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 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 ARE NOT MET AS EVIDENCED BY:
Based on observation, interview, and record review, the facility failed to maintain a safe physical environment for three of three residents (R1, R2, R3) reviewed for environmental hazards in the sample of three and one resident (R31) in the supplemental sample. This failure resulted in R2 falling and obtaining a left lower arm fracture.

FINDINGS INCLUDE:

1. R2's Nurses' Notes dated 6-3-14 at 9:00 p.m., document R2 was trying to close the closet door, tripped over the walker, fell, complained of left wrist pain, and was sent to the Emergency Department.
A Final Investigation Report dated 6-6-14 and signed by E1 (Administrator), documents on 6-3-14, R2 was found laying in R2’s room, on the floor, with the walker on top of R2. R2 stated the closet door stuck when R2 was trying to close it and R2 tripped, fell, and complained of left wrist pain. R2 was sent to the emergency room and was admitted to the hospital for a left wrist and elbow fracture.

R2’s X-ray report dated 6-3-14, documents R2 has a non-displaced distal radial (forearm) fracture.

On 6-17-14 at 1:50 p.m., R2 was in a wheelchair with the left arm wrapped and in a sling. R2 stated, "I was trying to close my closet door a couple weeks ago, and the door stuck to the floor. I tried to jerk the door, until the door finally broke loose, causing me to trip and fall. I fractured my arm because of the fall. My middle closet door sticks to the floor, also. The staff knew the closet door did not work right, but no one fixes anything around here, until someone gets hurt. Maintenance did not fix my closet door until I fell and fractured my arm. Maintenance still has not fixed my middle closet door. My bed does not lock, either. I am afraid when I am going to bed that my bed is going to move and make me fall. The staff know about that and have not fixed it, either."

On 6-17-14 at 1:55 p.m., R2’s right head of the bed and left foot of the bed brakes would not
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lock, and the right foot of the bed brake was missing, causing the bed to move freely. R2's middle closet door rubbed against the floor and was hanging off of the hinges at the top, causing it to catch on the floor, when attempting to open it.

On 6-17-14 at 2:30 p.m., Z2 (Physical Therapy Assistant) transferred R2 from the wheelchair to the bed. During the transfer, R2's bed moved. Z2 stated, "When I transferred (R2) to bed, R2's bed brakes did not work, causing (R2's) bed to move. That is a fall risk for (R2)."

On 6-17-14 at 2:30 p.m., E7 (Certified Nursing Aide/CNA) stated, "(R2) fell a couple of weeks ago. (R2) was lying on the floor with the walker. (R2) told me that the closet door would stick on the floor, and caused (R2) to fall. I know (R2's) closet door in the middle is off track, and doesn't work. (R2's) brakes on the bed do not work, either. I have reported (R2's) brakes on the bed not working for several days now. I have given maintenance a slip stating (R2's) brakes do not work. It is a fall risk to (R2)."

On 6-17-14 at 2:05 p.m., E3 (Maintenance Director) stated, "I am not aware of (R2's) brakes on the bed not working or (R2's) other closet door not working. I was told (R2) tripped and fell because the other closet door was sticking. I raised (R2's) that closet door up after the fall.

On 6-18-14 at 9:45 a.m., E8 (CNA) stated, "(R2's) closet door has stuck for several months, prior to (R2) falling. I just used a hanger to open it. I did
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not report (R2's) closet door not opening right, because it does no good to report it."

On 6-18-14 at 8:45 a.m., E1 (Administrator) stated, "(R2) fell because the closet door got stuck. The staff had not reported the closet door sticking, prior to (R2) falling. The staff should report any closet doors sticking to the floor immediately to myself or maintenance. If the staff report repairs needing done to maintenance, and the repairs do not get done, then the staff should report to a charge nurse or myself."

2. R1's Final Investigation Report dated 6-4-14 and signed by E1, documents, "On 6-1-14, (R1) got stuck on the non skid strips in front of R1's chair, and fell, resulting in a mid back fracture. To prevent reoccurring falls, physical therapy is to evaluate (R1), and the non skid strips in front of (R1's) chair will be removed."

On 6-17-14 at 1:15 p.m. and 6-18-14 at 9:35 a.m., R1 was sitting in the reclining chair, with three non skid strips on the floor in front of the chair.

On 6-18-14 at 9:55 a.m., E1 verified the three non skid strips were still on the floor in front of R1's chair, and should have been removed to prevent further falls.

3. On 6-17-14 at 9:20 a.m., the 100/300 C Hall shower room had a chair commode with four partially rusted out legs, that were missing paint.
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On 6-17-14 at 1:15 p.m., R1 stated, "I have noticed the legs on the shower chair being rusty. I have told the staff that continuing to use that chair could be fatal. They still have not got a new one."

On 6-17-14 at 1:50 p.m., R2 stated, "The bottom of the shower chair I use is rusty, and I am afraid I am going to fall."

On 6-17-14 at 1:40 p.m., R3 stated, "The legs on the shower room chair are rusty. It is not safe. It could break."

On 6-17-14 at 1:30 p.m., R31 stated, "The shower chair is dirty and rusty. It always looks unsafe to sit on."

On 6-17-14 at 9:20 a.m., E2 (Housekeeping Supervisor) stated, "No one has reported the chair commode having rusty legs. It needs to be replaced."

On 6-17-14 at 1:35 p.m., E9 (CNA) stated, "I have known about the shower commode chair legs being rusty for months. I tell maintenance about it."

An undated Maintenance Services policy documents, "The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times."
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<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>(X5) COMPLETE DATE</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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