STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146121	A. BUILDING _____ B. WING _____	C 10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTON REHAB & HCC	**1409 NORTH MAIN STREET, PO BOX 847 BENTON, IL 62812**

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F 000	INITIAL COMMENTS	F 000		
F 157 SS=D	Complaint Investigation 1555519/ IL 80669 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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F 157	Continued From page 1 by: Based on record review and interview the facility failed to notify the family member of 1 resident (R3) in a sample of 3, of a fall incident involving the resident. 1. The Notification for Change in Resident Condition or Status form with the issue date 7/1/12 documented, The facility and/ or facility staff shall promptly notify appropriate individuals (i.e., Administrator, DON (Director of Nursing), Physician, Guardian, HCPOA (Health Care Power of Attorney), etc) of changes in the resident's medical/mental condition and/or status. The Physician Communication and Progress Note with the date 9/16/15 documents R3 had fallen at 9:30am. The form was marked that "family or health care proxy" was notified. This same form has a hand written statement, "left message" at 9:30am. There is no documentation in R3's Nurse's Notes on 9/16/15 of R3's family being notified of the fall incident. 2. On 10/8/15 at 11:25am, E3 (Registered Nurse) said she was on duty when R3 fell. E3 said she did not make contact with R3's family to notify them of the incident but she did leave a message on an answering machine. On 10/9/15 at 10:12am, E2 (Director of Nursing) said R3's family should have been notified of the fall. On 10/8/15 at 8:15am, Z1 (R3's family member) said the family had not been notified of R3's fall.	F 157		

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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 record review and interview the facility failed to provide adequate assistance and supervision to prevent a fall with injury for one of three residents (R3) in a sample of 3. These failures resulted in a 5 day hospitalization, initially on the Intensive Care Unit and then on the Neurosurgical floor. R3 sustained a Traumatic brain injury - bifrontal and biparietal hemorrhagic contusions, right frontal subdural hematoma; Left parietal skull fracture and Status post fall from a standing position with loss of consciousness. The findings include: R3's undated, Profile Face Sheet, documented diagnoses to include Muscle weakness (generalized), abnormality of gait and difficulty in walking. Minimum Data Set dated 9-2-15 documents R3 has a score of 15 on the Brief Interview for Mental Status, meaning R3 is cognitively intact. The facility fall log lists 2 falls for R3 as follows: 1. 8-10-15 R3 attempted to get up unassisted and fell with no injury noted. 2. 9-16-15 (see below for details)	F 323		

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F 323	Continued From page 3	F 323		

R3's PT (Physical Therapy) Daily Treatment Note dated 9/16/15 (no time recorded) documented, "Found patient lying on the sidewalk supine with knees bent. Called for nursing. Patient reported he was standing outside with walker and closed his eyes to stand in sun he stated he thinks he got dizzy and fell down. Nursing examined patient. Therapy and nursing transferred pt from ground to standing position and patient became very dizzy losing his balance buckling his knees. Sat patient back down for couple of minutes to regain balance. Stood patient with therapy and nursing to transfer to wheelchair. Nursing took vitals and applied ice to back of head. Patient complained of bad headache and feeling dizzy. Asked patient how he fell outside or if he hurt anything and patient now had no memory of falling outside. Reminded patient of what he told us 10 minutes earlier and patient continued to have no memory of falling or of us picking him up off the sidewalk even after telling him 4 more additional times he continued to act surprised that he was outside and no memory of being found lying on sidewalk. Transferred patient care giver assist to bed per nursing request with ice pack on back of head and feet elevated. Patient complained of another dizzy spell while lying in bed. Nursing reported to Director of Nursing and was going to inform wife of fall. Patient refused to be sent out to hospital."

R3's Physician Communication and Progress Note with the date 9/16/15 documented at "9:30am therapy observed R3 laying on the sidewalk with his eyes closed." This form also documented R3 stated, "I was standing here with my eyes closed in the sun" and R3 did not know what happened. The form documented R3 stated,

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"I'm dizzy and my head hurts" and R3 "does have raised area on back of head which is sl (slightly) red but does not look like a contusion more like he might have rubbed his head concrete sidewalk." The form also documented R3 refused to go to the hospital.

On 10-8-15 at 11:00 a.m., the door that R3 had exited out of prior to falling on 9-16-15, was noted in a hall behind the nurses station and has a coded pad alarm present. The door requires a code to open it.

On 10/8/15 at 12:00pm, E10 (Therapy employee) said she went into R3's room on 9/16/15 to find him and he wasn't there. E10 said she looked out the window and seen R3 laying flat on his back on the ground so she notified the nurse as she went outside where R3 was. E10 said R3 opened his eyes and said he couldn't remember why he had fallen. E10 said she was present when the nurse assessed R3 and there was no bleeding anywhere but R3 had a "red bump" on the head that was tender to touch and R3 complained of a headache. E10 said she had been doing therapy with R3 and he was stand by assist at this time. E10 said she is unsure how R3 would have gotten outside because the door has a code to put in. E10 said she had seen R3 outside by himself before. E10 said R3 should should have been a stand by assist.

On 10/8/15 at 11:25am, E3 (Registered Nurse) said R3 has had two falls while residing in the facility. E3 said she was the nurse on duty when R3 fell outside on 9/16/15. E3 said she assessed R3 and he had not been unconscious but he did have "red blotchy spots on the back of his head." E3 said R3 complained of having a headache and

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dizziness but declined to go to the hospital. E3 said when asked R3 could not remember why he fell. E3 said R3 would have had someone open the door for him to go outside because he couldn't do it himself. E3 stated around a week ago the DON told E3 it was okay for R3 to go outside alone.

R3's Nurse's Notes dated 9/18/15 and timed 8:15pm documented, Late entry for 9/16/15. 10:15am. Neurological checks done and within normal limits. Ice applied to back of head. Resting in bed acts like normal self. Answers questions appropriately. Asked if he wanted to go to hospital he stated no, I am alright.

R3's Nurse's Notes dated 9/16/15 and timed 3:15pm documented, Alert and oriented. No complaint of headache or dizziness. Neurological checks were within normal limits.

R3's Nurses Note's dated 9/16/15, documented at 8pm, complaining of shortness of breath, oxygen applied and R3 refused to go to the hospital at this time.

R3's Nurses Notes documented at 10:00pm, R3 complained of severe head pain related to fall, shortness of breath noted, resident agreed to go to the emergency department.

On 10/9/15 at 9:15am, E5 (Licensed Practical Nurse) said she worked on night shift on 9/16/15. E5 said R3 complained of pain behind his eyes and a headache. E5 said R3 had a bump on the back of his head. E5 said R3 agreed to go to the emergency room at that time.

R3's Nurse's Note dated 9-17-15 at 2:40 am

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states that R3 was transferred to a local hospital.

R3's records dated 9-17-15 at 4:45AM from the out of state emergency department, where R3 was transferred to, documented R3's assessment as:" Traumatic brain injury - bifrontal and biparietal hemorrhagic contusions, right frontal subdural hematoma, Left parietal skull fracture and status post fall from a standing position with loss of consciousness." This documentation was electronically authenticated on 10/7/15.

R3's Nurses Notes documented R3 returned to the facility on 9/21/15 and then was discharged home on 9/30/15.

On 10/8/15 at 2:15pm, E7 (Registered Nurse, Care Plan Coordinator) said R3 should always have stand by assist. E7 said R3's care plans were marked to have assist with transfers and ambulation. On 10/13/15 at 9:10am, E7 said she was not aware R3 was going outside alone and had not added this to any care plan. E7 said she is not sure how R3 got outside but he shouldn't have been alone.

E2 (Director of Nurses) was interviewed at 10:12am on 10/9/15 and said R3 had two falls while living in the facility that she knows of. E2 said R3 used a walker and required assist to ambulate. E2 said R3 was not always compliant with this. E2 said R3 did go outside by himself on 9/16/15 and did have a fall. E2 stated R3 "had been going outside for weeks alone and knew how to get out the door." E2 said R3 was "alert and had rights. If he wanted to go out he could go out." E2 said the nurse on duty assessed R3 after the fall and he didn't have any injuries observed. E2 said R3 refused to go to the

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F 323	Continued From page 7 hospital and "she didn't fight it." On 10/8/15 at 10:05am, E4 (Licensed Practical Nurse) said she wasn't here at the time R3 had a fall. E4 said she did provide care for R3 when she works and R3 had asked her if he could go outside alone. E4 said she didn't think R3 should be going outside alone but the Director of Nursing said he could. E4 said she (E4) has opened the door for him to get outside before. R3's Minimum Data Set (MDS) with the date 9/2/15, documents R3 requires limited assist of one for transfers and ambulation and R3 receives Physical Therapy and Occupational Therapy for training of transfers and ambulation. The MDS documents R3 requires a walker or wheelchair for mobility. The MDS has no behaviors, wandering or rejection of care documented. There were no recent falls documented on the MDS. The MDS documented R3 has bilateral upper extremity impairment. R3's Certified Nurse Aide (CNA) Flow Sheet with the date September 2015, documented R3 required assist of one for ambulation. R3's Fall Risk Assessment completed on 9/16/15 documented R3 had loss of balance while standing, loss of balance while walking, wide base of support, jerking while turning, use of assistive device and required assist to stand. The form also documented R3 received an antipsychotic medication and had a diagnosis of arthritis. The form documented R3 was at high risk for falling. R3's Fall Care Plans documented: On 8/10/15, "educated to use call light for assistance. WW (wheeled walker) with SBA	F 323		

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F 323	Continued From page 8 (stand by assist)." On 8/21/15 the fall care plan was marked as reviewed and it was documented, R3 requires assist of one for transfers and use of one assist and gait belt for transfers. On 8/27/15, Resident has become noncompliant with safety. Ambulates without walker at times in spite of fall risk education per staff and therapy and family. Resident will comply by requesting assist to ambulate and use wheeled walker following fall risk safety and have no falls. Remind resident to use walker, request stand by assist and use call light. On 9/16/15, patient to use main courtyard with assistance until cleared by therapy. R3's PT (Physical Therapy) Daily Treatment Note dated 9/15/15 documented, patient ambulated without assistive device for 200 feet with two stand by assist / care giver assist.	F 323		