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F 466	Continued From page 92 designee: 3. Determines the need to begin utilizing emergency water supplies that are available on campus for cooking needs until other supplies are delivered. " The policy does not indicate how and to whom the on-hand emergency water will be distributed while awaiting delivery of water from other sources.	F 466		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210b) 300.1210d)6) 300.1220b)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. 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 b) The facility shall provide the necessary care and services to attain or maintain the highest	F9999		

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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 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.

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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 observation, interview and record review, the facility failed to assure adequate supervision and to implement effective injury prevention strategies for five residents (R2, R4, R9, R10, R12) in the sample of 15. These failures resulted in R9's fall on 3/6/2013 causing a left hip fracture.

Findings include:

The facility ' s Policy Number FT 323, titled " Accidents and Supervision " with an effective date of 12/17/12, includes the following relevant parts:
" III. Definitions - Supervision/Adequate Supervision refers to an intervention and means of mitigating the risk of an accident. Facilities are obligated to provide adequate supervision to prevent accidents. Adequate supervision is defined by the type and frequency of supervision, based on the individual resident ' s assessed needs and identified hazards in the resident environment. Adequate supervision may vary from resident to resident and from time to time for the same resident. "
" Resident Vulnerabilities - Falls: Assess, develop interventions, and/or revise the plan of care for a resident who has experienced falls, or who is identified as having risk factors for falling; Determine what may have caused or contributed

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to the fall; Address the factors of the fall; Revise the resident's plan of care and/or facility practices, as needed, to reduce the likelihood of another fall. "

1. As of 2/6/13, the quarterly Minimum Data Set (MDS) for R9 reflected a history of one recent fall on 12/30/12, coded R9 as needing the limited assistance of one person for transfers and reflected diagnoses of Parkinson ' s disease and syncope and collapse. A " Fall Risk Screen " dated 2/5/13 listed one additional fall for R9 that occurred on 10/28/12. The risk screen further indicated that R9 rises from a chair with " multiple attempts but successful. " Fall follow-up reports for both events indicate R9 fell in the bathroom having failed to call for assistance. On 10/28/12, R9 stated " I lost my balance. " On 12/30/12, R9 stated " I don ' t know what happened, I just got weak while I was at the sink. " The " Fall Occurrence Report " for 12/30/12 recommends a " stand-by assist in ADLs " and concludes " Gait unsteady. "
Nurses Notes for R9 dated 2/12/13 include an entry that " Z4 (Attending Physician) ... ordered orthostatic blood pressures daily and to follow-up with neurologist because family is concerned of syncope and unresponsive episodes. Per physician states Parkinson ' s Disease medications can cause hypotension. " The Medication Administration Record (MAR) reflects the implementation of new orders to check orthostatic blood pressures daily, which began 2/13/13.
Nurses Notes for R9 dated 2/19/13 (time of charting 2:18 PM, time of observation unclear) documents, " Noted by Activity staff to walk without walker in dine room to obtain cloth protector in the closet. Had unsteady gait. "

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Nurses Notes for R9 dated 2/20/13 as late entry documents, " Noted at 12:15 PM in television room by Activity staff that R9 was unresponsive. Nurse and Certified Nurse Aide assessed. Unresponsive to verbal and painful stimuli. " The period of unresponsiveness was listed as lasting approximately 3-5 minutes. Physician progress notes dated 2/20/13 describe the event as a " Syncopal episode " and orders were received 2/20/13 to reduce the dosage of a medication (Mirapex) with recognized side effects of orthostatic hypotension in some people.
Nursing Notes for R9 dated 3/1/13 at 2:15 PM indicate the appointment for a Neurology consultation had not yet been made by the family.
R9 ' s Falls care plan dated 2/12/13 includes in the Problem list a history of syncope and " unsteady gait at times with decreased strength and endurance. " Care plan interventions do not include any mention of monitoring blood pressure or monitoring for signs and symptoms of hypotension or precursors to syncopal episodes. Care plan interventions state " Instruct R9 to seek assistance as needed " but do not include interventions to instruct the resident about reporting symptoms or about causes of syncope to improve resident compliance with safety measures. The intervention for " Stand by assist with all his ADLs " is crossed out with no date or explanation. No update to R9 ' s Falls care plan was made noting the episode of unresponsiveness on 2/20/13.
The Fall Occurrence Report of 3/6/13, indicates R9 fell while standing from the dining table. The Post Fall Occurrence Follow-up dated 3/6/13 indicates R9, " lost balance when attempting to sit at table. Resident is in habit of leaving walker aside instead of keeping it in hand all the way to the chair. " Nursing Notes document that R9

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was transported to the hospital on 3/6/13 at 6:40 PM and was admitted with a diagnosis of left hip fracture. Nursing notes dated 3/9/13 indicate R9 was readmitted with a surgical wound and staples to the left hip and left lateral knee.
The Fall Occurrence Report dated 3/7/13 and the Post fall investigation summary report dated 3/8/13 describe R9 as sometimes forgetful, with poor safety awareness and poor judgment, yet care plans at the time of the R9's fall did not mention any ongoing or episodic lack of understanding, nor include strategies to safeguard R9 for such deficits.
On 6/30/13 at 1:00 PM, E3 (Assistant Director of Nursing) reviewed R9 ' s physician orders and acknowledged no parameters for reporting hypotension were present. E3 stated " Nurse should call the physician when readings drop. "
A review of blood pressure readings from 2/13/13 to 5/31/13 included episodes when either the systolic blood pressure was below 90 millimeters of mercury or the diastolic blood pressure was below 60 millimeters of mercury. Eleven episodes of blood pressures below those levels were recorded in the Medication Administration Record. Nursing Notes indicate the physician was contacted about the low blood pressures on two occasions, 3/21/13 ad 4/14/13. On 6/3/13 at 1:45 PM, Z4 (Attending Physician) stated " Maybe I'll give parameters and better directions about reporting symptoms " with regard to monitoring and reporting periodic low blood pressure readings.
Falls care plans dated 3/19/13 following the fall event of 3/6/13 that resulted in a hip fracture were not updated to address R9 ' s change in weight bearing status or changes in transfer needs related to hip precautions ordered upon readmission. Per orthopedic progress notes, as

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of 3/25/13, R9 was still limited to toe-touch weight bearing on the left leg and progressed to 25 percent weight bearing as of 4/8/13. Nursing Notes dated 3/20/13 indicate R9 required a two-person assist for transfer.

2. R10 had six falls in 2012 and one fall in 2013. Incident reports, nursing notes, care plans, and post fall occurrence follow-up sheets were reviewed. On 4/8/12, R10 walked back to the nurse's desk after supper and fell to the floor when she opened her chocolate candy. R10 had sustained slight redness in her left knee. No intervention was listed on the care plan. On 4/12/12, R10 slipped on floor while trying to get up. No injuries were noted. No personalized interventions were put in the care plan for this fall. Only pre-typed interventions were checked off on the care plan. On 6/7/12, R10 fell to the floor next to her bed. R10 sustained a skin tear over shin area 2x1.5x0.1cm (centimeter) in her right lower leg and also sustained a red bruise surrounding skin tear on shin 8x4 cm. The only intervention on the care plan was to add floor mats when R10 is in bed.
On 7/14/12, R10 fell to the floor and was found sitting by her recliner. No injuries were noted. The only intervention on the care plan was to increase nursing rounds. On 9/8/12, R10 fell while she was in the bathroom. No injuries were noted. The interventions on the care plan were to keep R10 close to the nursing station, anticipate resident needs, and assist with ADLs (Activities of Daily Living). On 11/20/12, R10 fell to the floor and was found sitting on her floor mat, next to the bed with her legs extended out in front of her, facing her bedside table. R10 sustained a skin tear 1.5cm x 1cm on her left lateral shin. The intervention on the care plan was to get resident

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up in wheel chair when awake. On 4/20/13, R10 fell out of bed and was found sitting on the floor mattress with both lower extremities extended forward. No injuries were noted. The interventions were to reposition frequently so that R10 will lie in the middle of the bed and do hourly monitoring.

3. R12 had two falls in 2013. On 4/10/13, R12 went to the toilet with her walker, fell to the floor and landed on her left hip and shoulder. R12 complained of pain to the left shoulder and hip. R12 sustained a 100% red superficial open area, skin tear. R12 sent to local community hospital. Left arm was put in a sling due to sprain. X-ray was negative. No individualized intervention was written on the care plan for this fall. Only the pre-typed interventions were checked off. On 4/13/13, R12 fell in her room. R12 was found to be sitting on her buttocks with her legs extended forward. No injuries noted. The only intervention on the care plan was to round every hour.

4. On 5/28/13, as R4 wrapping his stump and slid from his cart. R4 sustained a skin tear on his right upper arm that measured 4.5cm x 5.5cm. R4 sustained another skin tear on his right forearm that measured 2cm x 1.5cm. No individualized intervention was listed on the care plan. Only the pre-interventions were checked off. On 6/3/13 at 2:45pm, E4 (Rehabilitation Care Unit Manager) stated, " I'm sorry. I didn't get a chance to carry over the intervention that I wrote on the incident report to the care plan. "

5. Record review documents that R2 was admitted to the facility on 1/19/13 and re-admitted on 3/23/13. R2 has osteoporosis, esophageal

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reflux, history of falls, gastrostomy, gastro-paresis and multi system atrophy.
Facility Occurrence Report dated 6/27/12 documents a fall in the treatment room while R2 was ambulating. Physician and Power of Attorney (POA) were notified. R2 ' s cognition prior and after the occurrence was oriented X3. No injuries noted, no pain when range of motion (ROM) performed. R2 was placed in a chair. Registered nurse (RN) was notified and an assessment was done, then R2 was assisted to a standing position and to a chair.
Nursing notes dated 6/28/12 at 11:54 documents that R2 " was ambulating, with her rollator walker, across the therapy department and began turning to sit in armchair. R2 appeared to have caught her foot on back wheel of rollator and fell to the floor. " Witness statement documents " OT observe R2 with one hand holding rollator and the other hand/arm extended to the left, toward the floor. The fall was slow and gradual. " R2 was sitting when found and wearing well-fitting shoes.

Under general procedures the following were marked: (X)= factor was present.
-Root cause- no fault
-Factual description of accident added to nurse note-X
-Report and investigation completed in full-X
-Notifications completed and documented in nurse note-X
-Care plan updated-X
Staff interviews: no staff interviews available.
Recommendation: Therapy will continue to address safe turns using rollator.

On 6/3/13 at 2:45pm, E3 Assistant Director of Nursing (ADON) stated " R2 ' s care plan was

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not updated or new interventions addressed " because R2 fell in therapy room. "

Facility Occurrence Report dated 7/29/12 documents a fall in R2 ' s room while transferring R2. Physician and Power of Attorney (POA) were notified. R2 ' s cognition prior and after the occurrence was oriented X3.R2 complained of upper left back pain of 10/10.
" Neuro checks were initiated, R2 had pain when ROM performed, placed in wheel chair, toileted per demand, Physician made aware with orders received, noted and carried out. "
Nurse ' s notes at 12:01am documents " R2 alert, oriented and forgetful, stable gait with walker earlier. "R2 stated " do not know what happened earlier. " No witness.
Fall Details Report document under:
Fall Type: visually observed on floor, sitting upright on the foot side of the bed on the right side.R2 was in a quiet environment and barefoot.
Conclusion: " R2 tries to be independent but not able to do it safely, with poor balance and decreased strength, with unsteady gait , poor safety awareness. "
Staff Interviews: no staff interviews available
Recommendation: " Remind R2 to call for assist. "
Illinois Department of Public Health was notified.
Updated Care Plan dated 7/29/12 documents under:

Problem: Potential for falls due to:
-Previous history of falls
-Recent fall
Goals:
-will not fall
-will not sustain injury
The only new intervention for 7/29/12 after the fall

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F9999	Continued From page 102 was " increase nursing rounds. " R2 had history of falls on admission and a prior fall on 6/27/13. Facility Occurrence Report dated 2/7/13 documents a fall in R2 ' s room. Physician and Power of Attorney (POA) were notified. R2 ' s cognition prior and after the occurrence was oriented times three. No injuries noted no pain when range of motion (ROM) performed. R2 was placed in bed. Call light within reach and encouraged to use it. Nurses ' notes on 2/7/13 at 8:27pm document " Noted R2 is sitting on the floor facing her bed. R2 is AAOx3. R2 denies pain or discomfort. Able to move both upper and lower extremities. Assisted to bed, Assessment done, No apparent injury noted. " R2 stated that, "she was trying to reach for the waste can to vomit and fell on her knees. Kidney basin is by her side and verbalized that she wanted to use it to vomit. " They were no witness during the fall. Fall Details Report dated 2/7/13 documents the fall type as R2 visually observed. R2 was found sitting on the floor facing her bed. The environment was quiet, R2 was wearing socks only. Conclusion: " R2 with complaint of nausea, with some weakness, needs assist with activites of daily living, poor safety awareness, with unsteady gait, and poor balance. With poor judgment." Staff interventions: None available Recommendation: Increase nursing rounds for R2. Illinois Department of public Health was notified. Updated Care Plan dated 2/7/13 documents under:	F9999		

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F9999	Continued From page 103 Problem: Potential for falls due to: -Previous history of falls *same Goals: -will not fall *same The only new intervention for2/ 7/13 after the fall was " Remind R2 to call for assistance before attempting independent activity. " R2 had history of falls on admission and two (2) prior falls on 6/27/12 and 7/29/12. There was no implementation of other interventions consistent with R2 needs in order to reduce the risk of more falls. R2 ' s care plan did not reflect R2 ' s current conditions and other risk factors that have changed since the previous assessment. (B)	F9999		