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	IL6001275	A. BUILDING: _____ B. WING _____	03/11/2014

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S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS 300.1210b) 300.1210d)6) 300.3240a) 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 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)	S9999		

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S9999	Continued From page 1 THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY: Based on record review and interview the facility failed to provide adequate assistance and/or failed to develop effective interventions based on toileting needs/potential side effects of medications/cognitive status to ensure resident safety for 2 of 9 residents (R13 and R19) reviewed for falls in the sample of 24. These failures resulted in 2 Emergency room visits, a MRI, a Lumbar-3 Fracture to R19 with a referral to a neurosurgeon and an order to wear a corset when out of bed. Findings include: 1. The March, 2014 Physician's Orders state R19 was admitted to the facility on 11/22/13 with a diagnosis of Status Post Small Bowel Resection, Dementia and Macular Degeneration. The 11/28/13 Minimum Data Set (MDS) states R19 has a Brief Interview for Mental Status (BIMS) score of 7 (severely impaired)) with fluctuating behavior of inattention and disorganized thinking. The MDS dated 11/28/13 states R19 requires extensive assistance of two plus people for transfers and toilet use. The Facility's "Assessment of Fall Potential" form states a resident with a score above 8 is at "High Risk" for potential falls. An assessment was completed on R19 on the following dates: 11/28/13-a score of 7 12/02/13- a score of 8 12/09/13-a score of 10 01/17/14-a score of 8 01/17/14-a score of 10 02/07/14-a score of 12 02/17/14-a score of 13	S9999		

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03/03/14-a score of 13

The Incident Reports for R19 indicate that R19 has had 8 falls since admission to the facility on 11-22-13 as follows:

The Incident Report dated 11/29/13 states R19 fell at 7:20AM in his room and was found sitting on the floor by staff. The report states R19 sustained a 2-3 inch abrasion to the right upper extremity and notes he is confused at times. The "Incident Investigation" report dated 11/29/13 states the resident was attempting to independently transfer and the pressure alarm did not sound and that he knows how to "turn off/unplug" the monitor. The report states R19 needed to go to the bathroom. The "Preventative steps taken and put in place" area of the form is blank. The "Fall Communication For Week of December 12, 2013" states to see initial fall care plan, therapy services, Personal Safety Alarm (PSA) in bed and chair, close supervision so that he does not turn alarm off.

The Incident Report dated 12/08/13 states R19 fell at 2:30AM. The report states a CNA heard the personal safety alarm sounding and when they entered the resident's room he was sitting up in a bedside chair with a drinking cup knocked over and water on the floor. The report states he sustained an abrasion on the left upper eyelid and a bump/bruise to the outer left eyebrow. The report states R19 is alert and responsive with confusion at times. The report further states R19 was sent to the emergency room. The "Incident Investigation" dated 12/08/13 states the cause of the incident is that R19 is unsteady and fell when trying to ambulate to get the urinal. The "Preventive steps taken and put in place" states: "Reminded resident to use call light, informed that

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when he hears PSA sounding to sit back down and wait for help." The "Fall Communication For the Week of December 12, 2013" states to see initial fall care plan, therapy services as ordered, PSA in bed and chair and to see head injury care plan.

The updated 12/10/13 Fall/Vision Care Plan states the PSA was discontinued related to non-compliance 01/16/14.

The Incident Report dated 01/16/14 states R19 fell at 12:40PM. The report states R19 got up to look out the window and got dizzy and fell with no injuries noted. The report states R19 is pleasant and confused. The "Incident Investigation" dated 01/16/14 states the cause of the incident is that R19 stated he got light headed and fell up against the bed and fell to the floor. The "Preventative steps taken and put in place" states: "Moved room around so chair and bed are closer to window so its closer to look out."

The Nurse's Notes dated 01/16/14 states Z2 (Power of Attorney) was notified after the fall and informed the PSA was discontinued. The notes also state Z2 stated it was noticed during a visit that the PSA "agitated him at times."

The 01/17/14 Incident Report states at 11:05AM R19 was found on the floor in his room with his head against the wall and his walker on it's side with no injury noted. The "Incident Investigation" report dated 01/17/14 states R19 was attempting to independently transfer from the bathroom to the chair with a walker and R19 complained of losing his balance and becoming dizzy. The "Preventative steps taken and put in place" states-"Call to doctor to report, got order for PSA in bed and chair. Further orders pending." E19

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(Care Plan/MDS Coordinator) stated on 03/13/14 at 11:30AM that R19 had taken himself to the bathroom unassisted by staff.

The Nurse's Notes dated 01/17/14 at 11:30AM state R19 complained of low back pain, at 11:45AM R19 complained of dizziness when he stood, at 1:45 PM Z1 (Physician) discontinued Norvasc and gave orders to monitor the blood pressure every shift, at 4:10PM R19 was sent to the emergency room for an x-ray of the back.
The 01/17/14 Lumbar Spine Diagnostic Imaging Report states R19 had a possible acute fracture of the Lumbar-3 spine and recommended a Cat Scan or Magnetic Resonance Imaging (MRI). The 01/21/14 MRI report states R19 has a diagnosis of "Acute/Subacute L3 (Lumbar 3) compression fracture." The "Fall Communication For Week Of January 23, 2014" notes the 01/16 and 01/17/14 falls on this log with interventions of: Resident's room rearranged so that he could look out of window easier, PSA in bed and chair at all times, Norvasc discontinued related to orthostatic hypotension and dizziness, monitor blood pressures as ordered and report findings, provide increased assist related to dizziness and back pain, encourage rest and decreased ambulation at this time, x-ray MRI showed Lumbar 3 fracture-referred to a neurosurgeon.
The updated 12/10/13 Fall/Vision Care Plan states R19 was referred to a neurosurgeon. This evaluation was done on 01/28/14 and a corset brace was ordered to be worn when out of bed.

The "Incident Report" dated 02/06/14 stated R19 fell at 5:01PM while getting up to use the bathroom. The report states R19 did not use the call light and fell on his "bottom/left leg." The report states a bruise was noted to the right wrist

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on 02/07/14. The "Preventive step taken and put in place" were: "Constant reminders to use call light, ensure proper PSA placement."

The "Incident Report" dated 02/14/14 at 9:20AM states R19 "was trying to get out of recliner, while assisting resident he got dizzy and falling forward, pulled resident on me and sat in recliner." The report states no injury was sustained and R19 was sent to the Emergency Room. The "Incident Investigation" dated 02/14/14 states the cause of the incident was R19 became dizzy and started to fall forward and staff got him to his chair before falling. The report states R19 was pleasant, confused and anxious and he had a "blank stare, eyes fixed." The "Preventative steps taken and put in place" were: "Remind resident to use call light." The report further states R19 had been up several times to go to the bathroom to get his bowels to move and had been attempting to go again, pressure alarm sounded and a nurse went into the room. The report states R19 has a history of syncopal episodes. The report states, "When resident stopped feeling dizzy staff was going to assist to bathroom but resident denied needing to go." The "Preventative steps taken and put in place" were: "Remind resident to use call light."

The "Incident Report" dated 02/14/14 at 9:45AM states R19 was walking to the bathroom without his walker and was found holding onto the bed and wall with his right leg on the ground. The "Incident Investigation" dated 02/14/14 states the cause of the incident was R19 stated he was dizzy and his right leg gave out on him. The "Preventative steps taken and put in place" were: "reminded resident to use call light when needing assistance, put in wheelchair and given one on one." The "Fall Communication For Week Of February, 2014" log states R19 was sent to the

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local hospital on 02/14/14 and returned with a diagnosis of "Near Syncope", be aware that if resident has complaint of constipation or has received bowel medications he may want to attempt to toilet more often, and to assist to toilet often.

The "Incident Report" dated 03/03/14 at 12:30PM states R19 was attempting to independently transfer and when staff entered the room he lost his balance and was lowered to the floor by staff. The report states there was no injury. The "Preventative steps taken and put in place" were: "Encouraged use of call light."

This surveyor interviewed R19 on 03/10/14 at 1:55PM. R19 stated he does not recall falling and when asked how he gets help he stated he uses "a box" but stated he has never used it and could not find it right now. The call light was observed attached to his shirt. R19 stated he likes "getting up alone". R19 was able to push the call light button and E20 (CNA) entered the room during this observation and stated he does not push his call light and attempts to get up on his own often. Also during this observation, E21 (Physical Therapy Assistant) entered the room who stated she feels R19 will not be independent with ambulation and will require the assist of 1 or 2 to ambulate.

On 03/11/14 at 3:00PM, E19 confirmed E20's statement that R19 does not use his call light and attempts to ambulate independently often.

E19 stated on 03/13/14 at 11:30AM the 12/10/13 Fall/Vision Care Plan is the "Initial Care Plan", Occupation Therapy was started on 11/22/13, Physical Therapy was started on 11/23/13 and the PSA was placed on 11/23/13. E19 stated the

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hospital did inform the facility that E19 attempts to self transfer. E19 stated R19 was admitted to the facility on Restoril 15 milligrams one by mouth at bedtime and Celexa 20mg one by mouth daily. E19 stated the Celexa was increased to 40mg daily on 01/03/14. E19 stated the Nurse's Notes indicate R19 was non-complaint in regard to calling for help and attempted to get up alone often. E19 further stated R19 was not put on a toileting schedule due to the falls and that he is continent and the staff offer or take him to the bathroom when in the room. E19 stated the pharmacist is sent the "Fall Communication" logs at least monthly and when he visits the facility he "checks off" on the facility's log that it was reviewed in the "Pharmacy Review" column. E19 added the pharmacist did not recommend medication changes in relation to R19's falls.

The 2007 "Drug Information Handbook for Nursing" states Restoril (Temazepam) "causes CNS (Central Nervous System) depression (dose-related) which may impair physical and mental capabilities. Use with caution in patients receiving other CNS depressants or psycho-active agents. Benzodiazepines have been associated with falls and traumatic injury and should be used with extreme caution in patients who are at risk of these events (especially the elderly)." This reference further states, "Geriatric Considerations: Because of its lack of active metabolites, temazepam is recommenced in the elderly when a benzodiazepine hypnotic is indicated. Hypnotic use should be limited to 10-14 days. If insomnia persists, the patient should be evaluated for etiology."

Review of R19's record does not provide information that indicates the pattern regarding

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toileting concerns in relation to falls on 11-29-13, 12-8-13, 1-17-14, 2-6-14, and the two falls on 2-14-14 was addressed until 03/10/14. The interventions that were put in place on 3-10-14 were not individualized to R19's needs regarding toileting. The Incident Reports for R19 on 12-8-13, 2-6-14, both falls on 2-14-14 and on 3-3-14 indicate as interventions to remind R19 to use the call light; not taking into consideration the BIMS score of 7 with R19 being severly impaired cognitively.

2. The facility's Incident Report dated 3-2-14 for R13 indicates they had a fall at 4PM while being transferred from their bed to wheelchair. The report notes R13's knees buckled and E14, (Certified Nurse Aide-CNA), had to lower the resident to the floor. No injury was noted but the resident complained of neck pain. R13 was sent to the emergency room for evaluation and treatment. The Report notes R13 was confused and lethargic prior to the fall.

The Incident Investigation Form dated 3-2-14 indicates a gait belt was in use. Preventive steps taken and put in place were noted to be information passed on to doctor for possible new order to evaluate with physical therapy. The Investigation Form failed to note E14 was attempting to transfer R13 alone.

The medical record admission sheet 10-20-13 indicates Diagnoses including Morbid Obesity and Stroke.

The most recent Minimum Data Set, (MDS) is a quarterly review dated 1-27-14. The MDS notes R13's height as 64 inches and weight as 238 pounds, Section GO110B indicates two plus persons for transfer and Section GO400 notes

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S9999	Continued From page 9 range of motion limits on both sides of upper extremities and one side of lower extremity. E2, (Director of Nursing, (DON), stated at 2PM on 3-4-14, E14 was not inserviced on their failure to follow the plan of care (two assist) for R13 to ensure their safety. (B)	S9999		