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F 323	Continued From page 7 On 8/7/13 at 10:25am, E2 (Director of Nursing), stated if a fall occurs, a fall risk assessment and pain assessment are completed. In addition, the nurse is to complete an assessment every shift for 72 hours after the fall. The facility Fall Program, undated, documents fall risk assessments are to be completed on admission, readmission, quarterly and after each fall. The care plan is to address and apply appropriate interventions. If a resident is assessed at high risk, fall interventions and a care plan is to be implemented.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.610a) 300.1210a) 300.1210b) 300.1210d)6) 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. The written policies shall be followed in operating	F9999		

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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:

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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 300.3240 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 requirements are not met as evidenced by:

Based on interview and record review, the facility failed to implement interventions to prevent falls for 2 of 4 residents (R1 and R5) reviewed for fall risk in a sample of 5. This failure resulted in R1 incurring a fracture to the L4 vertebral body and R5 incurring multiple fractures to the spine requiring hospitalization and surgery.

Findings include:

1. The Facility Admission Sheet, 4/9/13, documents R5 was admitted to the facility on 2/15/13 with diagnoses to include post lumbar with myelopathy laminectomy T10-T11.

The Fall Risk Assessment, 2/15/13, documents R5 at risk for falls with a score of 20. The form documents, "Implement fall preclusions for a total score of 15 or greater." The facility Resident's Care Alert Card, 4/9/13, documents R5 as one person gait belt transfer and fall interventions to

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include a chair alarm, bed in lowest position and a dycem mat.

The facility Care Plan, 2/22/13, documents R5 as having restorative services for transfers from bed to wheelchair with extensive assist from staff. There is no care plan with fall interventions prior to the fall on 6/3/13. The facility was able to provide incomplete documentation of transfer assistance provided by staff via the Point of Care History Report. This report 4/1/13 through 5/31/13, documents R5's level of assistance varied between supervision of staff to extensive assistance to transfer. The facility Restorative Nursing Observation, 5/7/13, documents R5 as extensive assistance of one person physical assist for transfers.

The facility Occurrence Report, 6/3/13, completed by E13 (Nurse), documents R5 as being assisted by E12 (Nursing Assistant), to the floor as R5 was sliding from the wheelchair. The report documents R5 reported to E13 R5 was trying to go to bed and slid out of his wheelchair and fell to the floor. The immediate action taken was the application of a bed pressure alarm. The preventative measure a the time of the fall are documented as a low bed, no mats or alarm in place.

On 8/8/13 at 2:55pm, E12 stated she was a regular caregiver assigned to R5. E12 stated on 6/3/13 as she was passing R5's room, R5 was in the middle of transferring himself and was in an awkward position. R5 was very tall and E12 was unable to prevent R5 from falling so E12 assisted R5 to the floor between the wheelchair and the bed. E12 stated when R5 was first admitted he would transfer himself. E12 stated, "The staff

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talked amongst themselves and decided he needed assistance to transfer and staff should be in the room when he transferred. We told (R5) to ask for assistance." E12 stated on dialysis days R5 was weaker than usual. E12 stated there were no alarms in place at the time of the fall and couldn't remember if there was a non-slip mat in place in the wheelchair. E12 stated she is aware of fall interventions for residents by following the facility Care Cards.

On 8/8/13 at 3:10pm, E13 stated R5 reported to her that he slid from the wheelchair while transferring self. This was the first time E13 had cared for R5. E13 stated a non-slip wheelchair mat was in place. E13 stated R5 was a person assist for transfers. E13 didn't hear an alarm sounding and didn't recall R5 ever having an alarm. R5 had no complaints of discomfort, no injuries and no changes in assessment. E13 stated the facility Care Cards document fall interventions for each resident.

On 8/9/13 at 9:25am, E9 (Nurse), stated she cared for R5 on 6/7/13 and was a routine nurse for R5. R5 had complained of discomfort to the tailbone and the physician was notified. E9 stated R5 was very independent and wanted to do things for himself. E9 stated R5 would sometimes transfer self and would educate him on requesting staff assistance. R5 had a non-slip wheelchair mat but not an alarm. The Resident Progress Notes, 6/6/13, documents R5 was assessed by a Physician Assistant due to complains of pain to the lumbar region. An X-ray of the lumbar spine was ordered due to a fall with lumbar pain. The Resident Progress Notes, 6/7/13, documents R5 as being sent to the hospital after Z1 reported X-ray result of a

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possible T11, T12 and L5 fracture. The Resident Progress Notes, 6/7/13, documents R5 as admitted to the hospital with a diagnosis of spinal fracture post fall.

The hospital Emergency Room Physician Assessment, 6/7/13, documents R5 as presenting to the emergency room with possible compression fractures at T11, T12 and L5. R5 reported falling 4 days prior while going from the wheelchair to the bed. The admitting diagnosis was cervical compression fracture and accidental fall. The hospital Computed Tomography Scan of the thoracic, lumbar and cervical spine documents marked compression deformities of the C5 and C7 vertebral bodies, of indeterminate age. Probably remote compression deformities at the T9 and T10. Probable remote fractures of the left lamina of C1 and right lamina of C7. The neurosurgeon report, 6/7/13 documents marked compression deformities of the C5 and C7 vertebral bodies, of indeterminate age. Probably compression deformities at the T9 and T10. Partial fusion and compression deformities at T2 and T3, may be related to healed infection. The neurosurgeon operative note, 6/19/13 documents a posterior cervical Thoracic Laminectomy and Fusion was completed.

On 8/9/13 at 10:08am, Z1 stated R5 was alert. Z1 was unable to remember the specific fracture diagnosis but stated R5 did have spinal fractures and was admitted to the hospital. R5 required stabilization of the spine and surgery. Z1 stated he cared for R5 at the hospital also. Z1 was unable to recall the circumstance of the fall and stated once R5 was stabilized he was discharged from the hospital to another facility. Z1 stated the fractures incurred were "Possibly as a result of

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the fall, but R5 had severe osteoporosis."

On 8/8/13 at 3:35pm, E11 (Restorative Aide), stated R5 was a 2 person assist on dialysis days and a 1 person assist the other days.

On 8/8/13 at 10:14am, E10 (Nurse), stated she had readmitted R5 to the facility on 4/9/13. E10 stated R5 was at risk for falls and placed a bed alarm, chair alarm and mats as fall interventions on 4/9/13.

On 8/8/13 at 3:16pm, E14 (Nurse) stated, R5 was a one person transfer and R5 had to be reminded to ask for staff assistance because R5 would transfer without assistance. E14 stated the staff are aware of each residents fall interventions by observing the facility Care Cards.

On 8/8/13 at 1:54pm, E2 (Director of Nursing), stated the facility doesn't have a policy for the use of Care Cards. The purpose of the Care Cards is to give the nursing assistance information on how to take care of the residents.

2. The facility Face Sheet, 5/28/13, documents R1 was admitted to the facility on 5/28/13 with diagnoses to include, Dementia, Chronic Renal Disease with Dialysis and Hypertension.

The Admission Fall Risk Assessment, 5/29/13, documents R1 as being at risk for falls and fall interventions placed to maintain safety. The Admission Elopement Risk Assessment, 5/29/13, documents a preventative measures of a wheelchair/bed alarm as implemented.
The facility Care Plan, 5/28/13, documents R1 at risk for falling with an approach to use a personal alarm in bed and the wheelchair.

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The facility Occurrence Report, 6/2/13 completed by E5 (Nurse), documents R1 was found on the floor bedside at 7:30am. The fall was unwitnessed. The immediate actions taken include applying an alarm. The Falls detail report documents R1 with no alarms or mats at the time of the fall.

On 8/6/13 at 3:15pm, E5 (Nurse) stated on 6/2/13 another resident (couldn't remember name) informed E5 that R1 was on the floor and needed assistance. E5 stated she went to the room and assisted R1 off of the floor and no other staff members were present. R1 reported to E5 he was trying to get into the wheelchair. E5 stated no injuries were noted and R1 denied pain. E5 reported R1 had no changes or complaints of pain the entire shift. E5 stated at the time of the fall R5's bed was in low position and no alarm was in place. E5 stated a personal alarm was added after the fall.

On 8/7/13 at 3:36pm, E8 (Nurse), stated she had completed the admission fall risk assessment and initiated the initial care plan with fall interventions to include floor mats and a bed and chair alarm. E8 stated these precautions were implemented because R1 was, "antsy and wouldn't keep still. He was confused."

On 8/7/13 at 4:12pm, Z1 (attending physician), stated he had not taken care of R1 prior to the admission on 5/28/13. Z1 stated the facility notified him R1 had fallen. Z1 stated R1 had not complained of any discomfort at the facility and had been sent to the hospital for altered mental status. Z1 stated, " A fracture can happen with any fall. R1 had medical conditions making him

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more susceptible to a fracture. I would think R1 would have complained of pain right after the fall if it caused the fracture."

The Resident Progress Notes, 6/3/13 at 11:39am, documents R1 was sent to the hospital after a change in mental status.

The Emergency Room Department Note, 6/3/13 at 12:45pm, documents a physician assessment which includes R1 being sent for evaluation of altered mental status. The back assessment documents R1 as yelling and grimacing when sitting up in bed. R1 was admitted for altered mental status. The hospital Emergency Room Department Note, 6/3/13 at 12:45pm, documents a physician assessment which includes R1 being sent for evaluation of altered mental status. The physician impression of R1 was documented as altered mental status secondary to a likely urinary tract infection and hypertension. The hospital Computed Tomography of the Lumbar Spine, 6/4/13, documents the testing as completed due to post trauma, evaluate for fracture. The impression documents R1 as having compression fracture of the L4 vertebral body with mild to moderate loss of vertebral height.

On 8/6/13 at 2:40pm, E7 (Falls Nurse), stated the admission nurse does an initial assessment. If at risk the nurse implement appropriate interventions. Then a second fall risk assessment is done by E7 and makes any needed adjustments in interventions. If a fall occurs, a nurse follows-up with the resident every shift for 72 hours. The documentation includes an initial fall risk and pain assessment.

On 8/7/13 at 10:25am, E2 (Director of Nursing),

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