STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015812	A. BUILDING: _____ B. WING _____	12/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN VILLAGE CARE CENTER	27 AUERBACH PLACE GLEN CARBON, IL 62034

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S9999	Final Observations Statement of Licensure Violations: 300.610a) 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 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 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	S9999		

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S9999	Continued From page 1 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 300.3240 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 were not met as evidenced by: Based on observations, interview and record review, the facility failed to provide adequate supervision, identify causative factors contributing to falls and injuries, implement interventions based on these identified hazards, and failed to monitor and modify interventions when falls and injuries continue to occur for three of five residents (R1, R3, R11) reviewed for bruises and falls in the sample of 15. This failure resulted in R3 sustaining a fractured rib and a fractured hip. Findings include: 1. R3's Electronic Face Sheet, reviewed on 12/10/2013, documented she had the following partial diagnoses: Healing Traumatic Fracture, Senile Psychotic Condition, Anxiety State, Depressive Disorder.	S9999		

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R3's Minimum Data Set (MDS), dated 2/25/13, documented she had no cognitive impairment but had altered level of consciousness. R3's MDS documented she required extensive assistance from one staff person with transfers and toileting. R3's MDS documented she required limited assistance from one staff person with walking in her room. The MDS documented she was not steady, but able to stabilize without human assistance with moving from seated to standing position, walking, turning around, moving on and off toilet and surface-to-surface transfers. The MDS documented she had a history of falls and sustained injuries due to the falls.

The Facility's Incident Details from January 2013 through March 2013 documented she had fallen two times during this period.

The Facility's Incident Details, dated 3/17/2013, documented R3 was found on her bathroom floor at 8:30 PM. The Details documented "Resident stated she was in the bathroom to get an (adult diaper) to attend to toileting needs, upon reaching for the (the adult diaper), the (adult diaper) fell on the floor and resident reached further to obtain (adult diaper) and fell hitting her head on the right temporal area. A hard raised bruised centered hematoma measuring 2.5 cm (centimeter) x (by) 2 cm intact." The Facility's Investigation Report, dated 3/17/13, documented the following to prevent re-occurrence "Call a work-order to have maintenance place a shelf more accessible for resident to store (adult diapers) to prevent res. (resident) from bending over (and) reaching ." R3's Care Plan was updated on this date and documented "Family will bring in shelf to place briefs in reach."

The Facility's Incident Details report, dated

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3/29/2013, documented R3 was found in her room on the floor at 10:35 PM. The Details documented "Heard loud clang went to investigate and found resident at the doorway lying on her left side. Resident stated she hit her head on corner of brass stand. Resident stated she was trying to shut off the light. Resident was using wheeled walker. Encourage resident to call for assistance c (with) care - family to provide age appropriate shelving." The Care Plan was not revised to address this specific fall or address progressive interventions to prevent R3 from future falls.

The Facility's Incident Details report, dated 4/4/2013 at 10:45 PM documented "Was sitting on the floor next to her husband's bed, it appeared as if she slid from the edge of the bed. No apparent injury noted." The facility's Investigation Report, dated 4/4/13 documented this type of event had occurred before. The Report documented the following steps to prevent re-occurrence "non-skid socks and frequent checks." The Report documented "Informed resident to use the call light for assistance when getting up." R3's Care Plan was revised on 4/5/13. The Care Plan documented "I slid out of bed when trying to get to get walker. Place walker at bedside." The facility did not provide any documentation regarding what type of supervision and how frequently staff should supervise R3 to prevent her from independent ambulation.

The Facility's Incident Details report, dated 4/20/2013 at 12:15 PM documented "Care giver went to room to get resident for lunch, resident was sitting on floor by dresser, resident said she was rearranging items in dresser and lost her balance and bumped forehead on dresser

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drawer." The report documented "Spoke to resident, resident denies pain or discomfort. Encouraged resident to sit in chair when re-arranging dresser drawers. Team met to review fall assessment. Resident has Parkinson's Disease. Family signed a wavier to allow resident unlimited ambulation without supervision. Therapy will eval (evaluate) and treat." The Investigation Report documented "Instructed resident to use call light for help, check on resident frequently." The facility did not provide any documentation regarding what type of supervision and how frequently staff should supervise R3 to prevent her from independent ambulation.

R3's Minimum Data Set (MDS), dated 5/22/2013, documented she had no cognitive impairment but had altered level of consciousness. R3's MDS documented she required extensive assistance from one staff person with transfers and toileting. R3's MDS documented she required limited assistance from one staff person with walking in her room. The MDS documented she was not steady, but able to stabilize without human assistance with moving from seated to standing position, walking, turning around, moving on and off toilet and surface-to-surface transfers. The MDS documented she had a history of falls and sustained injuries due to the falls.

The facility's Reportable Event Form, dated 5/29/2013, documented on 5/25/2013, R3 was found on the floor in her room. The Form documented "Call to room by husband. This resident was lying on floor with her face against the foot of the overbed table. Resident was reaching over the over-the-bed table attempting to plug in cell phone. Overbed table roll and resident landed on the floor. To (local hospital).

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Transferred to (another hospital). Dx (Diagnosis) closed fx (fracture) of R (Right) 8th rib." On 5/25/2013, the facility revised R3's care plan documenting R3's over-the-bed table would be removed. There was no documentation in R3's medical record indicating the facility had reassessed her
for what type of supervision and how frequently staff should supervise R3 to prevent her from future falls in her room.

R3's MDS, dated 6/5/2013, documented she had a score of 7 (severely cognitively impaired) on the BIMS (Brief Interview for Mental Status). R3's MDS documented she required extensive assistance one one staff person for transfers, ambulation and toileting. The MDS documented she was not steady, only able to stabilize with human assistance for moving from seated to standing position, walking, turning around, moving on and off toilet and surface-to-surface transfers.

The Facility's Incident Details report, dated 7/14/2013, documented at 7:05 PM "Resident was found sitting on the floor next to husbands bed. She states that she did hit her head on the bed when she fell down. No witness present during time of incident but resident sates that she was trying to back up when husband was coming into the room and shutting the bathroom door to get through and she fell backwards." The Facility Investigation Report, dated 7/14/2013 documented "Frequent monitoring (and) encourage her to ask for help and not get up by herself." The Care Plan, dated 7/14/13, documented "staff to escort resident to room after supper."

The Facility's Incident Details report, dated

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8/1/2013, documented at 11:00 AM she fell in her bathroom. The Report documented " 11:00 AM reported to nurse that resident was observed in the bathroom, knees in contact with floor. Resident denies hitting head. Resident stated she was attempting to get something out her plastic cupboard located in the bathroom by the toilet." Details of Corrective Measures, Taken by Facility, dated 8/1/2013 documented "Spoke to staff and resident. Resident stated that she toileted self and while on toilet, she slid off when reaching into drawer of plastic cupboard. Team met to review fall risk assessment. It was determined that plastic cupboard would be turned sideways to allow easy access to drawers from toilet. Resident agreed." There was no documentation in R3's medical record documenting how and how often the staff should supervise R3 to prevent her from falling in her room.

The Facility's Incident Details report, dated 8/9/2013, documented at 7:15 PM R3 was found on the floor in her bathroom. The Report documented "This nurse heard a thug and this nurse to resident's room and found resident sitting on her buttocks in her bathroom in the shower stall, resident assessed for injury and a abrasion to bridge of nose noted and measured 0.5 cm linear in length. Small raised hematoma to the front aspect to the forehead with no break in skin." The Report documented "Risk team to review fall assessment and do investigation. Resident stated that she went to room after supper to do personal care in prep for hs (bedtime). She stated she reached to far and slipped from wc (wheelchair). Explained use of dyceom and resident agreed. Explained importance of leaving dyceom in place and not removing and resident agreed. Will place non-woven dyceom under wc cushion in attempt to

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prevent sliding." The Facility Investigation documented "Safety education with using call lights for assistance - Assist resident with toileting and changing clothes after meals."

The Facility's Incident Details report, dated 8/14/2013, documented at 2:00 PM she was found in her bathroom on the floor. The Incident Details report documented "Resident's husband yelled for help, went to room found resident sitting on bathroom floor, noted abrasion above right eye area, approx (approximately) 2 cm x 2 cm. Resident stated she was trying to get toilet paper, noted no toilet paper on roll." The Details of Corrective Measures Taken by Facility documented "Spoke to resident and husband. Resident stated she was leaning on her wheeled walker, reaching down to put an extra roll of toilet paper on top off the paper of the roll. Team met to review fall assessment and will keeps extra paper in residents reach." The Investigation Report, dated 8/14/2013 documented what steps had been taken to prevent re-occurrence as "monitor resident when going to room." The Report documented "put toilet paper on roll for resident." Again, the facility had no documentation regarding if they assess how and how often staff would supervise R3 to prevent her from future falls.

The Facility's Incident Details report, dated 8/27/2013, documented at 3:30 PM R3 was found on the floor in her room. The Report documented "Call to room by Care-giver, noted resident on floor on bottom, noted abrasion over left eye 1.3 cm and hematoma to left forehead, phone was ringing, daughter on phone, she said she was trying to call her mother, notified her of her mother falling while trying to answer the phone., no complaint of pain, moved extremities with no

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difficulty. Hematoma proxy. (approximately) 3 cm." The details of Corrective Measures taken by Facility documented "Spoke to resident. Resident stated ' I was sitting in chair beside husbands bed and he was lying in his bed. The phone began to ring, when I got up to answer phone, I was hurrying and fell." Resident admits to not using wc. Spoke to daughter. Daughter continues to refuse use of wc and bed alarms. Environmental assessment completed. Team met to review fall assessment. Decided to place safety awareness signage around room." Again, the facility had no documentation regarding if they assess how and how often staff would supervise R3 to prevent her from future falls.

The Facility's Incident Details report, dated 8/31/2013, documented at 12:40 PM R3 was found on the floor in her room. The Report documented "Heard resident call out. Arrived at room to find resident lying on her left side of floor. Noted right hip shorter. Complaints of pain in right hip. Tylenol 650 mg (milligrams) po (by mouth.)" The Report documented she was sent to the hospital and diagnosed with a right hip fracture. The Electronic Face Sheet documented R3 returned from the hospital on 9/6/13.

On 12/10/13, at 9:10 AM, during the initial tour of the facility, R3 was seated in a tiltback wheelchair in the dining room. R3 was crying. At 9:10 AM, an interview was conducted with E3, Neighborhood Nurse Coordinator (NNC)/ Registered Nurse (RN) . E3 stated R3 was confused and had fallen and sustained a fractured hip.

On 12/10/2013, at 11:20 AM, R3 was seated in her wheelchair. R3 was very confused and was continually asking someone to please remove the

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puppy next to her wheelchair. There was no puppy next to her wheelchair. At 12:51 PM, R3 was seated in her wheelchair in the dining room. R3 pushed up from the arms of her wheelchair and stood multiple times. No staff attempted to assisted or supervise R3. At 12:56 PM, E15, Registered Nurse asked resident what she was doing. R3 continued to attempted to stand without assistance.

On 12/11/2013, at 8:23 AM, R3 was seated in her wheelchair in the common area. R3 was seated at the edge of her wheelchair seat with her right leg hanging over the side of the right leg rest. R3 was crying out for help. There were no staff present at this time. At 8:40 AM, E16 and E17, Certified Nurse's Assistants (CNAs), transferred R3 onto the couch and assisted R3 into the lying position. E15 and E16 left the area. R3 began leaning off the side of the couch reaching for items on the floor which were not there. AT 9:02 AM, R3 sat up independently, scooted to the end of the couch seat and leaned forward and placed her hands on the floor. R3 stated "Feel these. Feel these." R3 attempted to stand independently. There were no staff present. At 9:05 AM , E17 and E18 (CNA), assisted R3 back into her wheelchair.

On 12/13/2013, 9:00 AM, an interview was conducted with E2, Director of Nurse's (DON). E2 stated R3 had a long history of falls and was at high risk for falls. E2 stated the family wanted to keep her as independent as possible and had refused alarms. E2 stated the facility had requested the family sign a waiver due to this refusal. E2 stated the facility had implemented 15 minute checks for R3 over a year prior. However, the family did not want the facility to check on R3 frequently because this upset her

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S9999	Continued From page 10 (R3) . The Facility's Fall Prevention and Management Program, dated 8/13/2012, documents "The interdisciplinary team will develop a plan for services to improve or maintain the resident's standing and sitting balance and other interventions to reduce the resident's risk for falls. The plan will include specific information about the resident's routine and personal habits that may place the resident at risk for falls such as night time voiding, night time wandering. The plan will also identify the level of over-sight required to support both resident safety and autonomy including recommendations for monitoring when alone or in a bathroom. (B)	S9999		