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<tbody>
<tr>
<td>F 309</td>
<td>Continued From page 15 neurological status and documentation of neurological checks by E5, RN Consultant.</td>
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<td>F 309</td>
<td>5/23/13-All licensed nurses were inserviced on the different anticoagulant medications, including Plavix, Aspirin, Coumadin and Lovenox, and the adverse effects of such medications, especially for residents who fall and hit their heads, by E5.</td>
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**LICENSURE VIOLATIONS:**

- 300.1010h)
- 300.1210b)
- 300.1210d(3)
- 300.3240a)

Section 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care.
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| F9999 | Continued From page 16 | 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:  
  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.  
  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 evidenced by:  
  Based on interview and record review staff neglected to operationalize the policy on Head Trauma for R1 who was experiencing headache and nausea following trauma to the head, resulting in a delay in medical treatment for six hours. This neglect resulted in R1's death from a Subdural Hemorrhage. R1 is one of three residents reviewed with falls, in the sample of | F9999 | | |


Based on interview and record review staff failed to recognize Plavix as an anticoagulant agent and failed to notify the Physician that R1 who had a fall with head trauma was receiving Plavix. Staff failed to recognize and immediately report R1’s headache and nausea to the Physician as signs of increased intracranial pressure, delaying medical treatment for six hours. These failures resulted in R1’s death from a Subdural Hemorrhage. R1 is one of three residents reviewed with falls in the sample of three.

Findings include:

The Head Trauma Policy dated 2/2003 states it is the policy of the facility to "evaluate head injuries for a minimum period of 72 hours, to determine any negative effects, and to allow for immediate treatment to minimize permanent damage.....The following procedure focuses on proper assessment of residents who have sustained a head trauma:.....Assess the resident including vital signs, consciousness and neurological status....Ongoing assessment(vital signs and neuro[neurological]checks should take place as follows: a) initially and every 15 mins[minutes] for 1 hour b) every 30 mins x 1 hour c) every hour for 4 hours d) Every 4 hours for 8 hours e) Every shift for the remainder of 72 hrs.....Assessments for the first 24 hours after injury shall be recorded on the Neuro[Neurological]/Head Trauma Assessment form. Additional documentation shall be recorded in the clinical record......Signs of increased cranial pressure must be reported to the physician immediately. These signs are as follows: Nausea and Vomiting, Headache..........."
Continued From page 18

The Physician's Order Sheet (POS) dated 5/11-5/31/13 states that R1 has diagnoses of Prostate Cancer, Defibrillator Implant Right Upper Chest, Parkinson's, Diabetes and Coronary Artery Disease.

The hospital Discharge Summary dated 5/11/13 states R1 has diagnoses of Upper Gastrointestinal Bleed secondary to Gastritis and Barrett Esophagus and Acute blood loss Anemia. The summary states, "...We stopped the aspirin and Plavix because of the bleeding problem...Discharge Medications:.......Continue Plavix 75mg[milligrams] daily....Aspirin 81mg to be given next week onwards..."


The Physician's Order dated 5/12/13 states Hydrocodone-Acetaminophen(Vicodin) 5-325mg one or two tablets every 6 hours PRN(as needed). The PRN Medication Record dated 5/11-5/31/13 documents the Vicodin being given multiple times for pain greater than 8, on a scale of 1-10, with 10 being the worst pain. The record documents that R1 does get relief of pain from the medication.

The Physician's Order dated 5/14/13 states Vistaril 25mg IM(intramuscular) 4 times daily as needed for nausea and vomiting. The PRN Medication Record dated 5/11-5/31/13 does not document any Vistaril being given until 5/18/13 at 5:10pm.
The Nurse's Notes dated 5/18/13 at 3:45pm state, "[R1's] call light on...[R1] laying in bed-walker was overturned next to closet-[R1] stated he just fell-had lg hematomas L[large] forehead e[and] L wrist area...Neuro's[nutritional] WNL[within normal limits]...pupils equal. [No] unusual pain just discomfort...Applied ice to area..." At 4:00pm the Nurse's Notes state, "MD[Medical Doctor, Z2] notified."

On 5/22/13 at 2:30pm E4, RN(Registered Nurse), stated that she notified Z2, On Call MD and told him that R1 fell. E4 stated she did not tell Z2 that R1 was receiving Plavix and Aspirin. When asked why she didn't tell Z2 about the anticoagulants R1 was receiving, E4 stated, "I kind of knew it[Plavix] was preventative for stroke. I thought it was more like Ibu profen, but did not thin the blood as much as Coumadin or Lovenox." E4 stated that Z2 told her to "monitor" R1, but "he implied if [R1's] condition changed to send [R1] to ER[Emergency Room]."

The instructions on the undated Neuro/Head Trauma Assessment state, "Record vital signs in appropriate box. Place an (x) in each box for each symptom found. Notify the physician if any abnormal results are found. Assess as follows: a) initially and every 15 mins[minutes] x[times] 4; b) every 30 mins x 1 hr[hour]; c) every 1 hr x 4 hours; d) every 4 hours x 8 hrs; and e) every shift for remainder of 72 hrs."

The Neuro/Head Trauma Assessment dated 5/18/13 at 3:45pm and 4:00pm documents R1 had no headache or nausea.

The PRN Medication Information documents on
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<td>F9999</td>
<td>Continued From page 20</td>
<td>5/18/13 at 4:00pm R1 was given Hydrocodone-Acetaminophen (Vicodin) 5-325mg two tablets for complaint of &quot;pain [greater than] 8&quot;, on a scale of 1-10 with 10 being the worst pain. There is nothing documented about whether the medication relieved R1's pain.</td>
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| | | | The PRN Medication Information documents on 5/18/13 at 5:10pm that R1 was given Vistaril 25mg IM for "nausea."
| | | | There is no documentation in the Nurse's Notes dated 5/18/13 of R1's headache or nausea. There is no documentation in the notes that Z2, On Call MD was notified of the change in R1's condition or the need to give R1 medication for pain and nausea.
| | | | The Neuro/Head Trauma Assessment dated 5/18/13 at 5:45pm documents that R1 had a headache, but the nausea was "better."
| | | | The Neuro/Head Trauma Assessment dated 5/18/13 at 4:15 and 4:30pm documents that R1 had "sl[slight]" headache, but no nausea. At 4:45 and 5:15pm the assessment documents that R1 had a headache and nausea. The Neuro/Head Trauma Assessment dated 5/18/13 at 5:45pm documents that R1 had a headache, but the nausea was "better."
| | | | On 5/22/13 at 2:30pm E4, RN(Registered Nurse), stated that R1 had "no headache, just general ache" when first assessed on 5/18/13 at 3:45pm. E4 stated the first time R1 mentioned a headache was on 5/18/13 at 4:15pm. E4 stated that R1 had "no nausea" when assessed on 5/18/13 at 3:45, 4:00, 4:15 and 4:30pm. E4 stated R1 complained of nausea at 4:45 and she gave him Vistaril for

| PROVIDER'S IDENTIFICATION NUMBER: 145948 |  | | | |

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NAME OF PROVIDER OR SUPPLIER

BEMENT HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

601 NORTH MORGAN
BEMENT, IL 61813
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his nausea(5:10pm). E4 stated that it was not unusual for R1 to have nausea, and that R1 had complained of nausea earlier in the day(5/18) and she had given him(R1) something for constipation, which took care of his nausea. E4 stated that she called Z2 when R1 fell initially and did not call him again. When asked why she didn't call Z2, MD, to report R1's headache and nausea, E4 stated, "It wasn't a bad headache, when I asked him[R1] he said he had a headache, a slight headache where he hit his head. It didn't scream out to me to call the Doctor[Z2] again." E4 stated she gave report to E2, RN, Director of Nursing(DON) the oncoming nurse at 6:00 pm. E4 stated she told E2 that R1 had a headache and nausea.


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On 5/22/13 at 3:00pm E2, RN, DON, stated R1 had a fall on 5/18/13 at 3:45pm and neurological assessments were started. E2 stated R1 had no increase in pain and she did not "feel [R1] was any different than before the fall", neuro's normal. E2 stated that R1 had a bruise to the right forehead above the eyebrow and ice was applied. E2 confirmed she documented that R1 had a headache and nausea at 6:45, 7:45, 8:45 and 9:45pm on the Neuro Assessment dated 5/18/13. E2 confirmed she did not document anything in R1's record, except that he had a "headache" on the Neuro/Head Trauma Assessment Form. E2 stated, "it was a headache to the hematoma area, it was more tenderness where ice was applied, he would say to "be careful, take it easy" when putting the ice on the hematoma. E2 stated she did not call Z2, On Call MD until 10:30- or 10:45pm on 5/18/13, when R1 had a "pounding headache and vomiting."

On 5/22/13 at 1:45pm Z2, On Call Physician, stated he remembered being called about R1's fall. Z2 stated "normally, especially if the head, will tell, if there is a change to send to ER." When asked his opinion if the onset of R1's headache(4:15pm) and nausea(4:45pm) constituted a change, Z2 stated, "With the headache and nausea, Yes, should send [R1] to ER."

The Emergency Medical Services Report dated 5/18/13 at 11:25pm states, "......found [R1] supine in bed, attended by RN[E2] vomiting into a basin......has hematoma.......on front R side of head with bruising and some bleeding......[R1] sluggish to respond but is A&O[alert & orientated] x 4 and answering appropriately.Reports pain 'everywhere' in head, primarily site of hematoma
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(name of provider or supplier)

STREET ADDRESS, CITY, STATE, ZIP CODE

SUMMARY STATEMENT OF DEFICIENCIES

(Each deficiency must be preceded by full regulatory or LSC identifying information)

ID PREFIX TAG

(ID PREFIX TAG)

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

COMPLETION DATE

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and posterior midline [cervical] spine and occipital region. Staff reports that [R1] fell seven and a half hours ago, and did not call 911 despite head injury and [R1] being on Plavix.....transported to ED[emergency department]....[R1's] responses became shorter and more delayed....."

The Emergency Department Report dated 5/19/13 states that R1 was seen by Z3, Emergency Physician on "5/18/13 [at] 11:48pm." The report states, ".....[R1] presents....with head injury....has a large hematoma to his right temple.[R1] appears confused and cannot answer most questioning.......says he is nauseous, has abdominal pain and feels 'miserable'.....Cannot tell me date or year. Will only follow commands after multiple prompts.......[R1's] mental status and obvious head injury while [on] Plavix were concerning for a likelihood of intracranial hemorrhage.....taken to CT[Computerized Tomography]....which showed a large right-sided subdural underlying his hematoma. When [R1] returned from [CT] scan we were unable to wake him....I spoke with [Z4, Physician] of neurosurgery.....who did not recommend Burr hole placement or Mannitol use at this time, and recommended transport....Transferred....in critical condition....Preliminary Clinical Impression...Subdural hematoma due head trauma..Coagulopathy....."

The Final Diagnostic Report dated 5/18/13 at 11:51pm of "head without contrast" states, "Large right holohemispheric acute subdural hematoma resulting in 9mm[millimeter] of leftward midline shift and moderate cerebral edema...Small left middle cranial fossa and tentorial subdural hematoma and moderate diffuse subarachnoid
Continued From page 24 hemorrhage...."

On 5/22/13 at 11:50am Z3, Emergency Physician stated, when he first saw R1 he had a hematoma on his right temple from a fall. Z3 stated his "biggest concern [for R1] was the Plavix." Z3 stated in his opinion Plavix is worse than Coumadin, because there is no blood test to monitor the drug. Z3 stated there is a higher risk of bleeding with the Plavix than with Coumadin. Z3 stated when a patient comes to the Emergency Department with "evidence of head trauma and is on Plavix, [Z3] will routinely admit to the hospital for monitoring for 24 hours." Z3 stated once R1's "headache and nausea started, even a slight headache they should have called [the Physician]." Z3 stated the headache was "significant." When asked if in his opinion neglect of R1 occurred, Z3 stated, "If [R1] has a headache, on Plavix and they waited 6 hours before calling [the Physician]. I feel like that's neglect."

The Emergency Department Report dated 5/19/13 states that R1 was transferred from the initial Emergency Department to a Regional Trauma Center.

The Regional Trauma Center Consultant History and Physical dated 5/19/13 states, "Ct of head: Large right subdural hemorrhage, seen to be increased since yesterday posteriorly about parietal lobe. Appearance of left middle cranial fossa subdural hematoma. Diffuse subarachnoid blood about both hemispheres appears mildly increased. There is increasing mass effect with increased right to left midline shift. Slight further enlargement of left lateral ventricle. Mild subfalcine herniation anteriorly is
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<td>Continued From page 25 present......Assessment...Neuro...Large SDH[Subdural Hematoma] with midline shift, traumatic....Evaluated by Neurosurgery, non operable.......Need to discuss with family...poor prognosis and massive ICB[Intracranial Bleed]....&quot;</td>
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The Regional Trauma Center Discharge Summary dated 5/20/13 states, "[R1] passed away as expected, he was pronounced at 11:55pm on 5/19."