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	145647	A. BUILDING _____ B. WING _____	C 11/19/2004

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ROSEWOOD CARE CENTER OF PEORIA	**1500 WEST NORTHMOOR ROAD PEORIA, IL 61614**

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F9999	FINAL OBSERVATIONS 300.1210(a) 300.1210(b)(6) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements are not met as evidenced by : Based on observations, interviews and record review, the facility failed to assess and analyze	F9999		

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possible similarities in a series of falls from a low bed with an intact electronic monitoring device. The facility failed to follow physician's orders to remove side rails from a low bed. The facility failed to monitor and evaluate the effectiveness of cord length and various placements of the electronic monitoring device to effectively alert staff of falls for 1 of 3 sampled residents, R1. R1 fell four times in two days from a low bed with an attached electronic monitoring device. R1 died from positional asphyxia after lodging her head between the side of the low air loss and alternating pressure therapy mattress and quarter side rail.

Findings include:

Nursing notes dated 10/8/04 at 12:00 noon document R1 was admitted from the hospital by E11, registered nurse. The current physician's orders list R1's diagnoses to include: dementia, seizures, cardiovascular accident with right sided weakness, hypertension, congestive heart failure, myocardial infarction, and history of obsessive compulsive disorder. The history and physical dated 10/8/04 by the attending physician, Z1, included R1's history of falls and her recent hospitalization from a fall at home.

The initial Fall Risk Assessment form completed by E11 on 10/8/04 notes "history of falls, impaired hearing, seizure history, diabetes and determines guest at risk for falls." The Seven Day Therapy Fall Risk Screening completed on 10/15/04 by E 24, licensed physical therapist assistant, determines "dizziness, unsteady gait, requires walker, inability to understand /follow directions, balance problems, weakness, fatigues quickly,

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F9999	Continued From page 10 requires wheel chair, impaired judgment and is at significant risk for falls." The initial care plan dated 10/8/04 indicates to " use personal alarm system if indicated to alert staff when guest gets up without assistance... evaluate for positioning devices to prevent fall... low bed." The current care plan lists the intervention: "monitor for restlessness and attempt to determine cause. Inquire if (R1) is hungry/thirsty/needs to be toileted. Monitor for signs of discomfort and address." Nursing progress notes and incident reports dated 10/29/04 at 3:00 a.m. and 10/30/04 at 2:00 p.m., 4:40 p.m. and 8:15 p.m. document four falls in two days after R1 received the low bed with quarter side rails. Each incident report indicates R1 was "found sitting on floor mattress with the personal alarm system fully intact." Interviews conducted on 11/3/04 to 11/5/04 with E2, Director of Nursing, E3, Registered Nurse and Certified Nursing Assistants, CNA's, E6, E 13, E14, E16 state most of the falls from the low bed did not activate the electronic monitoring device which had been placed to alert staff of R1 's restlessness. A review of incident reports dated 10/29/04, 10/ 30/04 and interview was conducted with E2, Director of Nursing who is generally involved with care plan decisions/instructions to staff and with safety committees on 11/3/04 at 1:45 p.m. E2 confirms R1's fall out of the low bed on 10/29/04 at 3:00 a.m. had the electronic monitoring device still attached to R1, but did not sound. E2 said R1 was not injured after the three falls at 2:00 p. m., 4:40 p.m. and 8:15 p.m. on 10/30/04, but	F9999		

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verified the alarm was "intact" and did not activate. E2 said R1 was wearing the newer model of safety alarm which has a longer cord than the older model. E2 describes R1 as restless at times, able to get up and sit on the side of the bed, on a alternating air mattress, in a low bed with a quarter rail, has a soft floor mattress by side of bed, can ambulate with assistance, has continuous oxygen and able to sit in a wheelchair without a restraint. E2 explains after R1 fell on 10/9/04 from a regular bed with the side rails down, the initial care plan included full side rails to prevent further falls and a low bed. On 10/26/04 , new physician orders were received to discontinue side rails and initiate a low bed for safety. E2 said the low bed arrived on 10/28/04 with two quarter side rails. E2 verifies the side rails were not immediately removed from the low bed.

Interview on 11/9/04 at 11:10 a.m. with E23, Acting Administrator, explains that side rails would normally be off a low bed on the facility's personally owned beds. E23 indicates R1's bed was a rental bed and all of the beds are delivered with quarter side rails.

Interview with E14, CNA, on 11/4/04 at 2:15 p.m. states she worked 10/29/04 on first shift. E14 went into R1's room because she went by the room and saw "R1's feet were out of the bed... side rails up...mattress on the floor" and she told the nurse. The personal alarm was still "attached ."

Interview with E13, CNA, on 11/4/04 at 2:00 p.m. states she worked first shift on 10/30/04. E13 said before 2:00 p.m., R1 was out of the bed "on

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the floor mat sitting on her buttocks" with the alarm still intact and told the registered nurse, E 11. E13 said she found R1 because she was making rounds and not by the activation of the alarm.

Interview with E16, CNA, on 11/4/04 at 2:45 p.m. states she found R1 "out of the bed twice" walking by the room on 10/30/04 on second shift. E16 said the electronic alarm was attached to R1 , but did not "sound." E16 commented if R1 " stood up, it would have gone off." E16 said the new alarm system had a longer cord than the older ones.

An interview was conducted on 11/4/04 at 6:25 a. m. with E6, CNA, who made the last round at 4: 50 a.m. on 10/31/04. E6 said R1 was wide awake and sitting on the side of the bed with the electronic alarm on. The alarm had not activated. E6 said R1 had also been on the floor mat another time during the night and the electronic monitor had not activated. E6 explains the reason she went into the room was to do routine vital signs related to a fall the night before.

An incident report dated 10/31/04 at 5:30 a.m. indicated R1 was "found on the floor and head and upper part of her neck in between the side rail and the bed...unable to assess fully... transferred to bed." Two interviews were conducted on 11/3/04 at 2:50 p.m. and 11/5/04 at 10:30 a.m. with E3, the nurse who found R1's body. E3 states she went into the room and turned on the light at 5:30 a.m. The head of the bed was facing the doorway as E3 entered the room. R1's body was off the bed, kneeling on both knees and leaning against the bed. E3

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could not see her face. E3 describes "her head was pointing straight down" wedged in between the alternating air mattress and side of the railing in the "up" position. R1's head was lodged so tight, E3 could not lift her out alone. E3 called for help. E6, E7 and E10, CNA's, helped free R 1 from between the railing and bed in order to assess. E3 states there was "no signs of life...no pulse...no respirations and the area under the eyes and lips were purple." E3 notes the oxygen tubing was still on her face and the electronic monitoring was attached to the gown. E3 confirms the personal body alarm did not activate and the reason she went into the room was to give medication.

E3 said the new electronic monitoring alarms have a longer cord than the older models. R1 had a new alarm device and it was attached to the quarter rail away from the wall. E3 does not recall the alarm being activated that night by R1 's restlessness. Nursing notes by E3 dated 10/31 /04 at 4:50 a.m. documents, "R1 attempted to get out of bed. Assisted to bed with one...alert confused...incontinent of stool and urine."

E3 said the electronic monitoring device was working properly. E3 said the cord was long enough to be still attached to R1 when she was out of the bed and on the floor. Record review of nursing notes dated 10/31/04 at 5:40 a.m. by E3 writes, "electronic monitor system loose on bed and end clipped to R1." The newer model of electronic monitoring device was observed on 11/ 3/04 attached to the bed rail with a cord extending 2 feet 9 inches in length from the alarm box. The alarm could slide up and down the length of the 2 feet 4 1/4 inch railing.

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F9999	Continued From page 14 An interview was conducted on 11/5/04 at 2:15 p. m. with E18, certified occupational therapy assistant, who worked with R1. E18 explains R1 could only follow one step commands only if the hearing aid was adjusted correctly. R1 would never volunteer information, but respond with a couple of words. R1's upper extremity was weak on both sides, could only raise both arms 90 degrees and had a "partial loss" to both hands. The Occupational Therapy Evaluation/Treatment Plan done on 10/9/04 by E25, occupational therapist registered/licensed notes " functional activity tolerance: 2-3 minutes." An interview was conducted on 11/5/04 at 2:35 p. m. with E9, licensed physical therapy assistant, who worked with R1. E9 states she would give visual cues to R1 to demonstrate what R1 should do because of the dementia. When asked about R1's death, E9 explains she "could not see how R1 could get out of that position without someone assisting her...and R1 would not be able to figure out how to get out of that position." E2 confirms no changes or interventions were made by staff to prevent future falls and to alert staff to R1's restlessness after a series of falls from the low bed. This includes the first fall at 3: 00 a.m. on 10/29/04 to the three falls at 2:00 p.m. , 4:40 p.m. and 8:15 p.m. on 10/30/04. The electronic monitoring device failed to alert staff to R1's movements because the alarm was still attached to R1 as she sat on the floor. E2 confirms the electronic monitoring device was attached to the side rail on the same side where R1's head was wedged next to the mattress on 10/31/04.	F9999		

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F9999	Continued From page 15 A telephone interview was conducted with the Coroner, Z3, on 11/4/04 at 1:10 p.m. Z3 gave the preliminary finding as "positional asphyxia" for R1's death.	F9999		