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| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610a)<br>300.1210b)<br>300.1210d)6)<br><br>Section 300.610 Resident Care Policies<br>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<br>Section 300.1210 General Requirements for Nursing and Personal Care<br>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.<br>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:<br>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All | S9999 | | |

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nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These requirements were not met as evidenced by:

Based on interview and record review facility failed to follow their falls prevention clinical guidelines for two residents (R1, R2) out of four residents reviewed for falls. This failure resulted in R1 not being properly supervised 1:1 after staff noted that R1 ' s gait was unsteady, then falling and sustaining a small subarachnoid and possible tiny parenchymal contusion, and staff not repositioning R2 in her wheel chair correctly before transferring her and subsequently led to R2 falling forward onto the floor and sustaining a spinous process fracture.

Findings Include:

R1 ' s care plan dated 2-25-15 denotes at risk for injury from falls and impaired balance secondary to dementia; requires staff participation to reposition and turn; resident in visible view of staff when up in chair, and encourage resident to transfer positions slowly.

R1 ' s nurse's note dated 4-27-15 denotes R1 is noncompliant with walker; numerous attempts made to redirect; R1 becomes combative when redirected. Unit manager notified, resident in need of one to one care due to combativeness and being noncompliant with walker and wheelchair.

E1 (Licensed Practical Nurse) stated on 4-30-15 at 1:15 pm she works the day shift mainly and

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that R1 is alert and oriented x2 and is noncompliant sometimes with using her walker and tries to walk without it, and when she is redirected she gets agitated. E1 stated R1 was able to walk with her walker , but had history of removing her bed alarm and would get out of bed. E1 stated R1 ' s medication made her drowsy and the doctor was notified and the medication was discontinued.

R1 ' s physician progress note dated 4-27-15 denotes called to attention R1 not steady and may not tolerate higher dose of Depakote. Was not so hyper now but watched 1to1. Was not so anxious and did stand with assistance and is now alert and not really sedated as she was when AM dose held. Will stop Depakote as not tolerated.

E9 (Certified Nurse Aide) stated on 5-1-15 took care of R1 on the pm shift of 4-27- E9 stated she noted during her shift R1 was drowsy and not steady and she was not as active as she usually was but continued to get up by herself and get out of bed. E9 stated that when she left R1 was in the bed, alarm was in place and R1 was supposed to be monitored 1:1.

E10 (Licensed Practical Nurse) stated on 5-1-15 at 9:40 am worked the pm shift (3-11) on 4-27-15 and she reported to night nurse (E7) that R1 was to have 1:1 because her gait was unsteady and she was attempting to walk without walker. E10 stated when she left that night R1 had a chair and bed alarm on . E10 stated during her shift R1 was continuously monitored and did not fall.

Facility ' s shift report sheet denotes 3-11 shift update one on one sitter/CNA due to risk for falls, noncompliant with staff. Resident (R1) won ' t stay in one place, constantly getting up, unsteady

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| S9999 | Continued From page 3<br>gait.<br><br>E7 (Registered Nurse) stated on 4-30-15 at 3:30 pm that she worked the night shift (11-7) and that R1 slept during the night of 4-27-15 and early am 4-28-15 and R1 had her bed alarm in place. E7 stated around 2 am the CNA (E9) reported that she had to do rounds and E7 went to monitor R1 1:1 until CNA did her rounds and came back to R1 ' s room and was supposed to be watching R1. E7 stated she gave the CNA (E9) specific instructions that R1 needed 1:1 monitoring during the night shift. E7 stated she did not see R1 fall during the night.<br><br>E11 (Certified Nurse Aide) stated on 5-1-15 at 10:10 am R1 was one of the residents assigned to her during the night shift (11-7) on 4-27-15 thru 4-28-15. E11 stated she did patient care on all of the residents assigned to her during the night as she usually does. E11 stated was never told by the night nurse (E7) that R1 needed 1:1 monitoring but was just told to monitor R1 for behavior problems. E11 stated prior to 4-28-15 R1was a fall risk and knew how to take her alarm off her body, turn her bed alarm off and would carry it around. E11 stated in the past she did inform one of the nurses about R1 removing her alarm but could not recall which nurse she told that R1 would remove her bed alarm. E11 stated during the night shift (11-7) on 4-27-15 thru 4-28-15 saw the nurse (E7) mainly sitting at the nurses ' station doing charting while she was going around from room to room giving patient care to her assigned residents. E7 stated she did not see R1 fall during the night.<br><br>E6 (Registered Nurse) stated R1 is alert times 1-2, was working am shift (4-28-15) and doing med pass when noted bruise to R1 ' s left face | S9999 | | |

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and complained of left hip hurting called doctor and got order for X-ray. E6 stated R1 was sent to the hospital afterwards. E6 stated was not told in report that R1 had fallen during the night.

R1 ' s nurse's note dated 4-28-15 denotes observed bruise to the left side of face close to R1 ' s eye. Doctor and family notified ; insisted resident go to hospital.

R1 ' s hospital record dated 4-28-15 denotes physical Ecchymosis of left upper face including eye and forehead. Computed Tomography scan dated 4-28-15 denotes suspicious for small subarachnoid and possible tiny parenchymal contusion.

Z1 Doctor) stated on 5-1-15 at 10:40 am that R1 sustained a subarchnoid hemorrhage which she probably sustained from a fall. . Z1 stated R1 is capable after a fall to get back up on her own. Z1 stated she did not know that staff did not see R1 fall.

R1 's progress note dated 4-29-15 denotes spoke to doctor at hospital R1 admitted for hematoma on the brain.

E4 (Director of Nursing) stated on 4-30-15 at 2:10 pm that there is no documentation in R1 ' s chart/records that she would remove her bed alarm and was not aware that R1 would remove her bed alarm. E4 stated E11 never reported to nursing staff that she would remove her alarm. E4 stated if they had known would had to change her fall care plan and implement other effective interventions because at that point when she was removing her alarm made it ineffective.

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Facility ' s fall clinical guideline denotes facility is committed to maximizing each resident ' s physical, mental and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. Residents at fall risk will be identified for staff awareness. Residents at risk for falls will have Fall risk identified on the interim plan of care with interventions implemented to minimize fall risk.

R2 ' s care plan dated 12-26-14 had fall related impulsiveness and poor safety awareness and poor balance.

R2 ' s fall risk screen dated 2-18-15 denotes R2 cannot walk even when assisted by staff, confined to a wheelchair and disoriented.

R2 ' s nurse note dated 4-19-15 denotes R2 found on the floor face down by the activity aide, placed in bed and assessed bump middle of forehead, doctor notified and to send R2 to hospital.

R2 ' s hospital records dated 4-19-15 denotes physical exam large frontal hematoma with ecchymoises bilateral eyelids swollen shut and Computed Tomography Scan denotes non-displaced fracture of the distal tip of the C5 spinous process.

Z2 (Doctor) stated on 5-6-15 at 11:35 am R2 ' s fracture was a consequence of her falling.

E1 (Licensed Practical Nurse) stated on 4-30-15 at 1:15 pm R2 is alert to name only, unable to ambulate but can scoot a little with her feet in her wheel chair. E1 stated was passing noon

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medications on 4-19-15 when the CNA reported that R2 had fallen in the dining room. E1 stated went to the dining room and saw R2 on the floor faced down in front of her wheel chair and saw the activity aide trying to pick R2 up by her arms. E1 stated assessed and noted a bump on the middle of R2 ' s forehead. E1 stated the three of them put R2 in the wheel chair. E1 stated asked activity aide (E5) what happened and he informed her that while he was pushing R2 to her table to eat , R2 fell forward onto the floor. E1 stated called her doctor and sent R2 to the hospital.

E2 (Certified Nurse Aide) stated on 4-30-15 at 1:50 pm was in the hallway walking towards the nurses ' station and heard a loud thump from the dining room. E2 stated went the dining saw R2 lying face down on the floor in front of her wheel chair. E2 stated activity aide was standing near R1 and told activity aide not to touch R2. E2 stated went and told the nurse (E1) and went back to the dining room and they picked R2 up to her knees then the three of them put her in her chair and then took R2 to her room.

E3 (Unit Manger) stated on 4-30-15 at 2:15 pm reviewed from the dining room video (4-19-15) saw R2 was sitting on the edge of the chair leaning forward when activity aide (E5) pushed the wheel chair and R2 fell out of the chair onto the floor. E3 stated before a staff member pushes a resident in a wheel chair they should make sure the resident is sitting back all the way in the chair and sitting up.

E5 (Activity Aide) stated on 4-30-15 at 2:30 pm was in the dining room giving another resident water. E5 stated saw R2 across the room scooting herself in her wheelchair and she was leaning forward while she was moving her feet

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and bumping into another resident. E5 stated went over to help get past the other resident and got behind her wheelchair while she was leaning forward and pushed her wheelchair when she suddenly fell forward and hit her face on the floor. E5 stated he had intended to reposition R2 by sitting her up and leaning her back her wheelchair but R2 fell out the wheelchair before he got a chance to.
E5 stated was only in-serviced after the incident that they should make sure residents are sitting all the way in their wheelchairs before they are moved.

E4 (Director of Nursing) stated on 4-30-15 at 2:10 pm had reviewed the dining room footage (4-19-15) and noted that R2 was in the dining room trying to move by another resident in her wheelchair using her feet and was leaning forward in her wheel chair when activity aide came behind R2 ' s wheel chair and started pushing R2 ' s wheelchair at the same time while R2 was leaning forward and saw from the video R2 fall forward out of the chair and land on the floor. E4 stated E5 was written up for R2 ' s fall incident.

E5 ' s employee report dated 4-19-15 denotes employee action/discipline: E5 failed to supervise the dining room resulting leading to a resident to fall. E5 in-serviced on fall precautions.

(B)