STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145473	A. BUILDING ______ B. WING ______	C 10/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE CARE CENTRE	**2330 WEST GALENA BOULEVARD AURORA, IL 60506**

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F 000	INITIAL COMMENTS Incident Report Investigation to Incident of 9/23/2013/IL 65873	F 000		
F 323 SS=D	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 interviews and record review, the facility failed to provide effective fall interventions and consistent supervision/monitoring for one resident (R1), who was assessed as high risk for falls. This applies to one of three residents (R1) in the sample, who were reviewed for their risk for falls. Findings include: R1's Admission Record showed R1 is a 92 year old with diagnosis including : Dementia and Cerebrovascular Disease. R1's Initial Treatment Plan For Rehabilitation (dated 7/31/13), and Admission History and Physical Examination (dated 8/01/13) showed R1 was assessed as being at risk for falls. R1's Nursing Communication Form, dated 8/23/13, showed the following fall occurrence for	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 R1: "At 6:55 AM... the dining room. R1 was lying on her right side attempting to get herself up..." Review of the Occurrence Report, dated 9/23/13, showed R1 had another fall incident with injuries: "9/23/13 at 4:35 AM... Head Injury (Requires Neuro Checks) Left Forehead ...Large hematoma palpated on left upper forehead.... Laceration/cut... Left Forearm... Large avulsion type laceration present on left forearm... Skin Tear... Right Knee... A small skin tear noted to right knee... Nurse's Note of what happened... The CNA (certified nurses aide/E6) stated she saw R1 on the floor as she was passing the room. R1 was facing the corner of the room with her head and shoulders underneath a straight chair. She was naked from the waist down. She had alarms attached to both sides but neither sounded. She does remove them (alarms)... 911 was called to transport to the emergency room..." R1 return to the facility on 9/23/13 from the hospital. The hospital did not identify any internal head injury, but R1 had significant facial bruising from the fall and was unresponsive. R1's family did not want further treatment and interventions, so she was placed on hospice. R1 expired on 9/25/13. An investigation into R1's 9/23/13 fall occurrence was done. The Final Investigation Summary, dated 9/30/13, showed: "R1 found on floor next to floor mat next to bed on 9/23/13 at 4:30 AM by the CNA assigned to care for her. R1 had fallen flat onto her face experiencing significant bruising and assumed head trauma. She was sent out 911 for evaluation... Final Conclusion: Resident likely got up from bed removing her alarms and attempted to walk on the floor mat next to her	F 323		

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F 323	Continued From page 2	F 323		

bed... While walking toward the end of the cushiony floor mat, she lost her balance and fell face first to the floor. She fell outside the parameters of the floor mat so nothing cushioned her fall..." This Final Investigation Summary also showed: "...RN (Registered Nurse) found the resident with her alarms in place on the bed but the resident had no clothing on her lower extremities while she lay on the floor. Neither of these alarms were sounding due to resident removing them..." This summary failed to identify/evaluate how the safety device failed to help staff monitor and prevent R1 from falling.

R1's care plan, dated 8/13/13, identified she was at risk for falls. The nursing interventions put into place before R1 fell include: mat on floor and use of alarms. R1's plan of care failed to showed any revision in the use of safety devices,. The use of alarms were found to be ineffective, because R1 removed the alarms without making a sound. The interventions in the plan of care did not specifically address R1 taking off her alarms, and the alarms ineffectiveness in alerting staff. R1 often got out of bed and tried to walk with mats on the floor. The care plan did not address R1 trying to walk while floor mats were in use, or possible tripping hazard. Another nursing intervention was to provide R1 with 1:1's. When R1 fell, she was not on 1:1 monitoring.

Z1 (the primary physician of R1) was interviewed on 10/10/13 at 10:05 AM. Z1 said R1's condition was deteriorating, causing her to fall and R1 needed staff interventions and close monitoring to prevent possible falls.

On 10/09/13 at 3:45 PM, E10 (CNA/certified nurses aide) was interviewed. E10 stated that

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F 323	Continued From page 3 R1's unit was for residents who needed to be monitored for falls. E10 said the morning of R1's fall occurrence she (E10) was assigned to monitor 15 residents. E10 reported that E6 (the other CNA on duty) also had 15 to 14 residents. E10 stated that E6 was assigned to go to the first floor to assist residents in getting up and dressed at 3 AM. E10 said from 3 AM till 5 AM she (E10) became responsible for monitoring and taking care of the 15 residents assigned to her as well as the 15 to 14 residents assigned to E6. E10 stated, "R1 is one of those people we have to watch. She still manages to get out of bed. She (R1) knows how to remove the alarms and she takes off her clothing." E10 said she found R1 on the floor face down around 4:25 AM. E10 described R1 as nude from the waist down. E10 said R1 had removed the blanket, sheets, and comforter from her bed. E10 stated R1 had the blanket, sheets and comforter on the floor. E10 stated she did not hear R1 alarm go off. E10 said she did not see or hear R1 fall. E10 indicated she was helping other residents get dressed and answering call lights. E10 said she would have the door closed giving care and might have water running while washing residents up. E10 stated, "I can't hear." E10 said she saw R1 on the floor as she was walking passed R1's room. E10 stated, "I think she tried to get up. She usually get up and try to walk." E10 said there was blood on the floor because of the skin tear to her left arm. E8 was the nurse on duty the night of R1's fall occurrence. E8 was interviewed on 10/09/13 at 10:55 AM. E8 described R1 as a confused resident, who was restless and frequently found out of bed trying to walk. E8 said that R1's gait was unsteady and she was at risk for falls. E8	F 323		

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stated staff checked on R1 every 2 hours. E8 said that staff put alarms on R1, but R1 takes them off . E8 said that staff put mats on R1's floor, but R1 got up to walk with the mats on the floor. E8 agreed that the mats could be a tripping hazards for R1. E8 said E10 reported to her that R1 fell around 4:25 AM on 9/23/13. E8 said she did not see or hear R1 fall. E8 stated she found R1 on the floor unresponsive. E8 said she thought R1 had a serious injury because R1 was unresponsive.

E6 was the certified nurse assigned to R1 on 9/23/13. E6 was interviewed on 10/09/13 at 12:41 PM. E6 was not on the unit to monitor and supervise R1, when R1 fell. E6 said he was unable to monitor R1 after 3 AM because he went to the first floor to help get residents up and dressed. E6 said R1 usually have 2 alarms attached to her which she (R1) remove often. E6 said R1 removed her alarms without making a sound.

E5 (nurse) was interviewed on 10/08/13 at 12:36 PM. E5 said she took care of R1 before and after the fall occurrence of 9/22/13. E5 said, "You could not leave R1 alone... Had to have her right there with you to keep her from falling... Have her do an activity to keep her from getting up..." E5 said after R1 fell she changed and became unresponsive.

E11 (CNA) was interviewed on 10/09/13 at 11 AM. E11 said R1 always tried to stand and walk. E11 stated R1 removed her alarms, without making the alarms sound. E11 said R1 needed to be monitored closely.

E7 (the restorative nurse) was interviewed on

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F 323	Continued From page 5 10/10/13. E7 said R1 was assessed to need a floor mat on one side and use of alarms to prevent her from falling. Z2 (the quality assurance coordinator of R1 hospice agency) was interviewed on 10/11/13 at 1 PM. Z2 said R1 was placed on hospice when she became unresponsive. The Facility Policy regarding resident's falls showed the following: "The facility is committed to minimizing resident falls so as to maximize each resident's physical, mental and psychosocial well-being... it is this facility's policy to act in a proactive manner to identify and assess those residents at risk for falls, plan for preventative strategies, and facilitate as safe an environment as possible."	F 323		