain) in the right parietal lobe with smaller adjacent hemorrhages and small amount of subarachnoid blood. 2. Right frontal scalp hematoma ...". An Emergency Physician Record dated 6/09/13 at 10:55 p.m. states, "... Head Injury... 5 by 3.4 (centimeter) Intraparenchymal hemorrhage right parietal lobe ... Discussed with (Z3 - R1's POA - Power of Attorney) patient is DNR (Do Not Resuscitate). Made aware of intraparenchymal hemorrhage and possible outcome. (Z3) does not want patient admitted or neurologist consulted. (Z3) wants patient sent back to nursing home for comfort care...".

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F9999	Continued From page 19 Power of Attorney) (Z3) didn't want (R1) admitted to ICU (Intensive Care Unit), a neurological consult, or surgery to (R1) was returned to the facility for comfort care. For someone of (R1's) age and condition we would probably not be doing surgical intervention anyway. We would have admitted (R1) to ICU and continued comfort measures. But definitely, left to run it's natural course, the injury would be fatal...". An IDPH (Illinois Department of Public Health) Notification form dated 6/10/13 at 3:50 p.m. states, "...Resident fell from bed. Received laceration to head. Sent to (Emergency Room) for evaluation. Returned to facility... ". The form completed by E1 (Administrator) states the 6/09/13 incident involving R1 at 10:00 p.m. was non-fatal. E1's documentation states the report is both the 24 Hour Preliminary report and the final report. On 7/25/13 at 1:15 p.m., E1 (Administrator) verified R1's death was imminent at the time the IDPH Notification form was faxed to the state agency's regional office. E1 (Administrator) also verified there was no follow up notification by phone or fax to the state agency's regional office after R1 expired. (B)	F9999		