| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145691 | A. BUILDING _____ B. WING _____ | C 07/02/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HALLMARK HOUSE NURSING CENTER | 2501 ALLENTOWN ROAD PEKIN, IL 61554 |

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| F 000 | INITIAL COMMENTS<br><br>Original complaint investigation 1322446/ IL# 64072 | F 000 | | |
| F 323 SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review the facility failed to identify one of three residents (R1) reviewed for falls in the sample of three, as needing more than one assist for ADL's (Activity of Daily Living). R1 was transferred by only one staff person, from a lying to a sitting position. R1slid from the bed and recieved a fractured leg.<br>The facility also failed to provide a root cause analysis for falls for three of three residents (R1, R2, and R3) reviewed for falls in the sample of three.<br><br>Findings include:<br><br>1. A physician's order sheet dated 7/2013 documents that R1 has diagnoses which include Dementia, General Muscle Weakness, and Osteoarthritis.<br><br>An activities of daily living (ADL) restorative | F 323 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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assessment dated 1-17-13 documents that R1 is "dependent/unable to assist" when sitting up or dressing.

A Minimum Data Sheet dated 4-18-13 documents that R1 is severely cognitively impaired, and requires total assistance of two people for transfers.

A fall assessment dated 5-17-13 documents that R1 is at "High Risk" for falls. The fall assessment documents that R1 has, "Balance problems sitting," and that R1 has, "legs contracted, unable to stand, non ambulatory."

A facility resident incident report dated 6-11-13 documents that on 6-11-13 at 4:00p.m. E7(Certified Nurse Aide) sat R1 up on the side of the bed from a lying position in order dress R1. The incident report documents that R1, "slid through (E7's) legs and (E7) lowered (R1) to the floor."

Nurse's notes dated 6-11-13 at 6:20p.m. document that there was "a noticeable deformity" to R1's left lower leg. The nurse's notes document that R1's physician was notified and an Xray of R1's left leg was obtained.

An Xray report dated 6-11-13 documents that R1 had a fracture to the left lower leg.

A care plan for R1 dated 9-28-11 documents that R1 requires total assistance for ADL's and assistance of two for transfers, but does not identify the number of staff assistance required for ADL's.

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On 7-02-13 at 11:00a.m. E4 (Wound Nurse), E5 (Certified Nurse Aide Coordinator), and E6 (Certified Nurse Aide) transferred R1 from the bed to the recliner chair using a mechanical lift device. R1's legs were contracted at the hips and knees and appeared rigid. R1 was unable to provide any assistance during the transfer. R1 was pleasant and cheerful but unable to answer questions or make needs known.

On 7-02-13 at 2:45p.m. E2 (Director of Nurses) stated that R1's fall on 6-11-13 was the result of E7 (Certified Nurse Aide) performing an improper one person transfer instead of a two person transfer as instructed in R1's care plan.

On 7-03-13 at 12:50p.m. Z1 (R1's Physician) stated that R1 was, "Very, very disabled." Z1 stated that R1 was unable to maintain balance while sitting up at the edge of the bed and that R1 required the assistance of two people to perform activities of daily living include dressing.

2. A facility incident log dated 4/2013 to 7/2013 documents that R2 fell on 4-14-13 without injury and fell again on 4-15-13 causing R2 to have a fractured bone.

A facility fall investigation dated 4-14-13 documents that R2 told facility staff that R2 had sat on a waste basket near R2's bed then R2 got back into bed. The fall investigation documents under incident type that R2 fell with no head injury. The fall investigation documents that the fall prevention measure of, "re education to wait for assistance," was given to R2. The fall investigation does not include a root cause analysis for R2's fall and does not include an

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evaluation of the effectiveness of the current fall prevention measures which where already in place on R2's fall prevention care plan.

A nurse's note dated 4-14-13 at 8:30a.m. documents that R2, "slid off bed and sat on garbage can next to bed. Assists self to bathroom."

On 7-02-13 at 2:45p.m. E2 (Director of Nurses) stated that when R2 "slid off bed and sat on garbage can next to bed," E2 did not consider that incident as a fall. E2 stated that R2 actually sat on the the garbage can and did not slide out of bed onto the garbage can as documented in the nurse's notes.

3. A facility fall investigation dated 4-15-13 documents that at 5:10 a.m. on that date R2 was, "found on the floor by bed after the alarm sounded." The fall investigation documents that R2's personal body alarm was in place and R2's bed was in the low position. The fall investigation documents that R2 was transferred to the hospital and diagnosed with a fractured right hip and right elbow. The fall investigation does not document a root cause analysis of R2's fall and does not include an evaluation of the effectiveness of the fall prevention measures which were already included on R2's fall prevention care plan.

4. A facility fall investigation dated 6-11-13 documents that on that date at 6:05 a.m. R3 was found in the bathroom with R3's, "head soaked in blood, blood on face and hands, blood noted on bathroom door leading to adjoining room as well as in bathroom and adjacent room." The

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| F 323 | Continued From page 4<br>investigation also documents that R3 had a cut on the back of R3's head and a skin tear to R3's right elbow. The incident report does not include a root cause analysis for the fall and does not include an evaluation of the effectiveness of the fall prevention measures which were already included on R3's fall prevention care plan.<br><br>On 7-02-13 at 11:50a.m. E2 (Director of Nurses) stated that E2 performed fall investigations for the facility. E2 stated that E2 had heard of a root cause analysis stating, "I've heard of that before. I think we did that at another facility where I worked." When asked about the root cause analysis for R2 and R3's falls, E2 was unable to provide an evaluation of the cause of R2 and R3's falls or an evaluation of the effectiveness of the fall prevention measures already in place on R2 and R3's care plans. | F 323 | | |