STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145142	A. BUILDING _____ B. WING _____	C 10/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN ALMA NELSON MANOR	**550 SOUTH MULFORD AVENUE ROCKFORD, IL 61108**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 323 SS=D	Complaint Investigation #1414463/IL#72442 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview and record review the facility failed to provide supervision to prevent falls. This applies to 3 of 3 residents (R1, R2, R3) in the sample of 3 reviewed for falls. The findings include: 1. On 10/7/14 at 9:30am R1 stated, " I fell in the bathroom I was left alone. I turned to wipe and fell off the toilet. I hit the left side of my face, left shoulder and left hip. " On 10/7/14 at 1248pm E5 - Certified Nursing Assistant (CNA) said, " I took R1 to the bathroom and I thought he was strong enough so I went to finish passing breakfast trays. I didn ' t realize at high risk for falls. " The Physician ' s Order Sheet of October 2014 shows R1 ' s diagnoses as Cerebral Vascular Accident (CVA) with Left-Sided Hemiplegia. The Minimum Data Set dated 9/5/14 shows R1 has no cognitive impairment. R1 requires extensive assist of 2 for transferring and toilet-use, did not ambulate during the	F 323		

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 323	Continued From page 1	F 323		

assessment period, extensive assist of 1 once in the wheelchair. R1 has upper and lower functional limitations on one side. R1 was assessed as frequently incontinent of bowel and bladder. The balance assessment for moving on/off toilet showed R1 was not steady and only able to stabilize with physical help.
The fall risk assessment dated 9/8/14 described R1 as high risk for falls. The assessment showed R1 had a history of falls in the past 1-6 months.
The facility provided a list of R1 ' s falls 8/31, 9/8, 9/16 and 10/3. The nurse ' s notes document the following: On 8/31, a CNA was assisting R1 with a shower. The CNA was transferring R1 from the shower chair to the bench. R1 ' s was unable to hold his weight and slid to the floor. The falls on 9/16 the CNA left R1 alone on the toilet.
The care plan dated 8/28/14 shows R1 was a mechanical lift with 2 assist. The intervention dated 10/3 shows do not leave unattended on the toilet.
The facility ' s falling star program policy dated 2010 documents the purpose of the policy is to minimize the chance further falls will occur. The policy documents residents at high risk for falls will have a star placed on the door and wheelchair/walker. R1 has a small star on the name tag of his door.
2. On 10/07/14 R3 was observed in the bathroom by himself on the toilet.
On 10/7/14 at 12:00pm E2 (Assistant Administrator) said R3 took himself to the bathroom.
On 10/07/14 at 1230pm R3 said his fall on 9/7/14 happened when he transferred himself from the bed to the chair.
The MDS of 8/28/14 showed R3 has moderate impairment in decision making. R3 was

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F 323	Continued From page 2 assessed as needing extensive assistance of 1 staff to transfer and to use the bathroom. R3 ' s care plan dated 5/28/14 shows R3 has difficulty understanding others. The care plan shows R3 is at risk for falls related to history, poor balance, muscle weakness and Left Hemiplegia from CVA. Approaches include: After meals resident to be in common area when up 3. The Physician ' s Order sheet of September 2014 shows diagnoses of Schizophrenia, Bipolar, and Altered Mental Status. The MDS dated 8/3/14 shows R2 requires extensive assist of 1 for all ADL ' s (Activities of Daily Living. R2 was unable to ambulate. R2 was incontinent of bowel and bladder. The facility ' s list of fall shows R2 had 10 falls from 7/9/14 to 9/7/10. Nurse ' s notes of 9/8/14 shows resident expired in the facility. R2 ' s fall prevention care plan dated 7/31/14 shows no new interventions since the 7/9/14 fall. The fall prevention policy dated 6/2013 shows review and/or modify the resident's plan of care at least quarterly and as needed in order to minimize risk for fall incidents and/or injury.	F 323		