STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145309	A. BUILDING _____ B. WING _____	C 04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED BUD REGIONAL CARE	**350 WEST SOUTH 1ST STREET RED BUD, IL 62278**

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F 000	INITIAL COMMENTS Incident of 3/25/2015/IL76072.	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 record review and interview, the Facility failed to provide supervision and functional fall prevention interventions to prevent falls for two of three residents (R1, R2) reviewed for falls in the sample of 3. Findings include: 1. R1's Physician's Order Sheet (POS) for March 2015 documents, diagnoses, in part, as Malignant Neoplasm of Colon, Malaise/Fatigue and Congestive Heart Failure. R1's Minimum Data Set (MDS), dated 2/27/2015, documents R1 is severely impaired with cognition and has unsteady balance when seated, standing and walking, and requires the use of an assistive device. The Fall Risk Assessment, dated 2/25/2015, documents R1 is a high risk for falls. The Event Detail Summary documents R1 had a fall from the wheelchair on 3/25/2015 at 9:45 AM. The Summary documents R1 was being assisted	F 323		

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

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to the bathroom by 2 Certified Nurses Aides (CNA). The Summary documents, in part, "CNA in room with (R1), and was not facing the patient and preparing supplies. (R1) slipped out of chair and landed on anterior portion of her body and head hit the floor. A hematoma formed about 4 cm (centimeter) to right midline of forehead, with trace spots of blood, no bruising noted at this time. (Z1's) office notified with orders to send to the ER (emergency room)."

On 4/01/2015 at 1:30 PM, E4, CNA reported she was pushing R1 into the bathroom while in a wheelchair. E4 reported R1 was weak that day and needed 2 staff to assist her to transfer to the toilet. E4 reported R1 had no foot pedals on the wheelchair and was sitting on a pressure relieving cushion. E4 reported she was standing behind R1 pushing the wheelchair when R1 began to slide, fell to her knees then forward, hitting her head on the floor. E4 reported she was not holding onto the gait belt around R1's waist. E4 reported R1 was wearing gripper socks due to edema to her lower extremities. E4 reported when R1 began to slide, she put her feet down on the floor and fell forward. E4 reported R1 would propel herself with her feet while seated in the wheelchair.

On 4/01/2015 at 1:37 PM, E5, CNA reported she was holding the bathroom door for E4 when she was pushing R1 into the bathroom. E5 reported she had reached down to pick up something, and when she turned around, R1 was already falling down to the floor. E5 reported E4 couldn't catch R1 in time.

The Nurses Note, dated 3/25/2105 at 3:00 PM, documents, "Clarification with second CNA in room at time of fall. (R1) being pushed in

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wheelchair. (R1) would not lift feet at that time. (R1) slid out of wheelchair."

The Radiology Report for R1, dated 3/25/2015 documents, in part, "There is a compression fracture of L1, age uncertain. Compression fracture of superior endplate of L2, age uncertain. Suspect mild deformities at T11 and T12, age uncertain. Moderate to severe arthritic changes noted. There is scoliosis."

On 4/02/2015 at PM, Z1, Physician stated, "The compression fractures were not acute. It is my understanding (R1) wasn't having acute pain at that time. I don't think the fall caused the fractures. Falling forward wouldn't cause compression fractures of the spine. Usually falls where people go down hard on their buttocks cause compression fractures. The cancer contributed to her weakness. It had spread all over her body and caused her death."

R1's Care Plan prior to the fall of 3/25/2015, updated 3/18/2015, documents, in part, "(R1) is at high risk for falls related to a history of multiple falls. Interventions: Maintain safe environment. Observe resident for proper fitting footwear to maintain their safety. May use non skid in recliner and non skid socks to prevent sliding. Provide assist if needed for transfers."

The Facility's Follow up Report for R1, dated 3/26/2015, from E3, Assistant Director of Nursing (DON) documents, in part, "Will also evaluate for need of adding foot rests to the wheelchair."

2. R2's March 2015 POS documents diagnoses, in part, as "Malaise/Fatigue, History of Cerebral Vascular Accident and Dementia. The MDS,

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dated 3/25/2015, documents R2 is severely impaired with cognition and decision making, and has unsteady balance for sitting to standing, walking and surface to surface transfers.

The Event Detail Summary documents on 3/20/2015 at 1:15 PM, "(R2) found by CNA and LPN (Licensed Practical Nurse) to be on floor in front of chair. Was picked up and placed back in chair, alarms were in place, but not sounding. The safety belt was in place, but not sounding. The safety belt was replaced by maintenance earlier in the AM. Batteries to be replaced in both alarms, Chair pad to be replaced. Skin tear found on right bicep 4 cm (centimeter) by 3 cm with 50% coverage of a skin flap."

The Post Fall Investigation Tool for R2, dated 3/20/2015, documents, in part, "New Interventions to implement: Replaced battery to alarm box, replaced pad, replaced safety belt."

On 4/02/2015 at 10:56 AM, E9, LPN reported R2 can remove the safety belt. E9 stated, "(R2) slid with the pressure pad alarm. It stayed with him and stuck to him. I remember they replaced the safety lap belt batteries."

On 4/02/2015 at 11:27 AM, E11, CNA stated, "I didn't see (R2) fall. The nurse (E9) said he was on the floor. Her and another nurse picked him up. The alarms were not sounding." E11 reported she helped check the alarms on the 400 hall the morning of 3/20/2015, and all were working, including for R2. E11 reported the safety alarm checks are not documented anywhere.

R2's Care Plan, dated 1/08/2015, documents, in part, "Is at risk for falls or fall related to injuries,

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F 323	Continued From page 4 cognitive impairment, decreased balance with poor safety awareness. (R2) cab transfer with 1-2 assist and is able to ambulate with a wheeled walker and 2 assist. (R2) has a history of falls. Monitors have been put in place to alert staff to unassisted movement. Alarming seat belt applied and is able to release upon command. (R2) is noted to often attempt to transfer himself without assistance. Interventions: Ensure alarming seatbelt and incline cushions with non skid are in place to rock n go (wheelchair) before each transfer and functioning properly. New seatbelt ordered for his wheelchair 3/20/2015." The Facility's policy and procedure, entitled, "Falls," dated 8/2014, documents, in part, "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling, and to try to minimize complications from falling. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant."	F 323		