

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/29/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145724	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/07/2009
NAME OF PROVIDER OR SUPPLIER ADDOLORATA VILLA			STREET ADDRESS, CITY, STATE, ZIP CODE 555 MCHENRY ROAD WHEELING, IL 60090		
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F 000	INITIAL COMMENTS	F 000			
F 224 SS=J	<p>Complaint investigations</p> <p>0991373 IL40594 - F224 and F309 0991463 IL40698 - F224 and F309</p> <p>A partial extended survey was conducted.</p> <p>483.13(c) STAFF TREATMENT OF RESIDENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews the facility neglected to timely, frequently and comprehensively assess 1 resident (R1) after a fall incident on 3/24/09. The facility neglected to notify the physician to obtain timely and appropriate medical care and failed to follow the policy regarding change in resident's condition, after R1 showed a change in the neurological status and change in the condition of the injured left eye. This failure resulted in R1 having 33 hour delay in medical treatment and needing hospital care.</p> <p>R1's left eye swelling and bruising progressed to the extent that the staff was unable to open the left eye to check for eye and pupil response within 24 hours post fall. R1 was sent to the hospital on 3/26/09 due to mental status change. R1 was admitted to the hospital with diagnoses of Cervical fracture and Brain bleed. This failure resulted in Immediate Jeopardy.</p>	F 224			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 224	Continued From page 1 E1 (Administrator), E6 (Executive Director) and E2 (Director of Nursing) were notified of the Immediate Jeopardy on May 4, 2009 at 11:54 AM via phone conference. The immediate Jeopardy was determined to have begun on 3/24/09 at 11:00 PM once it was determined that R1 had a sluggish left pupil response 45 minutes after sustaining a fall. Findings include: R1 is an 83 year old resident with multiple diagnoses to include Dementia with agitation, Difficulty in walking and acute MI (myocardial infarction). Review of R1's quarterly MDS (minimum data set) dated 2/22/09 showed that the resident is severely impaired with cognition, required limited assistance x 1 person physical assist for bed mobility, transfers and ambulation. R1's MDS also showed that the resident had problem with standing balance and the wheelchair is the resident's primary mode of locomotion. Review of the facility incident report dated 3/24/09 (10:15 PM) showed, "Description of Incident: Resident was sitting across from nurses' station. Nurse was working at the desk. She heard the chair alarm go off and when she looked up, resident was on the floor on her left side." "Resolution/Final Resident Outcome: Resident initially assessed at time on incident and found with laceration to lateral orbit and some facial swelling and bruising starting. Assessed resident back to a recliner chair and first aid administered. On 3/25/09, resident was responding, and eating,	F 224			

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F 224	<p>Continued From page 2</p> <p>with negative neuro checks. On the morning of 3/26/09, resident was noted to be more lethargic and sent to NWCH ER for evaluation. resident was admitted with a brain bleed and cervical fracture."</p> <p>Review of R1's neurological assessment showed the following documentation:</p> <ul style="list-style-type: none"> - 3/24/09 (11 PM) - left pupil, "Sl." Eye response, open spontaneously- checked. - 3/25/09 (12:05 PM) - left pupil, "Sl." Eye response, open spontaneously- checked. - 3/25/09 (1 AM) - left pupil, "*" Eye response, open spontaneously- checked. - 3/25/09 (2 AM) - left pupil, "*" Eye response, open spontaneously- checked. - 3/25/09 (3 AM) - left pupil, "*" Eye response, open spontaneously- checked. - 3/25/09 (4 AM) - left pupil, "*" Eye response, open spontaneously- checked. - 3/25/09 (6 AM) - left pupil, "*" Eye response, open spontaneously- checked. - 3/25/09 (10 AM) - left pupil, "C." Eye response, open spontaneously- checked "R." - 3/25/09 (2 PM) - left pupil, "C." Eye response, open spontaneously- not marked. - 3/25/09 (6:15 PM) - left pupil, "(*) Eye response, open spontaneously- checked. - "Comments: Left pupil sluggish, after 1 AM unable to check due to swelling." <p>Based on this neurological assessment documentation, the facility assessed R1, 45 minutes post fall, then every hour for 4 hours and then two to four hours thereafter. The facility assessed R1's neurological status 10 times within 19 hours post fall.</p> <p>Review of R1's computerized nurses' notes</p>	F 224			

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F 224	<p>Continued From page 3</p> <p>showed the following documentation:</p> <ul style="list-style-type: none"> - 3/25/09 (3:21:26 AM), "Res. with normal restless behaviors, attempting out of bed, Taken to toilet several times with success and taken to tv lounge, reclining chair for closer observation at 12:20 am. Res. denies pain, swelling continues into left eye area with left eye unable to open for pupil response by 1am. res. continues to refuse to keep cold ice pack over left forehead. At 2 am tylenol ES one tablet given even though res. denies pain, is restless and grimaces at times when repositioning self in chair." - 3/25/09 (6:15:59 AM), "Res. restless all night, another tylenol ES given at 4am (order is for 1-2 tabs, one tab given at 2am) res. attempting to get out reclining chair, out of w/c (wheelchair), returned to bed for HHN treatment and attempted to get out of bed. Res. gives no requests, toileted, given fluids, needing 1:1 care, did not give ativan the normal med for these behaviors due to fall and could mask any symptoms. Res. with normal vitals, bruising continues to spread over left forehead, left eye and now noted on left shoulder-normal ROM with no pain noted." - 3/25/09 (10:59:45 PM) showed a late entry documentation stating, "On 3/24/2009 at 11:31 PM return call recd (received), from Z1 with no new orders noted. Except for Neuro check per protocol and monitor closely. In case of any abnormal findings call Z1. Report informed to on duty nurse of 11 - 7 shift and informed by her that she already talked with Z1." <p>Review of R1's POS (Physician order sheet) showed, "(Late entry 3/25/09) Neuro check per protocol & monitor closely. In case of any abnormal findings. Call Z1." Review of R1's</p>	F 224			

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F 224	<p>Continued From page 4</p> <p>POS dated 3/1/09 through 3/31/09 showed orders for Aspirin 81 mg, 1 tablet daily and Plavix 75 mg, 1 tablet daily.</p> <p>During interviews held inside the first floor sitting room on 4/30/09 from 2:35 PM through 3:10 PM, E5 (nurse) stated that on 3/24/09 at 10:15 PM, she heard a wheelchair alarm go off while she was in the nursing station doing computer charting. E5 stated that she immediately went around the nursing station and saw R1 on the floor in front of the nursing station, on a left side laying position. Upon assessment, E5 stated that she noted a bump on R1's forehead (left side) and scrape skin without bleeding on the resident's left forearm. Per E5, there was no redness or eye swelling noted, R1's extremities are within normal range and the resident was able to walk and go back to the wheelchair with assistance from the staff. E5 stated that she attempted to call Z1 (physician) twice without response and on the 3rd call at around 11:30 PM on 3/24/09, Z1 responded. Per E5, she informed Z1 of R1's fall incident and the bump that was observed on the resident's left forehead area. Z1 told E5 to monitor and continue neuro check and to call the physician (Z1) for anything abnormal. E5 stated that at the time she talked to Z1, R1 did not have any left eye injury, bruising or swelling. Per E5 she informed E4 (incoming nurse) about the fall incident and about Z1 being aware of the incident and the order to do neuro check, monitor for behavior and to call the physician for any abnormal findings/assessment per neurological assessment. E5 informed the surveyor that she made late entry documentation on R1's nurses' notes on 3/25/09, because she (E5) was leaving when Z1 returned her call on 3/24/09 (post R1 incident). E5 stated that she called E4 after</p>	F 224			

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F 224	<p>Continued From page 5</p> <p>talking to Z1 on 3/24/09 and informed E4 about Z1's order to do neurological assessment per facility protocol for R1 and to call the physician for any abnormal findings/assessment.</p> <p>During a phone interview held on 4/30/09 from 12:16 PM through 12:42 PM, E4 stated that she worked on 3/24/09 from 10:30 PM through 7:00 PM and was the nurse assigned for R1. E4 stated that on 3/24/09, she arrived in the unit early at around 10:15 PM. Per E4, she was informed by out going nurse (E5) that R1 fell, sustained abrasion on the left forehead and an ice pack was applied. Per E4, she was informed by E5 that R1's ROM (range of motion) on all extremities were within normal limits. Per E4, she was informed by E5, that Z1 was called several times to report the incident but without response. E4 stated that after E5 left the unit, she (E4) called Z1 to inform him of R1's incident, but was informed by Z1 that he already spoke with the nurse and was informed of the incident. E4 stated that Z1 told her to continue monitoring R1. During the same interview, E4 stated that sometime during her shift on 3/24/09 (10:30 PM - 7:00 PM), E5 called and informed her that she (E5) spoke with Z1 prior to leaving the facility on 3/24/09. E5 informed E4, that Z1 did not make any orders for R1. Further interview of E4 stated that she first saw R1 on 3/24/09 at around 10:30 PM, R1 was in bed awake and the ice pack was off because the resident refused to have it on. Per E4, she saw R1 with swelling and redness on the left side of the forehead towards the left eye. Per E4, during this observation, R1 was still able to open both eyes. E4 stated that R1's left pupil was sluggish at the time of observation on 3/24/09 at 11:00 PM (which was 45 minutes post fall incident) and on 3/25/09 at 12:05 AM as</p>	F 224			

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F 224	<p>Continued From page 6</p> <p>documented in the neurological assessment written as "Sl." Per E4, she was not able to check R1's left eye pupil for response to complete the neurological assessment on 3/25/09 at 1:00 AM, because the resident's left eye was closed and swollen. E4 told the surveyor that the "*" documented on the neurological assessment dated 3/25/09 at 1:00 AM, 2:00 AM, 3:00 AM, 4:00 AM and 6:00 AM, meant not able to check the left pupil due to swelling of the eye. E4 acknowledged that the neurological assessment of R1 was not complete because the resident's left pupil response was not assessed. E4 also stated that she did not call Z1 to inform the physician of R1's sluggish left pupil response. E4 further acknowledged that she did not call Z1 when R1 showed signs and symptoms of pain (grimacing) when repositioning self in the chair and when R1's bruise spread over the resident's left forehead, left eye and left shoulder.</p> <p>During interviews held inside the first floor sitting room on 4/30/09 from 11:10 AM through 11:40 AM, E3 (nurse) stated that she worked on 3/25/09 during the 6:30 AM through 3:00 PM and was the nurse assigned to take care of R1. E3 reviewed R1's neurological assessment sheet and confirmed that on 3/25/09 at 10:00 AM, R1's left eyelid was swollen, therefore was not able to see the left eye pupil. E3 stated, " I did not open the left eye lid, because of the swelling." "I was afraid to open it to worsen the condition of the left eye." E3 told the surveyor that she did not do the test for R1's left pupil response because the eyelid was closed due to swelling. Per E3 she documented this observation on the neurological assessment sheet under left pupil response as "C" indicating the eye lid was closed. During the</p>	F 224			

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F 224	<p>Continued From page 7</p> <p>same interview, E3 acknowledged that she did not call R1's physician to inform him that a complete/comprehensive neurological assessment cannot be performed due to the worsening condition of the resident's left eye. During another interview held on 5/7/09 at 10:46 AM via phone, E3 stated that she paged Z1 on 3/26/09 at around 8:45 AM to inform the physician of R1's mental status change. Per E3, Z2 (covering physician) responded on 3/26/09 at around 9:00 AM and gave the order to sent the resident to the hospital for evaluation.</p> <p>Review of the facility policy regarding Change in a resident's condition or status showed, "Policy Statement - Our facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's condition and/or status." "Policy Interpretation and Implementation - 1. The nurse Supervisor will notify the resident's attending physician when: b. There is a significant change in the resident's physical, mental or psychosocial status."</p> <p>During interviews held inside the first floor sitting room on 4/30/09 at 2:00 PM, E2 (Director of Nursing) stated that the facility uses a standardized form to perform neurological assessment of residents post fall. Review of the standardized neurological assessment form used by the facility for R1 (post fall incident) showed, "Instructions: Complete form and describe any neurological problems in comments. Frequency per facility policy." E2 was asked regarding the facility policy for frequency of monitoring residents post fall. E2 responded that the facility does not have any policy and or protocol in place</p>	F 224			

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F 224	<p>Continued From page 8</p> <p>regarding frequency of neurological assessment monitoring. E2 stated that the standard nursing practice and the expected neurological assessment frequency are as follows: every 15 minutes for 1 hour post fall incident, every 30 minutes for 2 hours and every hour thereafter for the first 24 hours and then every shift until 3 days or 72 hours post fall. E2 stated that this frequency of neurological monitoring should have been followed by the nurses.</p> <p>During interview held inside the first floor sitting room on 3/30/09 from 3:20 PM through 3:35 PM, Z1 stated that he received a call from the facility on the night of 3/24/09, informing him of R1's fall. Z1 stated that he was notified that R1 hit her head, but the resident is alert, oriented to name and with no visible injury. Per Z1 he ordered to continue neurological check and to call him if there is any change in R1's neurological status. Z1 stated that the facility did not call him when R1's neurological status changed as evidenced by sluggish left pupil. Per Z1, he would order to immediately send R1 to the hospital for evaluation and treatment if the facility called and informed him that R1's left pupil response was sluggish after hitting the head post fall incident. Z1 stated that R1 was receiving Aspirin and Plavix while in the facility, the combination of these medications have the tendency to increase bleeding. Z1 who is also the facility's Medical Director acknowledged that the facility does not have a policy in place to address the neurological monitoring frequency of residents post fall. Z1 stated that the expected neurological assessment frequency are, every 15 minutes for 1 hour post fall incident, every 30 minutes for 2 hours and every hour thereafter for the first 24 hours and then every shift until 3 days or 72 hours post fall.</p>	F 224			

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F 224	<p>Continued From page 9</p> <p>Z1 stated that R1 was diagnosed with Sub-arachnoid hemorrhage in the hospital ER and was immediately transferred from the ER to another hospital for further evaluation and treatment.</p> <p>This failure and neglect to provide timely, frequently and comprehensive neurological assessment, and failure and neglect to notify the physician in a timely manner for a change in neurological status resulted in a 33 hour delay of medical treatment for R1.</p> <p>Although the the Immediate Jeopardy was removed on May 4, 2009 at 3:50 PM. E1 was notified per telephone conversation. However, the facility remains out of compliance at a severity level II in order to allow for the implementation of the facility plan of correction for F224 and allow time for the facility to evaluate the effectiveness of their interventions.</p> <p>The facility submitted the following plan:</p> <ol style="list-style-type: none"> 1. Development of Facility protocol for frequency of Neurological Checks following head injury. 2. In-service education on 5/4/09 at 2:30 PM for all licensed nursing staff and will continue on an ongoing basis including discussion of: <ul style="list-style-type: none"> - "Assessing and Communicating Changes of Physicians" See attached for outline. - Review of facility protocol on Resident Post-incident flow sheet. (72-hour incident follow-up flow sheet). - Review of facility protocol on Frequency of Neurological Checks. 	F 224			

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F 224	Continued From page 10 - Review of facility Neurological Assessment tool. - Components of a "Comprehensive Assessment." 3. Developed a revision to policy entitled "Incidents" to include directive to revise resident care plan as appropriate after incidents. 4. Renamed policy entitled "Change in Resident's Condition or Status" to "Physician Notification - Change in Resident Condition or Status." 5. Facility has identified recent falls with injury within the last 7 days and assessed resident for change in condition. Identified resident care plans have been updated initially 5/4/09 and will be completed 5/5/09 by Nurse manager. This will be ongoing as necessary. 6. Quality Assurance: the Director of Nursing, or her designee, will review each incident report involving resident injury for the next three months to ensure that: 1. Comprehensive assessment completed by Licensed Nurse. 2. In case of head injury, appropriate completion of Neurological checks. 3. Physician notified as appropriate; thorough follow through to physician orders. 4. Results of these audits will be identified and reviewed on a case-by-case basis as they occur. Monthly, the issue will be reviewed and discussed in the facility Performance Improvement Committee meeting.	F 224			
F 309 SS=J	483.25 QUALITY OF CARE Each resident must receive and the facility must	F 309			

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F 309	<p>Continued From page 11</p> <p>provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews the facility failed to timely, frequently and comprehensively assess 1 resident (R1) after a fall incident on 3/24/09. The facility failed to immediately notify the physician to obtain timely and appropriate medical care and failed to follow the policy regarding change in resident's condition, , after R1 showed a change in the neurological status and change in the condition of the injured left eye. The facility also failed to have a policy in place to address neurological monitoring frequency post fall. This failure resulted in R1 having 33 hour delay in medical treatment and needing hospital care.</p> <p>R1's left eye swelling and bruising progressed to the extent that the staff was unable to open the left eye to check for eye and pupil response within 24 hours post fall. R1 was sent to the hospital on 3/26/09 due to mental status change. R1 was admitted to the hospital with diagnoses of Cervical fracture and Brain bleed. This failure resulted in Immediate Jeopardy.</p> <p>E1 (Administrator), E6 (Executive Director) and E2 (Director of Nursing) were notified of the Immediate Jeopardy on May 4, 2009 at 11:54 AM via phone conference. The immediate Jeopardy was determined to have begun on 3/24/09 at</p>	F 309			

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F 309	<p>Continued From page 12</p> <p>11:00 PM once it was determined that R1 had a sluggish left pupil response 45 minutes after sustaining a fall.</p> <p>Findings include:</p> <p>R1 is an 83 year old resident with multiple diagnoses to include Dementia with agitation, Difficulty in walking and acute MI (myocardial infarction). Review of R1's quarterly MDS (minimum data set) dated 2/22/09 showed that the resident is severely impaired with cognition, required limited assistance x 1 person physical assist for bed mobility, transfers and ambulation. R1's MDS also showed that the resident had problem with standing balance and the wheelchair is the resident's primary mode of locomotion.</p> <p>Review of the facility incident report dated 3/24/09 (10:15 PM) showed, "Description of Incident: Resident was sitting across from nurses' station. Nurse was working at the desk. She heard the chair alarm go off and when she looked up, resident was on the floor on her left side."</p> <p>"Resolution/Final Resident Outcome: Resident initially assessed at time on incident and found with laceration to lateral orbit and some facial swelling and bruising starting. Assessed resident back to a recliner chair and first aid administered. On 3/25/09, resident was responding, and eating, with negative neuro checks. On the morning of 3/26/09, resident was noted to be more lethargic and sent to NWCH ER for evaluation. resident was admitted with a brain bleed and cervical fracture."</p>	F 309			

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F 309	<p>Continued From page 13</p> <p>Review of R1's neurological assessment showed the following documentation:</p> <ul style="list-style-type: none"> - 3/24/09 (11 PM) - left pupil, "Sl." Eye response, open spontaneously- checked. - 3/25/09 (12:05 PM) - left pupil, "Sl." Eye response, open spontaneously- checked. - 3/25/09 (1 AM) - left pupil, "*" Eye response, open spontaneously- checked. - 3/25/09 (2 AM) - left pupil, "*" Eye response, open spontaneously- checked. - 3/25/09 (3 AM) - left pupil, "*" Eye response, open spontaneously- checked. - 3/25/09 (4 AM) - left pupil, "*" Eye response, open spontaneously- checked. - 3/25/09 (6 AM) - left pupil, "*" Eye response, open spontaneously- checked. - 3/25/09 (10 AM) - left pupil, "C." Eye response, open spontaneously- checked "R." - 3/25/09 (2 PM) - left pupil, "C." Eye response, open spontaneously- not marked. - 3/25/09 (6:15 PM) - left pupil, "*) Eye response, open spontaneously- checked. - "Comments: Left pupil sluggish, after 1 AM unable to check due to swelling." <p>Based on this neurological assessment documentation, the facility assessed R1, 45 minutes post fall, then every hour for 4 hours and then two to four hours thereafter. The facility assessed R1's neurological status 10 times within 19 hours post fall.</p> <p>Review of R1's computerized nurses' notes showed the following documentation:</p> <ul style="list-style-type: none"> - 3/25/09 (3:21:26 AM), "Res. with normal restless behaviors, attempting out of bed, Taken to toilet several times with success and taken to tv lounge, reclining chair for closer observation at 12:20 am. Res. denies pain, swelling continues 	F 309			

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F 309	<p>Continued From page 14</p> <p>into left eye area with left eye unable to open for pupil response by 1am. res. continues to refuse to keep cold ice pack over left forehead. At 2 am tylenol ES one tablet given even though res. denies pain, is restless and grimaces at times when repositioning self in chair."</p> <p>- 3/25/09 (6:15:59 AM), "Res. restless all night, another tylenol ES given at 4am (order is for 1-2 tabs, one tab given at 2am) res. attempting to get out reclining chair, out of w/c (wheelchair), returned to bed for HHN treatment and attempted to get out of bed. Res. gives no requests, toileted, given fluids, needing 1:1 care, did not give ativan the normal med for these behaviors due to fall and could mask any symptoms. Res. with normal vitals, bruising continues to spread over left forehead, left eye and now noted on left shoulder-normal ROM with no pain noted."</p> <p>- 3/25/09 (10:59:45 PM) showed a late entry documentation stating, "On 3/24/2009 at 11:31 PM return call recd (received), from Z1 with no new orders noted. Except for Neuro check per protocol and monitor closely. In case of any abnormal findings call Z1. Report informed to on duty nurse of 11 - 7 shift and informed by her that she already talked with Z1."</p> <p>Review of R1's POS (Physician order sheet) showed, "(Late entry 3/25/09) Neuro check per protocol & monitor closely. In case of any abnormal findings. Call Z1." Review of R1's POS dated 3/1/09 through 3/31/09 showed orders for Aspirin 81 mg, 1 tablet daily and Plavix 75 mg, 1 tablet daily.</p> <p>During interviews held inside the first floor sitting room on 4/30/09 from 2:35 PM through 3:10 PM,</p>	F 309			

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F 309	<p>Continued From page 15</p> <p>E5 (nurse) stated that on 3/24/09 at 10:15 PM, she heard a wheelchair alarm go off while she was in the nursing station doing computer charting. E5 stated that she immediately went around the nursing station and saw R1 on the floor in front of the nursing station, on a left side laying position. Upon assessment, E5 stated that she noted a bump on R1's forehead (left side) and scrape skin without bleeding on the resident's left forearm. Per E5, there was no redness or eye swelling noted, R1's extremities are within normal range and the resident was able to walk and go back to the wheelchair with assistance from the staff. E5 stated that she attempted to call Z1 (physician) twice without response and on the 3rd call at around 11:30 PM on 3/24/09, Z1 responded. Per E5, she informed Z1 of R1's fall incident and the bump that was observed on the resident's left forehead area. Z1 told E5 to monitor and continue neuro check and to call the physician (Z1) for anything abnormal. E5 stated that at the time she talked to Z1, R1 did not have any left eye injury, bruising or swelling. Per E5 she informed E4 (incoming nurse) about the fall incident and about Z1 being aware of the incident and the order to do neuro check, monitor for behavior and to call the physician for any abnormal findings/assessment per neurological assessment. E5 informed the surveyor that she made late entry documentation on R1's nurses' notes on 3/25/09, because she (E5) was leaving when Z1 returned her call on 3/24/09 (post R1 incident). E5 stated that she called E4 after talking to Z1 on 3/24/09 and informed E4 about Z1's order to do neurological assessment per facility protocol for R1 and to call the physician for any abnormal findings/assessment.</p> <p>During a phone interview held on 4/30/09 from</p>	F 309			

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F 309	Continued From page 16 12:16 PM through 12:42 PM, E4 stated that she worked on 3/24/09 from 10:30 PM through 7:00 PM and was the nurse assigned for R1. E4 stated that on 3/24/09, she arrived in the unit early at around 10:15 PM. Per E4, she was informed by out going nurse (E5) that R1 fell, sustained abrasion on the left forehead and an ice pack was applied. Per E4, she was informed by E5 that R1's ROM (range of motion) on all extremities were within normal limits. Per E4, she was informed by E5, that Z1 was called several times to report the incident but without response. E4 stated that after E5 left the unit, she (E4) called Z1 to inform him of R1's incident, but was informed by Z1 that he already spoke with the nurse and was informed of the incident. E4 stated that Z1 told her to continue monitoring R1. During the same interview, E4 stated that sometime during her shift on 3/24/09 (10:30 PM - 7:00 PM), E5 called and informed her that she (E5) spoke with Z1 prior to leaving the facility on 3/24/09. E5 informed E4, that Z1 did not make any orders for R1. Further interview of E4 stated that she first saw R1 on 3/24/09 at around 10:30 PM. R1 was in bed awake and the ice pack was off because the resident refused to have it on. Per E4, she saw R1 with swelling and redness on the left side of the forehead towards the left eye. Per E4, during this observation, R1 was still able to open both eyes. E4 stated that R1's left pupil was sluggish at the time of observation on 3/24/09 at 11:00 PM (which was 45 minutes post fall incident) and on 3/25/09 at 12:05 AM as documented in the neurological assessment written as "Sl." Per E4, she was not able to check R1's left eye pupil for response to complete the neurological assessment on 3/25/09 at 1:00 AM, because the resident's left eye was closed and swollen. E4 told the	F 309			

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F 309	<p>Continued From page 17</p> <p>surveyor that the "*" documented on the neurological assessment dated 3/25/09 at 1:00 AM, 2:00 AM, 3:00 AM, 4:00 AM and 6:00 AM, meant not able to check the left pupil due to swelling of the eye. E4 acknowledged that the neurological assessment of R1 was not complete because the resident's left pupil response was not assessed. E4 also stated that she did not call Z1 to inform the physician of R1's sluggish left pupil response. E4 further acknowledged that she did not call Z1 when R1 showed signs and symptoms of pain (grimacing) when repositioning self in the chair and when R1's bruise spread over the resident's left forehead, left eye and left shoulder.</p> <p>During interviews held inside the first floor sitting room on 4/30/09 from 11:10 AM through 11:40 AM, E3 (nurse) stated that she worked on 3/25/09 during the 6:30 AM through 3:00 PM and was the nurse assigned to take care of R1. E3 reviewed R1's neurological assessment sheet and confirmed that on 3/25/09 at 10:00 AM, R1's left eyelid was swollen, therefore was not able to see the left eye pupil. E3 stated, " I did not open the left eye lid, because of the swelling." "I was afraid to open it to worsen the condition of the left eye." E3 told the surveyor that she did not do the test for R1's left pupil response because the eyelid was closed due to swelling. Per E3 she documented this observation on the neurological assessment sheet under left pupil response as "C" indicating the eye lid was closed. During the same interview, E3 acknowledged that she did not call R1's physician to inform him that a complete/comprehensive neurological assessment cannot be performed due to the worsening condition of the resident's left eye. During another interview held on 5/7/09 at 10:46</p>	F 309			

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F 309	<p>Continued From page 18</p> <p>AM via phone, E3 stated that she paged Z1 on 3/26/09 at around 8:45 AM to inform the physician of R1's mental status change. Per E3, Z2 (covering physician) responded on 3/26/09 at around 9:00 AM and gave the order to sent the resident to the hospital for evaluation.</p> <p>Review of the facility policy regarding Change in a resident's condition or status showed, "Policy Statement - Our facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's condition and/or status." "Policy Interpretation and Implementation - 1. The nurse Supervisor will notify the resident's attending physician when: b. There is a significant change in the resident's physical, mental or psychosocial status."</p> <p>During interviews held inside the first floor sitting room on 4/30/09 at 2:00 PM, E2 (Director of Nursing) stated that the facility uses a standardized form to perform neurological assessment of residents post fall. Review of the standardized neurological assessment form used by the facility for R1 (post fall incident) showed, "Instructions: Complete form and describe any neurological problems in comments. Frequency per facility policy." E2 was asked regarding the facility policy for frequency of monitoring residents post fall. E2 responded that the facility does not have any policy and or protocol in place regarding frequency of neurological assessment monitoring. E2 stated that the standard nursing practice and the expected neurological assessment frequency are as follows: every 15 minutes for 1 hour post fall incident, every 30 minutes for 2 hours and every hour thereafter for the first 24 hours and then every shift until 3</p>	F 309			

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F 309	<p>Continued From page 19</p> <p>days or 72 hours post fall. E2 stated that this frequency of neurological monitoring should have been followed by the nurses.</p> <p>During interview held inside the first floor sitting room on 3/30/09 from 3:20 PM through 3:35 PM, Z1 stated that he received a call from the facility on the night of 3/24/09, informing him of R1's fall. Z1 stated that he was notified that R1 hit her head, but the resident is alert, oriented to name and with no visible injury. Per Z1 he ordered to continue neurological check and to call him if there is any change in R1's neurological status. Z1 stated that the facility did not call him when R1's neurological status changed as evidenced by sluggish left pupil. Per Z1, he would order to immediately send R1 to the hospital for evaluation and treatment if the facility called and informed him that R1's left pupil response was sluggish after hitting the head post fall incident. Z1 stated that R1 was receiving Aspirin and Plavix while in the facility, the combination of these medications have the tendency to increase bleeding. Z1 who is also the facility's Medical Director acknowledged that the facility does not have a policy in place to address the neurological monitoring frequency of residents post fall. Z1 stated that the expected neurological assessment frequency are, every 15 minutes for 1 hour post fall incident, every 30 minutes for 2 hours and every hour thereafter for the first 24 hours and then every shift until 3 days or 72 hours post fall. Z1 stated that R1 was diagnosed with Sub-arachnoid hemorrhage in the hospital ER and was immediately transferred from the ER to another hospital for further evaluation and treatment.</p>	F 309			

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F 309	<p>Continued From page 20</p> <p>This failure to provide timely, frequently and comprehensive neurological assessment, failure to notify the physician in a timely manner for a change in neurological status and failure to have a policy in place to address neurological monitoring frequency post fall resulted in a 33 hour delay of medical treatment for R1.</p> <p>Although the the Immediate Jeopardy was removed on May 4, 2009 at 3:50 PM. E1 was notified per telephone conversation. However, the facility remains out of compliance at a severity level II in order to allow for the implementation of the facility plan of correction for F309 and allow time for the facility to evaluate the effectiveness of their interventions.</p> <p>The facility submitted the following plan:</p> <ol style="list-style-type: none"> 1. Development of Facility protocol for frequency of Neurological Checks following head injury. 2. In-service education on 5/4/09 at 2:30 PM for all licensed nursing staff and will continue on an ongoing basis including discussion of: <ul style="list-style-type: none"> - "Assessing and Communicating Changes of Physicians" See attached for outline. - Review of facility protocol on Resident Post-incident flow sheet. (72-hour incident follow-up flow sheet). - Review of facility protocol on Frequency of Neurological Checks. - Review of facility Neurological Assessment tool. - Components of a "Comprehensive Assessment." 3. Developed a revision to policy entitled 	F 309			

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F 309	Continued From page 21 "Incidents" to include directive to revise resident care plan as appropriate after incidents. 4. Renamed policy entitled "Change in Resident's Condition or Status" to "Physician Notification - Change in Resident Condition or Status." 5. Facility has identified recent falls with injury within the last 7 days and assessed resident for change in condition. Identified resident care plans have been updated initially 5/4/09 and will be completed 5/5/09 by Nurse manager. This will be ongoing as necessary. 6. Quality Assurance: the Director of Nursing, or her designee, will review each incident report involving resident injury for the next three months to ensure that: 1. Comprehensive assessment completed by Licensed Nurse. 2. In case of head injury, appropriate completion of Neurological checks. 3. Physician notified as appropriate; thorough follow through to physician orders. 4. Results of these audits will be identified and reviewed on a case-by-case basis as they occur. Monthly, the issue will be reviewed and discussed in the facility Performance Improvement Committee meeting.	F 309			