STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145259	A. BUILDING _____ B. WING _____	C 12/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN PARK STRATHMOOR	**5668 STRATHMOOR DRIVE ROCKFORD, IL 61107**

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F 000	INITIAL COMMENTS Complaint #1015038/ IL 51159	F 000		
F 323 SS=D	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 provide safety and supervision for residents when being toileted. This is for 2 of 3 residents reviewed who are at risk for falls (R1 & R3). The examples are: 1. An Incident Report dated 12/17/10 for R1 showed, "Describe Incident: R1 was sitting on buttocks on floor. Certified Nursing Assistant (CNA) helped R1 to the bathroom and was asked when done to use the call light. R1 self transferred, was standing up, tried to turn around to flush the toilet but when R1 went to grab hand rail he missed it and fell....; Describe injuries: Reddened slight abrasion (shown on body diagram as R1's back on the left side.) No swelling or bruising at this time. Denies any pain or discomfort. No facial grimacing to touch of area.; Was physician called? Yes.; Action	F 323		

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

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F 323	Continued From page 1 Taken by Nurse: Assessed, vitals, got R1 back into bed, notified director of nursing and power of attorney." The Post Fall Assessment dated 12/17/10 for R1 showed, "Time: 10:50 pm.; Location: In R1's bathroom.; Usual status of resident: Not aware of safety needs. Poor judgement.; What was the footwear at the time of the fall? Bare feet.; Are assistive devices used? Yes, wheelchair.; Is a restraint/safety device used? Yes, Bed alarm." On 12/27/10 at 4:19 pm, E2 (Certified Nursing Assistant - CNA) was asked what she would do if a resident is at risk for falling and needs to be toileted? E2 stated, "I would stay in there with them for their safety because I would be afraid they would fall." R1's Care Plan dated 11/17/10 showed, "High Risk for Falls related to unsteady gait, resists care at times, memory deficit, cognitive impairment, occasional episodes of problem behavior, impaired balance, tolerance and strength, poor decision making ability.; Approach: Maintain clutter free environment. keep personal items and frequently used items within reach. Ensure resident is wearing appropriate footwear for all transfers and ambulation. Encourage use of handrails when walking in hallway. Monitor for changes in functional ability with transfers and ambulation. Quarterly ADL assessment. Remind resident of the importance of call light use and asking for assist. Monitor for side effects of medications.... Keep bed in lowest possible position. Low bed. Personal alarm to bed/wheelchair to alert staff to unassisted attempts at transfer or ambulation. Quarterly fall assessment. Ensure adequate	F 323		

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F 323	Continued From page 2	F 323		

lighting. Keep the call light in reach at all times." R1's care plan for falls dated 11/17/10 is not resident specific. R1 does not ambulate in the hallway, have a low bed or behaviors.

R1's Care Plan for Falls dated 11/17/10 was updated on 12/20/10 and showed, "Educate staff not to leave R1 on toilet unattended."

On 12/27/10 at 1:35 pm, R1 was observed in bed with 1/2 side rails up. R1 was not in a low bed and the bed he was in was not in the lowest position. R1 was interviewed about his fall on 12/17/10. R1 stated, "I can get up and walk myself. I didn't get hurt. I missed touching the rail next to the toilet and fell."

The Monthly Nursing Summary for R1 dated 11/5/10 showed, "Requires assistance" for the performance of bathing, personal hygiene, dressing, transfers and mobility. R1's Monthly Nursing Summary dated 11/5/10 showed R1 has no behavior or mood problems, is "quiet" and has a wheelchair as an assistive device. The safety section on R1's Monthly Nursing Summary dated 11/5/10 had no checkmarks next to "at risk for falls, at high risk for falls, falling star program, bed alarm, chair alarm, low bed, floor mat or self release belt."

R1's Minimum Data Set (MDS) with an Assessment Reference Date of 11/25/10 showed a 6 out of 15 for the Brief Interview for Mental Status.; No Behaviors.; Extensive assistance required for toilet use and personal hygiene. Limited assistance required for bed mobility, transfers and walking in room.

The Care Area Assessment dated 11/25/10 for

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F 323	Continued From page 3 R1 showed, "Activity of Daily Living (ADL) Functional Status/Rehabilitation Potential: Problems resident is at risk for because of functional decline... Falls...Muscular Atrophy.; Transfer: Requires step by step repeated verbal direction to begin and complete daily tasks. Has decreased strength, balance and tolerance. Wears prescription eyeglasses. Is able to follow directions but is not always 100% willing to be cooperative with staff.; Analysis of Findings: Has cognitive loss with inconsistent ability. Has decreased strength, balance and tolerance. Is at risk for ...falls and ADL decline related to present ADL status." The Care Area Assessment dated 11/25/10 for R1 showed, "Falls: Physical Performance Limitations: Difficulty maintaining standing position. Impaired balance during transitions. Gait problem....; Internal Risk Factors: Decline in functional status. Visual impairment. Impulsivity or poor safety awareness. Cognitive impairment.; Analysis of Findings: R1 is at risk for falls, has decreased strength, balance and tolerance." R1's Physician Progress Note dated 12/15/10 showed, "R1 is dependent on staff for ADL's due to weakness and memory loss." 2. An Incident Report dated 12/4/10 for R3 showed, "Time: 1:00 pm.; Describe Incident: CNA put R3 on toilet without alarm....; Describe injuries: Complains of right thumb hurting, no redness noted to the area. R3 can move thumb. Examined R3's head - no redness noted. No bumps noted.; Was physician called? Yes. Nursing order received to get an x-ray of right thumb to rule out fracture.;	F 323		

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F 323	Continued From page 4 CNA educated by nurse on duty - see attached." The Nurses Notes for R3 (attached to the Incident Report dated 12/4/10 for R3) showed, "12/4/10 - CNA was educated per nurse to please do not leave R3 on toilet by herself or any other resident by themselves especially those that have an alarm." The Post Fall Assessment dated 12/4/10 for R3 showed, "Usual status of resident: Not aware of safety needs. Poor judgement.; Is a restraint/safety device in use? Yes, chair alarm.; Are assistive devices used? Yes, wheelchair." On 12/27/10 at 4:19 pm, E2 (Certified Nursing Assistant - CNA) was asked what she would do if a resident is at risk for falling and needs to be toileted? E2 stated, "I would stay in there with them for their safety because I would be afraid they would fall." An Incident Report dated 11/30/10 for R3 showed, "4:35 am - R3 slid out of wheelchair to the floor when trying to reach for door knob." An Incident Report dated 11/30/10 for R3 showed, "3:45 pm - R3 observed in bathroom sitting on the floor." R3's Fall Risk Assessment dated 11/30/10 showed a score of 21, twelve or above equals high risk with individualized high risk interventions to be implemented. R3's Care Plan dated 11/30/10 showed, "At High Risk for Falls related to unsteady gait, psychotropic medication use, resists care..., memory deficit, cognitive impairment, occasional	F 323		

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F 323	Continued From page 5 episodes of problem behavior, impaired balance..., poor decision making ability." The physical therapy assessment tool for R3 dated 12/7/10 showed, "Sitting balance: Leans or slides in chair.; Arises: Unable without help.; Immediate standing balance: Unsteady without help.; Sitting down: Unsafe, misjudged distance, falls into chair." The facility's "Falling Star Program" showed, "Policy: To minimize the chance that a fall will occur, residents who are assessed at High Risk for falls, or who have a history of falls within the last 180 days, will be included in the Falling Star Program.; Procedure: Place a falling star icon outside the resident's room next to the resident's name. Attach a falling star icon to the resident's mode of transportation if applicable. Initiate/update fall risk care plan. Educate the resident and/or family on the falling star program and the resident's individualized high risk interventions. A resident will be removed from the falling star program if 180 days have elapsed without a fall and the resident does not score at high risk for falls. (12 and above on the Fall Risk Assessment.)" The facility's Fall Risk Assessment Policy showed, "Policy: Resident's will be assessed for risk factors that increase their potential for falls in order to identify the need to initiate additional safety measures.; Procedure: resident's shall be assessed upon admission, re-admission, with significant change, post fall and quarterly using the Fall Risk Assessment Form. The resident who scores 12 or greater will have individualized High Risk interventions implemented, including the falling star program. If a resident falls the	F 323		

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F 323	Continued From page 6 nurse will complete the Post Fall Assessment form and submit it to the Accident/Incident Management Meeting Committee for review, evaluation and care plan update."	F 323		