STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146147	A. BUILDING _____ B. WING _____	C 08/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAVERLY PLACE OF STOCKTON	**501 EAST FRONT STREET, PO BOX #38 STOCKTON, IL 61085**

(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
F 000	INITIAL COMMENTS Complaint investigation survey # 1514508 / IL 79489 Off hour entrance at 5:00 AM on August 25, 2015.	F 000		
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, interview, and record review the facility failed to supervise a resident identified as high risk for falls. The facility failed to analyze risk factors contributing to falls. The facility failed to evaluate the effectiveness of fall prevention measures. The facility failed to revise and individualize fall prevention measures to prevent fall related injuries. These failures contributed to R1 falling and sustaining a right femur fracture and right humerus fracture, severe pain, and decline in function on August 21, 2015. This applies to 1 of 3 residents (R1) reviewed for falls in the sample of 3. The findings include:	F 323		

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

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R1 was admitted to the facility on September 17, 2014 with a fractured pelvis from a fall at home.

R1's Nursing Notes documented a pattern of R1 getting up to go to the bathroom on the night shift unassisted and increasing her risk for falls.

9/20/14 4:10 AM found resident up trying to go the the bathroom unassisted.
9/25/14 2:00 AM up looking for the bathroom.
9/28/14 5:05 AM attempted to get up unassisted three times.
10/4/14 5:00 AM attempting to toilet self unassisted.
10/20/14 2:55 AM, R1 was found on the toilet unassisted.
10/23/14 12:15 AM, found on the toilet unassisted. Said she forgets to get help.
10/25/14 1:30 AM, going to bathroom unassisted.
10/28/14 2:35 AM R1 up several times unassisted.

The nursing note of October 17, 2014 at 12:10 AM shows R1 fell when attempting to go to the bathroom. "Resident states, she doesn't understand the call light system, " she is old and can't remember all of that."

R1's Morse Fall Scale dated August 22, 2015 at 7:05 AM states R1 is high risk for falling

R1's current Minimum Data Set (MDS) dated June 19, 2015 shows R1's brief interview for mental status score is 2. (Severe cognitive impairment.)

R1's incident report dated June 29, 2015 at 12:44 AM, states, "Heard loud noise coming from

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resident's room. When entering noted Certified Nursing Assistant - E5 holding direct pressure to back of R1's head." The same report shows that prior to her fall, R1 was ambulating unassisted with an unsteady gait. She fell backwards into the dresser and struck her head and sustained a laceration.

R1's care plan documented no additional or revised fall prevention measures following this fall with injury on 6/29/15.
The care plan interventions at this time included to keep call light within reach and remind her to use it, encourage her to participate in activities, and ensure appropriate footwear. (No changes/additions were made to the prevention measures)
From 6/29/15 until R1 fell and sustained fractures 8/20/15 no care plan modifications were made.

The incident report of August 21, 2015 at 9:30 AM completed by E4 states, "Patient's bed alarm sounded off, I ran down to patient's room immediately and noted patient sitting on her buttocks with both legs stretched out in front of her. I called for CNA back up and patient requested to use the bathroom, patient lifted by 2 staff without difficulty. Bed was in low position, bed alarm intact and functioning, call light was at reach. Patient is normally alert but can be forgetful and non compliant at times." The same report show that prior to her fall, R1 was ambulating , unassisted with an unsteady gait. R1 said "Can you please just take me somewhere to die. " R1 was starting to urinate and asked to be taken to the bathroom. Her call light had been within reach prior to this incident.

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The progress notes in the medical record, showed R1 fell on August 20, 2015 at 4:40 AM. (Discrepancy in time of fall is noted from incident report).

On August 26, 2015 at 8:02 AM Z1 (Paramedic) stated, "When we first pulled up to the facility, I saw through a window, a staff member in a resident's room having difficulty managing the resident. (R3) I entered the facility and went to the room (where I saw the nurse) she directed me to R1's room and stated, "The CNA (certified nursing assistant) is in R1's room, please send her down to help me." Z1 said she did not see any other staff members in the facility until she got to R1's room. Z1 said the CNA stated, "I am the only CNA here."
A written report by Z1 dated 8/20/15 documents that R1 fell on 8/20/15 and they responded to the facility call for help at 4:24 AM. Z1 documents the CNA reports after resident fell, she was walked to the bathroom, and she (CNA) noticed a change in R1's ability to walk. R1 complained of pain in her right leg, and later in her right arm.

R1's X-ray report dated 8/20/2015 states, "Comminuted oblique fracture distal femoral shaft and displaced fracture surgical neck right humerus."

R1's Morse Fall Scale dated August 22, 2015 at 7:05 AM states R1 is high risk for falling.

On August 25, 2015 R1 was observed laying in bed leaning towards her left side. R1 was heard screaming from the nurses station. At 2:30 PM, E2 (Director of Nursing-DON) stated, "We have been trying to get a call back from the physician regarding a request for liquid Morphine and Ativan

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for better pain control."

On August 25, 2015 at 5:15 AM, E3 (CNA) stated, "I was with someone else that was a high fall risk at the time that R1 fell." At 12:58 PM, "R1's alarm was sounding when she fell but I was with another resident. I'm pretty sure the fall could have been prevented if there was another CNA."

On August 25, 2015 at 5:30 AM, E4 (Licensed Practical Nurse-LPN) stated, "Staffing is not good here, there have been a lot of resident falls. R1 peed in her bed and took her legs off of the bed. When I found her, her legs were in front of her and she was sitting on her bottom on the floor."

On August 25, 2015 at 6:45 AM, E5 (CNA) stated, "On August 19, 2015 there were two CNAs until 2:00 AM, after 2:00 AM it was just E3." At 12:45 PM E5 said "If I cannot get another CNA to come in and fill in for someone that calls in, I come in myself. "

On August 25, 2015 at 8:57 AM, E6 (CNA) stated, "I am having a hard time taking care of residents because of the lack of help. Yesterday I had 20 residents to take care of myself. Sometimes resident cares are not met because of staffing."

On August 25, 2015 at 9:20 AM E7 (CNA) stated, " Sometimes we are unable to monitor residents that are a high risk for falls, due to lack of staff. "

On August 25, 2015 at 12:30 PM E9 (LPN) stated, "Two weeks ago the CNA's were ready to cry. The administrator said they would have two CNAs on nights. There was only one CNA and one nurse the night R1 fell."

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On August 25, 2015 at 2:30 PM, E2 (DON) stated, "R1's family is deciding on palliative care at this time. They decided against surgery. R1 required a one person assist and was able to use the bathroom prior to her fall and now requires a two person assist and she is on bed rest. There should be two CNAs on the night shift. If a CNA calls off on third shift, the PM CNA stays for an extra four hours. It is my expectation that E5 find a replacement CNA or come in herself to cover a shift if there is a call off." (E5 did not come in the night of 8/21/15 to cover in the absence of a CNA."

On August 27, 2015 at 2:30 PM, Z2 (Medical Director) stated, "I was not aware the facility had one nurse and one CNA to care for 32 residents. The ratio of one nurse and one CNA for 32 residents sounds low to me to safely monitor all the residents."

The undated facility "Fall and Fall Preventions Management Program" policy states
The floor nurse will be responsible for (a) ensuring interventions for fall prevention are being utilized and implemented by support staff. (b.) re-evaluating residents at risk for falls, change of conditions, and resident's with a recent fall. (d) evaluating a residents plan of care in relation to falls.
I. (a). Fall assessment tool is to be completed upon admission, annual MDS review, with a significant change of condition...and within four days of a resident fall.