| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145494 | A. BUILDING _____ B. WING _____ | C 08/25/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **MCLEAN COUNTY NURSING HOME** | **901 NORTH MAIN NORMAL, IL 61761** |

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| F 000 | INITIAL COMMENTS<br><br>Complaint #1664853/IL87999 | F 000 | | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and interview, the facility failed to update care plans with post fall interventions for three of three residents (R1, R2, and R3's) reviewed for care plans in the sample of three.<br><br>Findings Include:<br><br>1. R1's August 2016 POS (Physician Order | F 280 | | |

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

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| F 280 | Continued From page 1<br>Sheet) documents the following Diagnoses: Falls and Weakness.<br><br>The ongoing facility Occurrence Log documents R1 was visually observed on the floor on 4/12/16 at 7:50 am. R1 has "impaired cognition, able to answer yes/no questions. Requires staff assist with ADL's (Activities of Daily Living) and transfers. Has periods of lethargy and slides down in w/c (wheelchair) at times. Resident noted on the floor on (R1's) left side. Contour cushion placed in w/c to facilitate w/c positioning."<br><br>R1's Care Plan dated 7/20/16 documents, R1 is "at risk for falling related to impaired safety awareness." This care plan does not document that R1 is to have a contour cushion in place.<br><br>On 8/24/16 at 9:15 am, R1 was sitting up in a w/c with a contour cushion in the seat of the w/c.<br><br>On 8/24/16 at 12:20 pm, E4 RN/QA (Registered Nurse/Quality Assurance) stated that R1 is to have a contour cushion in the w/c because of poor positioning and sliding out of the w/c, "that was an intervention that was put into place after (R1's) last fall." E4 confirmed that the contour cushion was not added to R1's care plan.<br><br>2. R2's August 2016 POS documents a Diagnosis of Alzheimer's Dementia.<br><br>The ongoing facility Occurrence Log documents R2 falling to the ground on 7/24/16 at 12:45 pm. "(R2) is alert with confusion. Needs assist with ADL's and transfers. Follows cues well but can be easily agitated and distracted...encourage (R2) to sit in supervised area when up." | F 280 | | |

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| F 280 | Continued From page 2 | F 280 | | |

R2's Occurrence Report dated 7/24/16 documents, R2 was propelling wheelchair when staff heard R2 yelling and observed R2 laying on R2's back on the floor. R2 was down the hall from R2's room. R2 stated, "I'm trying to leave" at the time. A new intervention of : "encourage (R2) to sit in supervised area when up" was implemented.

R2's Care Plan dated 8/16/16 documents, R2 is at risk for falls related to being a high fall risk: impaired safety awareness related to impaired cognition, impaired balance/mobility, history of frequent/multiple falls. There are no fall interventions added to the care plan since 5/27/16. This care plan does not document that R2 should be placed in a supervised area when up in the w/c.

On 8/24/16 at 12:30 pm, E4 RN/QA confirmed that the new intervention for R2 to be in a supervised area when up in the wheelchair, had not been added to R2's care plan.

3. R3's August 2016 POS documents a Diagnosis of Dementia.

The ongoing facility Occurrence Log documents R3 was visually observed on the ground on 4/29/16 at 9:35 am. "(R3) is alert with general confusion. (R3) has poor safety awareness and gait is unsteady. (R3) will not always use call light to ask for assistance. (R3) has a low bed, curved mattress and personal alarm to alert staff when (R3) is getting up. 1-1 education provided with poor results. Staff will continue to remind and encourage (R3) to ask for assistance Alarm box {will be} attached to w/c frame, out of reach, for (R3) to shut off."

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| F 280 | Continued From page 3<br><br>R3's Occurrence Report dated 4/29/16 documents, "trying to transfer self to take a nap." A new intervention of : "alarm box attached to w/c frame, out of reach, for (R3) to shut off."<br><br>R3's Care Plan dated 8/22/16 documents, R3 is at risk for falling related to daily medications which include an antianxiety and antidepressant. There are no fall interventions added to the care plan since 6/21/16. This care plan documents that R3's uses a personal alarm and pressure alarm but does not document where the alarm box should be kept to prevent R3 from turning the alarm off by self.<br><br>On 8/24/16 at 12:45 pm, E4 RN/QA confirmed that the alarm box needs to be out of R3's reach and that the intervention was not added to R3's care plan.<br><br>The facility/s Fall Prevention Policy and Procedure dated 2/12/16 documents, "Nursing Administration: The Nurse Managers are responsible for: making fall and fall related injury prevention a standard of care. Enforcing the responsibilities of the staff nurses to comply with fall interventions..Updating resident care plans appropriately and to ensure proper interventions are in place." | F 280 | | |
| 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. | F 323 | | |

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| F 323 | Continued From page 4 | F 323 | | |

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to follow implemented fall interventions for two of three residents (R2, R3) reviewed for falls in the sample of three.

Findings Include:

1. R2's POS (Physician Order Sheet) dated July 2016 documents a Diagnosis of Alzheimer's Dementia. This POS documents orders for: low bed with floor mat for positioning and comfort, pressure alarm to chair pad on wheelchair to alert staff to mobility.

R2's Care Plan dated 8/16/16 documents, R2 is at risk for falls related to impaired safety awareness due to impaired cognition, impaired balance/mobility, and history of frequent/multiple falls. Fall interventions listed on this care plan include: a floor mat for safety, low bed with scoop mattress and pressure pad alarm to bed, pressure pad alarms to the bed and wheelchair to serve as a reminder to call for assistance.

R2's Occurrence Report dated 7/18/16 documents, R2 had been lying in bed prior to CNA (Certified Nursing Assistant) observing R2 beside the bed, on the floor. R2 stated R2 was trying to find R2's husband. R2 had a skin tear to R2's right forehead. This report documents no alarm or mattress on the floor was in place at the time of the incident, as care planned and ordered by the physician.

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| F 323 | Continued From page 5<br><br>On 8/24/16 at 12:30 pm, E4 RN/QA (Registered Nurse/Quality Assurance) confirmed that the ordered fall prevention measures were not in place at the time of the fall.<br><br>2. R3's POS dated July 2016 documents a Diagnosis of Dementia. This POS documents orders for: low bed, pressure release alarm to bed to alert staff to mobility, canoe mattress for comfort and positioning, personal alarm in wheelchair due to decline in condition/unsteady gait.<br><br>R3's Care Plan dated 8/22/16 documents, R3 is at risk for falling related to daily medications which include an antianxiety and an antidepressant. Fall interventions listed on this care plan include: wear slip resistant footwear/slippers, encourage to be up in wheelchair with non slip surface and personal alarm, pressure release alarm when in the bed for reminders to wait/call for assistance.<br><br>R3's Occurrence Report dated 7/10/16 documents, R3 fell while transferring self. Staff heard R3 calling for help and observed R3 on the floor in the bathroom. This report documents, "alarm not sounding." E4 RN/QA stated, "I don't know if the alarm wasn't attached or if it just wasn't working, the report doesn't say. All I know is that it didn't alarm to alert staff the (R3) was up."<br><br>The facility Fall Prevention Policy and Procedure dated 2/12/16 documents, "Nursing staff including RN's, LPN's (Licensed Practical Nurse) and CNA's are responsible for: ensuring compliance of fall and fall related injury | F 323 | | |

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| F 323 | Continued From page 6<br>interventions...implementing fall prevention measures as indicated on the plan of care and to communicate their effectiveness to the administrative nursing staff." | F 323 | | |