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	145939	A. BUILDING _____ B. WING _____	01/29/2015

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WATERFRONT TERRACE	**7750 SOUTH SHORE DRIVE CHICAGO, IL 60649**

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F 000	INITIAL COMMENTS Annual Licensure and Certification Complaint Investigation: 1580385/IL74478-F-323	F 000		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to have documentation of an indication for an indwelling catheter for one of three residents reviewed (R7) in a total sample of 19. Finding include: R7 was admitted to the facility on 9/11/14 with diagnoses of the following; Hypertension,Dementia, Urinary Tract Infection, Emphysema, Status Post Sepsis,etc. On 1/26/15 at 1:32pm R7 is sitting in the wheelchair near room 108 with O2 in use per nasal cannula at 2 liters. R7 has an indwelling catheter attached to the wheelchair contained in a privacy bag. POS (Physician Order Sheet) dated	F 315		

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

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F 315	Continued From page 1	F 315		

1/6/15 indicate that R7 may be straight catherized to collect a urine specimen for labs. POS dated 1/21/15 states, "May insert indwelling catheter, catheter care every shift, and drainage bag change twice monthly."

Further review of R7's records consisting of Physicians notes in the record dated 10/23/14, and 12/4/14 is without any change of condition indicating a diagnosis for catheterization. Nurses notes dated 1/18/15 through 1/28/15 is without documentation of a change of condition indicating catheterization. Care plan 8/20/14-1/20/15 is without documentation of R7 having an indwelling catheter or change in treatment plan regarding the catheter.

On 1/27/15 nurses notes indicate that Z1(Medical Doctor) was called for clarification of the indwelling catheter.

On 1/29/15 at 10:40am review of record is with a phone order clarification written 1/27/15 indicating that a diagnosis of Hydronephrosis and Renal Insufficiency.

On 1/29/15 at 11:06am Z1 (Medical Doctor) states,"R7 has a decreased urine output, just not putting out urine. If R7 don't have the catheter then R7 will have the incontinent briefs on and get bed sores from being wet. We have to have some means of keeping R7 from getting bedsores."

During interview Z1 does not present any new diagnosis for an indwelling catheter at this time. States,"Does R7 still have the catheter now, what is her output like now." Call referred to Director of Nursing.

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F 315	Continued From page 2 On 1/29/15 at 11:10am E3(Director of Nursing) states,"I tried to create a form and keep it on the record for the CNA's (Certified Nursing Assistants) to keep track of her intake and output. It should be another sheet, I'll let you know. " Current records in R7's chart is without proper documentation of I/O (intake/output). Intake and output record is without a month being indicated, and the date on the sheet is starting at 16-31. There's no intake documentation for this period of time, and the output is starting from 21-28. No other documentation received regarding R7's I/O for this survey.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to apply orthotic device in accordance to its range of motion care plan for one resident(R4) in a sample of 19, reviewed for assistive devices. Findings Include: On 1/26/15 at 10:55am during initial tour with E5	F 318		

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F 318	Continued From page 3 (Nursing Supervisor), R4 was observed sitting up in chair next to bed. R4 has right hand contracture. Right hand splint was not applied to R4. E5 stated on 1/26/15 at 10:57am, that "R4 should have the splint on and that restorative usually puts it on when they get the resident up out of bed." On 1/27/15 at 11:50am, E13(Restorative Aide) stated, "R4 should have on right hand splint on Monday, Wednesday, and Friday. I usually put it on first thing in the morning when I get here. I don't think that the CNA (Certified Nursing Assistant) put it on him yesterday (Monday)." R4's splint care plan dated 12-10-14 was reviewed. Goal of R4's care plan denotes: Resident will tolerate orthotic device to prevent further contractures through 3-10-15. Staff should apply right hand splint on Monday, Wednesday, and Friday according to the care plan.	F 318		
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 observation, interview and record review,	F 323		

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the facility failed to follow their fall policy for 2 of 4 residents (R1, R12) in the sample and one resident outside the sample (R20). This failure resulted in R20 being admitted to the hospital with a head injury from a fall, 1/20/2015.

Findings Include:

1. R20 has the following diagnosis which added to making R20 high risk of falls: Hypertension (HTN), Congestive Heart Failure (CHF), Dementia with Behaviors, Syncope with Falls and Altered Mental Status. Per Incident reports and Nurse's Notes, R20 has fallen 7/10/2014, 9/8/2014, 12/24/2014, 12/27/2014 and 1/20/2015. R20 sustained injuries when she fell, 7/10/2014, 9/8/2014, 12/27/2014 and 1/20/2015.

Nurse's Notes dated 12/24/2014 at 7:30pm, stated that R20 was found on the floor by staff. R20's Physician (Z2), Administration, and the Family were called. Vitals were taken. R20 was not injured. Z2 at 8pm, 12/24/2014, gave a telephone order to watch and monitor R20 at bedside for 72 hours. Monitoring was not updated in R20's care plan after this fall.

Nurse's Notes dated 12/27/2014 at 7pm, state that R20 was found on the floor by her bed by CNA (Certified Nursing Assistant/E16). A written statement in the Incident Report dated 12/27/2014, from E16 states that she heard the bed alarm go off in room 302 and found R20 on the floor mat next to R20's bed. Nurse's Notes state that R20 sustained a bruise to the right side of her forehead. No bleeding was observed. Z2's office was called at 7:15pm, Z3 (Physician) ordered application of a ice pack to the Hematoma and 72 hour monitoring. Monitoring

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was not updated in R20's care plan after this fall. 12/30/2014, Z3 ordered an X-ray of the right facial bones by telephone.

Nurse's Notes dated 1/20/2015 at 5:45pm, state that R20 fell out of a recliner in the hallway outside of room 302. R20 sustained a laceration to the left side of her forehead. 1/20/2014 at 6:08pm, the Hospice Nurse (Z4) okayed R20 being taken to the Emergency Room for evaluation. Nurse's Notes dated 1/21/2015 at 4:15am, R20 was admitted to the hospital with the following diagnoses: Urinary Tract Infection (UTI), Head Injury and Cardiac Arrhythmia.

1/29/2014 at 11am, a tour of room 302 and the hallway, where all 3 falls occurred was made with E5 (Nursing Supervisor). E3 stated that R20 was in a low bed with bed alarm and mats on the floor when R20 fell out of the bed, 12/27/2014. E5 said nothing about the 12/24/2014 fall. It was clarified that R20 was not in a recliner for the 1/20/2015 fall. R20 was in a specialized high back wheelchair given to R20 by Hospice. The wheelchair was still in room 302. A large accumulation of dried food and dirt was observed on the wheelchair.

During the 1/29/2015 interview at 11am with E5, R20's fall care plan was discussed. E5 confirmed that before the 12/24/2014 fall, R20 was in a low bed (added 7/10/2014) with a bed alarm (added 9/11/2014) and mats (added 7/10/2014). 12/24/2014, R20's fall care plan was updated with keeping the resident close to the nurse's station while up in recliner with chair alarm (added 7/17/2014). E5 was asked if the monitoring requested by Z2 and Z3 added to R20's care plan. E5 stated that Z2 and Z3's request was only

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F 323	Continued From page 6 for 72 hours and no adaptation was added to R20's care plan. After the fall of 12/27/2014, the staff increased telling R20 to asked for assistance. R20 has a care plan for cognitive impairment that was initiated, 4/29/2014. On her most recent Minimum Data Set (MDS) dated 12/26/2014, R20 was not given the Brief Interview for Mental Status (BIMs/Score = 00) because of the severity of her cognitive impairment. R20 cannot follow directions. R20's fall care plan contains interventions which R20 is incapable of doing based on her cognitive impairment. These interventions are safety training, education and calling for assistance. An individualized monitoring program was not initiated and put in place as apart of R20's fall care plan. 2. R12 was admitted to the facility in July 21, 2014. R12 has the following diagnoses: Cardiovascular Accident (CVA), HTN, CHF, Anemia, Back Pain, BPH. 11/4/2014, a Psychiatric Progress note written Z5 (Psychiatrist) gave R12 the diagnoses of Major Depression Disorder and Dementia/Organic Disorder. R12 has been 'at risk for falls' since his initial fall assessment, 7/21/2014. R12 has fallen 8/3/2014, 8/27/2014, 10/23/2014, 11/6/2014 and 12/4/2014. R12 sustained pain to his left hip after the 8/3/2014 fall. 1/29/2015 at 10:30am, R12 was observed sitting in a recliner during activities. R12 was not participating in the activity (Bingo). 1/29/2015 at 11am, R12's falls and fall care plan was discussed with E5. E5 stated that R12's falls occur in the evening, when he tries to get out of bed without assistance. After the 8/5/2014 fall, R12 was put in a low bed with alarm and mats on	F 323		

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F 323	Continued From page 7 the floor. A chair alarm was added when up in a chair. R12's latest fall care plan was initiated 10/29/2014. R12 has fallen twice, 11/6/2014 and 12/4/2014. The fall care plan was not changed after the 2 additional falls. E5 was asked what was implemented to prevent R12 from falling after the last 2 falls. E5 said R12 was encouraged to ask for assistance more often. R12's BIMs score is 7/15 in his MDS assessment dated 10/29/2014. R12 is cognitively impaired which means R12 cannot take direction. Asking R12 to call for assistance is an inappropriate intervention. The facility's Fall Policy was reviewed. The policy states that residents are to be assessed after every fall. A Fall Committee will assess the effectiveness a resident's care plan as it relates to fall prevention. Tracking and trending of falls is to be done for each resident in order to discover the root cause of a resident's falls. Interventions are to based on that cause. 1/29/2015 at 12:40pm, the facility fall policy was discussed with the Director of Nursing (DON/E3) and E5. E3 and E5 presented a log of falls for E12 and E20, but not documentation showing that a root cause for the falls were used to develop appropriate fall interventions for E12 and E20. E12 and E20 were allowed to continue to falling because of inappropriate interventions.	F 323		

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Example:

R1 was observed two days of the survey 01/26/15 and 01/27/15 in a recliner with back of chair reclined back seated at the entrance of room door (318) or in bed with G-Tube feeding in progress via pump. At no time during the observation period did R1 attempt to remove self from the recliner or bed. R1 remained quiet and immobile during the entire time. The resident requires extensive total care with activities of daily living (bed mobility, transferring surface to surface, toilet use and personal hygiene).

During record review of (incident/accident reports), it was determined R1 had multiple falls in July 2014 as follows:
- 07/05/2014 at 3:00pm on matt next to low bed
- 07/12/2014 at 8:00pm on matt next to low bed
- 07/25/2014 at 7:00pm on floor next to bed
- 07/28/2014 at 6:00pm on floor with G-Tube pole next to resident

Four episodes of falls (from a low bed onto matt in room) within a one month period of time, no injuries documented.

R1's Fall Risk Screening Tool dated 05/22/2014 to 07/12/2014 indicated the resident is at risk for falls (scored from 19 to 20). "A score of 14 or greater means the resident is at risk for falls."

In addition, R1 had six falls in a four month period time from August 2014 to December 2014 as follows:
- 08/01/2014 at 7:10am face down on matt next to bed

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F 323	Continued From page 9 - 09/20/2014 at 1:20am on back on matt next to bed - 09/24/2014 at 6:30pm on the matt on the floor next to bed -11/04/2014 at 10:40pm on matt on floor next to bed -11/30/2014 at 9:15am on floor next to bed in room - 12/02/2014 at 6:40am on mattress on floor with small amount of blood on forehead. Although the "Unusual Occurrence Investigation Form" describe a left sided gash to the forehead, E5/nurse supervisor reports the wound was a small area. Interview with E5/nurse on 01/29/2015 at 1:30pm about the alleged gash to the forehead, E5's written statement is, "R1 had fall on 12/1/14, E15/nurse did do incident report and used term gash. Resident did have a small opening to forehead, however did not have gash, nothing with depth was noted with bleeding at time of fall. However, upon fall review area was healed on 12/2/14, no gash noted. E15/nurse did use inappropriate words for assessing resident." R1's Fall Risk Screening Tool dated 08/25/2014 to 12/02/2014 scored the resident from 18 to 23, at risk for falls. Based on the 06/28/2014 and 12/26/2014 Minimum Data Set (MDS) Section C, Brief Interview for Mental Status (BIMS), R1 is scored as 03. A (BIMS) score is classified as being severely impaired, according to E14/social services director. On 01/29/2015 at 12noon when questioned about the score, E14's/social service	F 323		

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F 323	Continued From page 10 director written statement is, "severely impaired cognition. R1 has impaired insight, judgement and decision making skills. Due to R1's cognitive impairments, pulling resident call light may not be something R1 thinks to do mentally. Instead R1 may occasionally call out. Due to resident's cognitive impairments R1 doesn't understand safety issues. Due to the resident not understanding safety, R1 may continue to roll himself out of R1's bed." The resident's care plan reviewed from 07/05/2014 to 12/02/2014 and there is a problem "at risk for falls related to past history of falls." Several of the interventions are as follows: place resident near nurses station when not in bed/activities, continue to encourage resident not to roll out of bed, staff will monitor every 2 hours for signs/symptoms of restlessness, staff will provide safety training and education as needed, follow up to ensure understanding, and monitor for behaviors with interventions to reduce risk for falls. R1 is severely cognitively impaired. E5/nurse supervisor interviewed 01/29/2015 at 1:30pm about how R1 is being monitored related to the multiple fall events. E5's/nurse written statement is, "resident is being monitored every two hours and as needed, based on behavior. There is no rounding log used at this facility, however the facility does document in the kiosk behaviors and care concerning resident. Resident is not in a room close to nursing station because the facility will revisit with fall committee."	F 323		
F 328	483.25(k) TREATMENT/CARE FOR SPECIAL	F 328		

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F 328 SS=D	Continued From page 11 NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to maintain proper respiratory care for one sampled resident (R13) in a total sample of 19 and two supplemental residents (R21,R22), reviewed for respiratory care. Findings include: On 1/26/15 at 10:15am R21 is sitting in the wheelchair at the bedside with 02 tubing and cannula hanging on the outside of the oxygen machine uncontained dated 1/26/15. R22 is at his bedside and his O2 nasal cannula is on the floor dated 1/19/15, and the O2 is on during this observation. E14 (Director of Social Services) states, "It's shouldn't be out like that or on the floor, I'm going to get that taken care of right away." Facility policy 1/2015 indicate that Oxygen all	F 328		

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F 328	Continued From page 12 oxygen equipment should be changed weekly on Sunday and as needed. Equipment should be free of microorganisms. On 1/26/15 at 11:00am during initial tour with E5 (Nursing Supervisor), R13's oxygen tubing was observed laying on the floor next to the bed. Oxygen was not in use at the time. E5 stated at 11:02am on 1/26/125 that, "the oxygen tubing should be put in a Ziploc or regular plastic bag so that it does not touch the floor." According to the policy Cleaning and Disinfecting Non-Critical Resident Care Items with Revision date 01/2014: Semi-critical items consist of items that may come in contact with mucous membranes (e.g. respiratory therapy equipment). Such devices should be free from all microorganisms.	F 328		