STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006902	A. BUILDING: _____ B. WING _____	11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-ELGIN	355 RAYMOND STREET ELGIN, IL 60120

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300.1210b)
300.1210d)6)
300.1220b)3)
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. 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:
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

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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
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 record review and interview the facility failed to ensure the staff supervised and implemented appropriate fall prevention measures for R9; failed to ensure the staff transferred R8 in a safe manner; and failed to use appropriate sling when transferring R7.
This applies for three of six residents (R9, R7 and R8) reviewed for falls in a sample of 18.
This failure led to R9 falling and sustaining a hip fracture.
Findings include:
1. R9 is a 92 year old female admitted to the facility on 12/31/13. R9 ' s medical record documents the following: Urinary Tract Infection, dementia, hypertension, osteoporosis, spinal stenosis, mitral insufficiency, Lumbar and thoracic compression fractures prior to admission, and anemia. R9 Minimum Data Set (MDS) dated 10/6/14 documents: Cognition- Brief Interview for Mental Status; score 2/15 indicating cognitive impairment. Transfers - extensive assistance, one person physical assist; Ambulation- extensive assistance, one person physical assist; Balance during transfers and

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walking- Not steady, only able to stabilize with staff assistance.
R9 ' s fall risk assessment documents a score of 15 indicating high risk for falls.
R9 ' s fall care plan dated 10/16/14 documents that she has a mobility alarm for her bed and chair. The care plan documents the alarms as being discontinued on 10/27/14. R9 ' s Restorative Care Plan documents that she gets confused, forgetful, and disoriented, with a diagnosis of Dementia. There are no interventions to address as how the staff would monitor R9 when her bed and chair alarm was discontinued.
R9 ' s Wandering Assessment dated 6/30/14 documents that she does not have a history of wandering. There were no further reviews located in R9 ' s medical record. There was no assessment in R9 ' s medical record to determine the safety of her propelling unsupervised throughout the facility.
R9 ' s restorative assessment dated 1/1/14 documents that she has decreased endurance; decreased stamina; decreased muscle coordination, decreased balance, decreased strength, and requires cues.
The facility ' s incident report for R9 dated 11/13/14 at 1:15 pm, documents that R9 tried to transfer herself from the wheel chair to bed, and sustained a fall. R9 complained of left hip pain and was sent to the local hospital.
On 11/19/14 at 8:55 am, E7 (Restorative Registered Nurse / RN) stated that R9 was able to transfer with 1 person contact assistance. E7 stated that R9 is confused and roams the facility alone in her wheel chair. E7 confirmed, by providing the Restorative assessment that R9 has decreased strength and balance with limitation to both shoulders. E7 also stated that R9 was admitted to the facility with compression fractures

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to her spine and was high fall risk. E7 said R9 was given a bed and chair alarm when she was initially admitted to the facility. E7 added that the purpose of the alarm is so that if R9 tries to get up, staff may intervene right away. However, according to E7, the bed and chair alarm was discontinued on 10/27/14.

On 11/19/14 at 1:04 pm, E10 (Certified Nursing Assistance / CNA) stated that R9 is a wanderer and she wheeled herself from the South unit onto the North. E10 stated she provided care for R9 the day she fell. E10 stated that R9 entered R39 ' s room attempting to get into R39 ' s bed. E10 was asked when was the last time she had seen R9 was. E10 did not give a time, only stating that she tried to lay R9 down earlier and she refused. E10 stated that R9 has a history of trying transfer herself to bed. According to E10 staff reminds R9 not to transfer herself but she tries anyway. E10 stated " she is confused because she ' s always looking for a way out. "

On 11/19/14 at 1:15 pm, E9 (CNA) stated that she was working on the North unit when R9 sustained the fall. E9 stated that she did not see R9, but she heard screaming from R39 ' s room. Upon entering the room, E9 noted R9 on the floor by the bed. E9 also added that R9 is confused. E9 stated that R39 ' s room is in the back hall on the North unit.

On 11/19/14, E14 (Registered Nurse) stated that she did not see R9, but was summoned to R39 ' s room where she observed R9 on the floor, and that R9 ' s room is on the South unit.

R9 ' s nursing notes dated 11/13/14 by E14 documents that she was summoned to R9 ' s room where she noticed her on the floor on her left side. The note also documents that R9 tried to transfer from the wheel chair to the bed and lost her balance. R9 was complaining of severe pain to the left hip according to the

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documentation and was transferred to the local hospital.
The location of R9 where she was found is contradicting from R9's documentation (11/13/14 incident report and and 11/13/14 nurses notes) and staff interviews (E9 and E14).
On 11/19/14 the surveyor walked the distance from R9 ' s room to R39 ' s room. At the time of the fall, R9 ' s room was located at the back end of the hall on the South unit, approximately 10-11 doors down from the nursing station. When leaving the nursing station on the South the traveler went down a hall with resident rooms and offices. The traveler would also pass by the doorway leading to the main entrance of the facility, two dining rooms, and the North nursing station. Upon reaching the nursing station, the traveler would take a right and travel to back hall. The very last room on the right was R39 ' s room (approximate 14 doors down from the nursing station). The travel from R9 ' s room to R39 ' s room was in a " U " shape, as noted on the facility ' s floor plan. Staff interviewed were unable to state where R9 ' s route began. However, R9 made her way inside R39 ' s room unnoticed by staff.
R9 ' s radiology report from the hospital dated 11/13/14 documents: Impression- There is a comminuted left femoral neck fracture with displaced greater trochanteric fragment. R9 ' s medical records documents that R9 was admitted to the hospital where she received left hip ORIF (Open Reduction Internal Fixation) surgery.
The facility ' s Fall Management policy documents: The potential for injury will be care planned when appropriate, based on the results of the Fall Assessment. The interdisciplinary care plan will be individualized to reflect the specific needs and risk factors of the resident.
2. On 11-18-14 at 10:05 AM, E5 and E 6 were

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observed to transfer R 7 using a full mechanical lift (Hoyer) from chair to bed. When R7 was lifted, R 7 was observed like in a cocoon, R 7 ' s head and legs were enclosed in the sling. E 5 explained, " We are supposed to use a small size sling for her because she is so tiny (96 pounds). "

When E 5 was asked if the sling they used for R 7 is small, E 5 was unable to answer and said this other one here (that was not use) is the small size. "

On 11-18-14 at 1:25 PM, E 7 (Restorative Nurse) explained, " We do not have an assessment for appropriate sling size for the residents. " R 7 was unable to show any documentation regarding the sling size to be used for R 7.

On 11-20-14 at 11:10 AM, E 4 (Restorative Aide) explained, " The patient head is supposed to be exposed, the canvas is position to the neck of the resident and the lower part of the canvas should be by the resident ' s coccyx. No! The patient should not be enclosed like a cocoon. "

3. On 11/18/14 at 11:10 am E5 and E6 (Certified Nurse Aides - CNAs) transferred R8 using a sit to stand mechanical from wheel chair to toilet in the bath room. During the process of the transfer the strap (Velcro) that held R8's legs in place to the immovable board on the machine came off two times. There was thick layer of lint build up on the straps made the straps to come off. No staff stood behind R8 to prevent him from accidental falling from the mechanical lift. When the surveyor brought to the attention of E5 about the loose straps, she attempted reinforce, but did not stick together to contain R8's legs fastened to the immovable part of mechanical lift. E5 stated one staff should have had R8's back when moving

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S9999	Continued From page 6 him from wheel chair to the toilet, but E6 had to leave R8's room to access R8 to position him on the toilet from the adjacent room entrance to the bath room. (B)	S9999		