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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 and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to	S9999		

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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 record review and interview the facility failed to evaluate hazards and risks and implement interventions including adequate supervision to prevent falls for 2 of 6 residents (R2, R5) reviewed for falls in the sample of 6. This failure resulted in R2 sustaining a right hip fracture.

Findings include:

1. R2's face sheet documents R2 was admitted to the facility on 4/1/15 with the following partial diagnoses of Cerebrovascular Accident with multiple contractures, multiple pressure sores with infection, Alzheimer's Disease, and Non-ruptured cerebral aneurysm.

R2's Minimum Data Set dated 4/8/15 documents R2 is totally dependent on 2 staff for bed mobility, transfers, ambulation. R2 has range of motion impairment on bilateral upper and lower extremities. R2 has no speech and is rarely/never understood. R2 usually understands.

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R2 has severely impaired vision. R2 has both short and long term memory problem and has moderately impaired cognition.

The Facility's "Occurrence Log" for 3/1/15 through 4/21/15 documents R2 had a fall at 3:23 a.m. on 4/12/15. "Fall Details Report" documents E5, Certified Nursing Assistant (CNA) found R2 parallel to bed on right side on floor. The Report documents bed rails and alarm were not in use for R2 at time of fall. E6, Registered Nurse (RN), documents E5 turned and repositioned R2 at 3:00 a.m. on 4/12/15. The Report documents E6 gathered dressing supplies for R2's dressing changes. E6 was called to R2's room and found R2 lying on her right side parallel to her bed. The Report documents R2 assessed and found to have right iliac crest is pushed upwards as well as protruding outwards towards her skin more than usual. The Report documents R2 has a hematoma beginning to show at her right eyebrow. E2, Director of Nursing (DON) documents the following conclusion: "Based on investigation and staff interviews, (R2) with voluntary and involuntary movement of extremities, was positioned for dressing changes, as a result of movement, resident rolled from bed onto floor."

1. R2's face sheet documents R2 was admitted to the facility on 4/1/15 with the following partial diagnoses of Cerebrovascular Accident with multiple contractures, multiple pressure sores with infection, Alzheimer's Disease, and Non-ruptured cerebral aneurysm.

R2's Minimum Data Set dated 4/8/15 documents R2 is totally dependent on 2 staff for bed mobility, transfers, ambulation. R2 has range of motion impairment on bilateral upper and lower

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extremities. R2 has no speech and is rarely/never understood. R2 usually understands. R2 has severely impaired vision. R2 has both short and long term memory problem and has moderately impaired cognition.

The Facility's "Occurrence Log" for 3/1/15 through 4/21/15 documents R2 had a fall at 3:23 a.m. on 4/12/15. "Fall Details Report" documents E5, Certified Nursing Assistant (CNA) found R2 parallel to bed on right side on floor. The Report documents bed rails and alarm were not in use for R2 at time of fall. E6, Registered Nurse (RN), documents E5 turned and repositioned R2 at 3:00 a.m. on 4/12/15. The Report documents E6 gathered dressing supplies for R2's dressing changes. E6 was called to R2's room and found R2 lying on her right side parallel to her bed. The Report documents R2 assessed and found to have right iliac crest is pushed upwards as well as protruding outwards towards her skin more than usual. The Report documents R2 has a hematoma beginning to show at her right eyebrow. E2, Director of Nursing (DON) documents the following conclusion: "Based on investigation and staff interviews, (R2) with voluntary and involuntary movement of extremities, was positioned for dressing changes, as a result of movement, resident rolled from bed onto floor."
On 4/22/15 at 10:00 a.m., E2 stated R2 was assessed by E2 and E4, Licensed Practical Nurse/Restorative Nurse, for a specialty mattress due to multiple pressure sores. In addition, E2 stated the facility uses side rails for residents that need them for mobility. During this interview, E4 said it is the admitting nurse's judgment as to whether a resident receives side rails on their bed. E4 also said she re-assesses residents side rails quarterly for continued use, but she does not

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S9999	Continued From page 4 do an initial assessment for side rails upon admission. Review of "Proper Use of Side Rails" policy and procedure on 4/23/15 documents "Side rails are considered a restraint when they are used to limit the resident's freedom of movement (prevent the resident from leaving his/her bed). (Note: The side rails may have the effect of restraining one individual but not another, depending on the individual resident's condition and circumstances.) Side rails are only permissible if they are used to treat a resident's medical symptoms or to assist with mobility and transfer of residents. An assessment will be made to determine the resident's symptoms or reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's: a) Bed mobility; and b) Ability to change positions, transfer to and from bed or chair, and to stand and toilet." Review of the (Low Air Loss Bariatric Mattress) Owner's Manual on 4/23/15 documents Indications for use: "The above mattress is a flotation therapy mattress that provides pressure management to assist in the prevention and treatment of up to Stage IV pressure ulcers. The alternating pressure and low air loss mode provided with this mattress is indicated for use as a preventive tool against further complications associated with critically ill residents of immobility. The mattress Air Cells: There are 20 air-filled polyurethane air cells are divided into two separate, every other cell alternating pressure zones. These air cells inflate to a height of 8 inches. Specific cells are designed with holes which allow the (Air) mattress to provide low air loss. The Side Perimeters: There are two air-filled side perimeter to help contain the	S9999		

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resident with the mattress system. The Mattress Height: The total pressure-management surface height is 10 inches, 13 inches with optional raised perimeters." Warnings for this mattress documents "This product is designed to assist in the prevention and treatment of pressure ulcers and may require other equipment. This may include, but is not limited to: 1. Bed rails for repositioning and fall prevention."

Observation of the (Low Air Loss Mattress) was completed at 12:00 p.m. on 4/23/15. The bed frame that holds the mattress is 18 inches from the floor and the mattress itself is approximately an additional 10 inches high.

On 4/23/15 at 2:10 PM , E6 stated that she never saw R2 attempt to turn herself or move independently prior to R2's fall from bed on 4/12/15. E6 said R2 was non-verbal except when E6 changed R2's pressure ulcer dressings. E6 stated that she heard R2 say "ow" and "stop" when she was in pain during dressing changes.

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On 4/23/2015, at 10:50 AM, E7, Licensed Practical Nurse (LPN), stated she never saw R2 move prior to her fall on 4/12/15, but after R2's fall she observed R2 to turn herself independently to her right side while waiting for the ambulance to arrive. E7 said R2 had many contractures and was shocked R2 could move herself.

On 4/22/2015, at 2:45 PM, E5, stated that R2 seemed to become more alert during the late evening or night shift and would answer "Yes/No"

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questions. In addition, when she wanted her television channel changed she pointed with her toes. E5 said he turned and repositioned R2 on her left side with pillows behind her back and a pillow between R2's knees. E5 said he did not have any positional devices in front of R2 and R2's bed did not have side rails at 3:00 a.m. on 4/12/15 to prevent R2 from rolling out of bed. In addition, E5 said R2's bed height was pretty high and there were not any mats on the floor to soften a fall if R2 fell out of bed. E5 said that R2 had changed position in bed on one night (date unknown) before the 4/12/15 fall. E5 said he checked with all of his co-workers to see if they had repositioned R2 and forgot to tell him, but they had not. He asked R2 if she turned herself onto her right side and she indicated "Yes" to him. E5 said he found R2 on the floor at 3:23 a.m. on 4/12/15 when he went back into R2's room to assist E6 with R2's pressure ulcer dressing changes. E5 informed the nurse and rolled R2 onto a bath blanket to make her more comfortable while they waited for the ambulance. E5 said while they waited for the ambulance, R2 turned on to her right side independently.

R2's nurse's notes dated 4/12/15 at 5:45 a.m. completed by E6 document that R2 is being transferred from the local emergency room to a local city hospital emergency room due to a right hip fracture.

2. R5's admission face sheet documents that R5 has diagnoses which include in part of: a history of falls. The Minimum Data Set (MDS), dated 3/23/15 documents that R5 is mildly cognitively impaired, requires extensive assistance for transfers and ambulation, and has poor balance. The MDS documents that R5 uses a walker and a wheelchair for locomotion, with one assist.

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S9999	Continued From page 7 R5's Progress Nursing notes dated 3/27/15 document that R5 was found unresponsive due to low blood sugar and was transferred to the emergency room. While there it was determined that R5 also had a urinary tract infection. R5's Nurse's notes on 3/29/15 document that R5 was still weak and being monitored when she fell on 3/29/15. On 4/23/15, at 1:50 PM, E10, Certified Nurses Aid (CNA), who was the documented caretaker at the time of the fall on 3/29/15, stated "I was taking (R5) to the bathroom. She was walking with her walker and I was walking next to her. I noticed the toilet was dirty so I went in to clean off the toilet and left (R5) to stand with her walker while I did that. I thought she was stable with the walker, but I guess she wasn't. She tried to walk without it. and then fell back and hit her head on the floor." Review of policy and procedure for "Assisting a Resident to Walk to the Bathroom" dated October 2010 documents the following: "After resident done using toilet, assist the resident to stand. Allow the resident an opportunity to maintain his or her balance. Reposition the resident's clothing. Allow the resident to wash his or her hands. Assist the resident back into a comfortable position. Place the call light within easy reach of the resident. Clean the bathroom as necessary (i.e. flush commode, wipe up spills, etc.)" The facility Occurrence reports for 3/29/15 and 4/1/15 were reviewed. The Report documented on 3/29/15, as a result of the fall, near the bathroom, R5 had a large hematoma with bleeding that required transfer to the emergency room, and a pressure dressing and pain medication for 4 days afterwords.	S9999		

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