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F 000	INITIAL COMMENTS	F 000		
F 157 SS=D	Complaint #1645526/IL88770 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced	F 157		

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

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by:
Based on record review and interview, the facility failed to timely notify the physician of a change in condition and a fall for 2 of 6 residents (R1, R3) reviewed for physician notification in the sample of 12.

Findings include:

1. R3's Physician Order Sheet for September 2016 documents diagnoses to include Pneumonia, Cardiac Arrhythmia, and pulmonary hypertension.

R3's Minimum Data Set (MDS) documents R3 has severe cognitive impairment.

R3's Progress Notes Report on 9/15/16 at 2:43 AM, by E8, Registered Nurse (RN), documents "Res (resident) had small emesis noted, thin brown color notes. Res bowel sounds normal, abdomen soft non tender. Res temp 98.8, p (pulse) 22, BP (blood Pressure) 110/60, 95% on RA (room air). Lungs diminished, crackles noted to right upper lobe. Res has no distress noted. Res denies pain. Res HOB (head of bed) elevated, incontinent of bowel and bladder."

R3's Progress Notes Report by E8 documents, on the same day at 5:57 AM, "Res lung sounds diminished, crackles throughout, audible wheezing noted upon walking into residents room. Res HR (heart rate) 48-55, SPO2 (arterial blood oxygen level) 95% on RA, BP 100/50. Temp (temperature) 99.0. Res abdomen soft, non tender, another emesis noted, small thin brown. Res skin pale and clammy."

R3's Progress Notes Report by E8 documents,

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on the same day at 6:03 AM, "This nurse placed call to POA (power of attorney), notified her of residents change of condition, POA agreed and wanted resident sent to (Local Hospital) ER (emergency room) for evaluation."

R3's Progress Notes Report by E8 documents, at 6:05 AM, "Call placed to 911 for resident to be transported to (local Hospital) for evaluation."

R3's Progress Notes Report by E8 documents at 6:15 AM, "(Local) Ambulance service arrived to facility to transport resident to (local Hospital) to be evaluated. Res at this time, appears more pale, clammy. Res HR 35, SPO2 98% on RA, Respirations rapid an shallow and increased to 30 per minute. Res states he does not feel good and wants to see a doctor. No further emesis noted. Res lungs congested, with crackles, unable at this time to assess apical HR due to lung sounds blocking out apical HR. This nurse and EMT's (Emergency Medical Technician) transferred resident onto stretcher, sliding over from bed without difficulty. MD (Medical Doctor) notified of res POA wanting resident to be transferred."

R3's Progress Notes Report by E14, RN, documents at 2:50 PM, "This nurse called (local hospital) ER and spoke with (nurse), res being admitted to ICU (Intensive Care Unit) dept (department) with dx (diagnosis): acute MI (Myocardial Infarct) with cardioeversion."

R3's vital signs, prior to the incident, were documented on 8/26/16, at 11:00 PM under the MAR (Medication Administration Record)/TAR (Treatment Administration Record) section of R3's electronic record as Temp 97.6, HR 74,

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Respirations 18 and BP 122/72.

A change in condition was first documented at 2:43 AM on 9/15/16 in the Progress Notes Report. The Progress Notes Report, dated 9/15/2016 documents the Doctor not being notified until 6:48 AM, over 4 hours later.

2. The Fall Details Report, completed by E9, Registered Nurse (RN), dated 8/19/2016 at 3:00 AM, documents R1 fell on her buttocks in the shower room from the shower chair, with no bruising, redness, injury or complaints of pain. The Occurrence Report completed by E9 at the same time, documents Z3, Physician, was notified by fax at 3:00 AM. The Message Form sent to Z3 on 8/19/2016 is dated 8/19/2016, but has no time documented or fax confirmation.

The Report sent to the Department via fax on 8/19/2016 at 2:34 PM, documents Z3 was notified at 7:00 AM on 8/19/2016 about R1's fall. The Report documents that on 8/19/2016 at 10:00 AM, R1 had bruising to the left side of the back of the head and neck, and was sent to the local hospital for evaluation and admitted with a cervical fracture (C2) and a UTI (urinary tract infection). The Neurological Assessment Form for 8/2016, R1 documents the facility began neurological checks for R1 at 5:30 AM with complaints of a headache.

The Progress Notes Report for R1, dated 8/19/2016 at 4:24 AM by E9 documents, in part, "(3:00 AM) resident up in shower room with CNA (Certified Nurses Aide), fell to floor. No injury noted, no bruising, no redness noted, denies hitting head, VSS (vital signs stable). Returned to bed." There is no documentation Z3 was notified.

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The Progress Notes Report for R1, dated 8/19/2016 at 6:56 AM, by E9 documents in part, "(5:30 AM) resident complained of headache, Tylenol given, neuro (neurological) checks negative, perrl (pupils equal, reactive to light) 6 mm (millimeter), grips equal, moves all extremities. Alert and oriented times on. (6:25 AM) POA (power of attorney) notified of fall, shunt checked, Some ropey areas, but others soft, mushy. Neuro checks unchanged." There is no documentation Z3 was notified.

The Progress Notes Report for R1 by E16, Licensed Practical Nurse (LPN), dated 8/19/2016 at 10:08 AM, documents, in part, "(R1) has bruise/bump to left side of crown of head, Complaints of headache and neck pain. POA called, raised concern due to patient's shunt placed in right side of head. This nurse did full neuro assessment. Shunt was assessed." There is no documentation Z3 was notified.

The Progress Notes Report for R1 by E16, on 8/19/2016 at 10:46 AM, documents, in part, "POA wants (R1) to be sent to ER (emergency room) to check placement of shunt and address neck pain from previous fall. This nurse left message with (Z3) to make aware of family request." There is no documentation that Z3 returned E16's call or gave a physician's order related to R1's fall.

The CT (computerized tomography) of R1's cervical spine, dated 8/19/2016 at 12:20 PM, documents, in part, "The examination reveals transverse fractures through the pedicels of C2 bilaterally. This effectively separates the anterior and posterior elements at C2. This therefore, would be classified as an unstable fracture."

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On 9/29/2016 at 2:56 PM, E9 stated, "I remember she (R1) fell in the shower. She was in bed when I saw her. One of the aides told me she fell. Don't remember who-one of the ones who was on a different hall. She had no loss of consciousness. The shower aide said she didn't think she hit her head. I didn't know she had shunt in her head until after I talked to the daughter/POA. I checked it. I did neuro checks when she complained of a headache. I faxed (Z3). I don't remember the time. It was in the notes or on the fax. If there is no injury, I just fax the doctor. If there is an injury, I would have called the doctor on call. I went to her room to assess her, not the shower room. She was already in bed. I think they are supposed to wait until the nurse gets there to assess before moving a resident. Rolling her in bed or moving her could have caused harm."

On 9/29/2016 at 5:43 PM, Z3 reported he could not remember much about R1's fall on 8/19/2016, but R1 has always been a high risk for falls due to her history of hydrocephalus and unsteady gait.

On 9/29/2016 at 4:20 PM E1, Administrator, reported they currently could not find the policy for the use of a shower chair.

The facility's policy and procedure, dated 4/2011 and entitled, 'Change in a Resident's Condition or Status' documents, in part, "Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (for example, changes in level of care, billing/payments, resident rights). The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call

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F 157	Continued From page 6 Physician when there has been: An accident or incident involving the resident; a significant change in the resident's physical/emotional/mental condition." The facility's policy and procedure, dated 4/2013 and entitled, 'Accidents and Incidents-Investigating and Reporting' documents in part, "The following data, as applicable, shall be included on the Report of Incident/Accident form. The time the injured person's Attending Physician was notified, as well at the time the physician responded and his or her instructions."	F 157		
F 323 SS=G	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, record review and interview, the facility failed to initiate a safety intervention to prevent a fall during a shower for 1 of 6 residents (R1), reviewed for falls in the sample of 12. This failure resulted in R1 sustaining a cervical fracture and was sent to the hospital for evaluation and treatment. Findings include: The ECR (electronic clinical record) for R1	F 323		

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documents diagnoses, in part, of Morbid Obesity, Arthropathy, Obstructive Hydrocephalus with a Right Ventricular Shunt, Ataxia and Dementia.

R1's Minimum Data Set (MDS), dated 8/09/2016, documents R1 is moderately impaired with cognition and requires extensive assistance of 2 staff for transfers, is nonambulatory and has unsteady balance for sitting and surface to surface transfers.

The Fall Risk Assessment, dated 8/09/2016 documents R1 is a high risk for falls.

On 9/23/2016 at 1:50 PM, R1 was seated in a recliner, wearing a cervical collar to her neck. R1 was tall and morbidly obese. A sit to stand mechanical lift was near her bed. A sensor pad alarm was attached to the recliner. R1 stated, "I had an accident with, I don't know. I didn't fall. I broke a bone in my neck about 3 weeks ago. I wear the neck brace all the time." R1 reported she uses a sit to stand mechanical lift for transfers.

The Fall Details Report, completed by E9, Registered Nurse (RN), dated 8/19/2016 at 3:00 AM, documents R1 fell on her buttocks in the shower room from the shower chair, with no bruising, redness, injury or complaints of pain. The Occurrence Report completed by E9 at the same time, documents Z3, Physician, was notified by fax at 3:00 AM. The Message Form sent to Z3 on 8/19/2016 is dated 8/19/2016, but has no time documented or fax confirmation.

The Report sent to the Department via fax on 8/19/2016 at 2:34 PM, documents Z3 was notified at 7:00 AM on 8/19/2016 about R1's fall. The

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Report documents that on 8/19/2016 at 10:00 AM, R1 had bruising to the left side of back of the head and neck, and was sent to the local hospital for evaluation and admitted with a cervical fracture (C2) and a UTI (urinary tract infection). The Neurological Assessment Form for 8/2016, R1 documents the facility began neurological checks for R1 at 5:30 AM with complaints of a headache.

The Progress Notes Report for R1, dated 8/19/2016 at 4:24 AM by E9 documents, in part, "(3:00 AM) resident up in shower room with CNA (Certified Nurses Aide), fell to floor. No injury noted, no bruising, no redness noted, denies hitting head, VSS (vital signs stable). Returned to bed." There is no documentation Z3 was notified.

The Progress Notes Report for R1, dated 8/19/2016 at 6:56 AM, by E9 documents in part, "(5:30 AM) resident complained of headache, Tylenol given, neuro (neurological) checks negative, perrl (pupils equal, reactive to light) 6 mm (millimeter), grips equal, moves all extremities. Alert and oriented times on. (6:25 AM) POA (power of attorney) notified of fall, shunt checked, Some ropey areas, but others soft, mushy. Neuro checks unchanged." There is no documentation Z3 was notified.

The Progress Notes Report for R1 by E16, Licensed Practical Nurse (LPN), dated 8/19/2016 at 10:08 AM, documents, in part, "(R1) has bruise/bump to left side of crown of head, Complaints of headache and neck pain. POA called, raised concern due to patient's shunt placed in right side of head. This nurse did full neuro assessment. Shunt was assessed." The Progress Notes Report for R1 by E16, on

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8/19/2016 at 10:08 AM, documents, in part, "POA wants (R1) to be sent to ER (emergency room) to check placement of shunt and address neck pain from previous fall. This nurse left message with (Z3) to make aware of family request."

The CT (computerized tomography) of R1's cervical spine, dated 8/19/2016 at 12:20 PM, documents, in part, "The examination reveals transverse fractures through the pedicels of C2 bilaterally. This effectively separates the anterior and posterior elements at C2. This therefore, would be classified as an unstable fracture."

On 9/28/2016 at 2:00 PM, E5, CNA, reported she was across the hall from the 100 hall shower room, when she heard a loud noise and went into the hall to investigate. E5 stated, "I noticed the 100 hall shower door was open with legs sticking out. I went around the door and saw (R1) laying on the floor with a walker across her chest. (E7, CNA) was straddled over (R1). (E7) said (R1) fell." E5 reported she, E7 and E17, CNA used a mechanical lift to get R1 off of the floor and took her to her room.

On 9/28/2016 at 3:20 PM, E7 reported when she had done a bed check on R1 she found "stool everywhere". E7 stated, "I got her up with a walker.
There was no gait belt on her. (R1) went from the bed to the shower chair. No shoes. The crash pad on the floor was full of stool. I covered (R1) and wheeled her to the closest shower, the 100 hall shower stall. I washed and rinsed her hair, and got (R1) washed off. She fell out of the shower chair when I was shutting the water off. I didn't leave her. The door was open. I called out for help. Another CNA, (E5) and (E17) came by. I

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refused to pick her up with a gait belt. The nurse (E9) came down after (E17) went and got him to evaluate her. (R1) had no complaint of pain or crying. Her bottom bounced when she hit the floor. She didn't holler. It was an unfortunate accident that happened. The seat was plastic, a vinyl covered soft foam. It's slippery when wet."

On 9/29/2016 at 9:37 AM, E17, CNA, stated, "I saw the 100 hall shower room door open and light on. I went to see why the door was open. (R1) was on the floor already. (R1) was alert, (E7) was in the room with her. (E9), the nurse said it was ok to get her up. I was one that helped her down the hallway in the mechanical lift. I know that's the wrong way to transport somebody. I did help put (R1) in bed from the lift. She wasn't hurt and no complaints of pain."

On 9/29/2016 at 8:45 AM, E2, Director of Nursing (DON), stated, "(R1) had a foam seat, vinyl covered on the shower chair, The CNA (E7) failed to have the seat belt fastened. That's why (R1) slid out."

On 9/29/2016 at 2:56 PM, E9 stated, "I remember she fell in the shower. She was bed when I saw her. One of the aides told me she fell. Don't remember who-one of the ones who was on a different hall. She had no loss of consciousness. The shower aide said she didn't think she hit her head. I didn't know she had shunt in her head until after I talked to the daughter/POA. I checked it. I did neuro checks when she complained of a headache. I faxed (Z3). I don't remember the time. It was in the notes or on the fax. If there is no injury, I just fax the doctor. If there is an injury, I would have call the doctor on call. I went to her room to assess her, not the shower room. She

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was already in bed. I think they are supposed to wait until the nurse gets there to assess before moving a resident. Rolling her in bed or moving her could have caused harm."

On 9/29/2016 at 5:43 PM, Z3 reported he could not remember much about R1's fall on 8/19/2016, but R1 has always been a high risk for falls due to her history of hydrocephalus and unsteady gait.

A Summary Report of Meeting, dated 8/19/2016, documents, in part, "All shower chairs are equipped with seat belts. When a resident is in the shower chair, the seat belt must be fastened."

R1's Care Plan, updated 9/17/2016, documents, in part, "Is at risk for falls or trauma related to unsteady balance, and use of multiple meds (medications) and diagnoses which include: cognitive impairment, use of narcotics, diuretic meds and recent history of falls. Approach-Follow Keep Me Safe Transfer Status: sit to stand lift with 2 assist with belt and leg strap donned."

The Keep Me Safe Screen for R1, dated 8/04/2015, documents a transfer status as "Assist of 2 with a gait belt. Patient requires verbal cues and extra time to process 1 step command during transfers to step from/to wheelchair/bed/recliner." The Keep Me Safe Screen for R1, dated 8/24/2016, documents, in part, "Prior transfer status: 2 assist with walker. New transfer status: 2 assist with sit to stand (mechanical lift)."

On 9/29/2016 at 4:20 PM, E1, Administrator, reported they currently could not find the policy or procedure for the use of a shower chair.

On 9/29/2016 at 12:30 PM, E2 reported the

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	145465	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEYVILLE NSG & REHAB CENTER	1001 SOUTH STATE STREET JERSEYVILLE, IL 62052

(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
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facility's policy and procedure for the use of mechanical lifts is called the "Please Keep Me Safe Program."

The Please Keep Me Safe Program documents, in part, "Definition: A program designed to ensure a safe environment of care for our residents during resident handling and movement. Handling and movement includes: repositioning, lifting/lowering, pushing/pulling, carrying or turning, holding and supporting, The facility will have adjustable equipment/technology available for the health care worker to facilitate safe work practice. The program focuses on a culture of safety and consists of education, intervention, monitoring and communication. 2 person assist-Resident requires physical assistance of 2 people with the use of a gait belt and verbal cues to ensure a safe transfer, Resident is able to bear weight. All CNA's and Nurses will be instructed in and demonstrate competence with resident handling, mobility and transfers prior to their first day of direct care with the residents."

The Employee Disciplinary Action for E7, dated 8/22/2016, documents, in part, "Specific Infraction-Category I, # (number) 19-Violation of safety rules. On 8/19/2016, did not apply safety belt on resident during shower. Resident slid out of shower chair resulting in resident injury."