STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145908	A. BUILDING _____ B. WING _____	12/01/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD TERRACE NURSING HOME	2313 NORTH ROCKTON AVENUE ROCKFORD, IL 61103

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F9999	FINAL OBSERVATIONS 300.1210a) 300.1210b)4) 300.1210b)6) 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. Personal care shall be provided on a 24-hour, seven day a week basis. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. An owner, licensee, administrator, employee or agent of a facility shall not neglect a resident. These regulations are not met, as evidenced by the following: Based on observation, interview and record review the facility failed to provide supervision to prevent accidents for residents residing on the alzheimer unit by: a. having only 1 staff member assigned to the unit to provide care and supervision for 13	F9999		

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F9999	Continued From page 31 residents with alzheimer's dementia and behaviors; b. not securing empty rooms to prevent confused residents from entering them without staff knowledge; c. not having an effective way for staff to have visual control over the entire resident care area. These failures resulted in R1 having large bruises of unknown origin to her buttocks, chest, bilateral breasts, forehead, chin, bilateral hip, right flank, bilateral knees, and left inner thigh which were discovered on 11/14/04 . R1 had 5 additional injuries of unknown origin. On 11/2/04 R10 was observed to have large bruises of unknown origin on his buttocks and left thigh. R10 had 2 additional injuries of unknown origin. R8, R11, R 15, R19 and R20 all had injuries of unknown origin or fell without staff observation. This is for 5 of 15 residents in the sample (R1, R8 , R10, R11 and R15) and 3 additional residents (R18, R19 and R20). The findings include: 1. R1 has diagnoses of Alzheimer's Dementia, Urinary Tract Infection, Rib Fractures, Esophagitis and Anxiety per physician's orders for November 2004. The nursing assessment of 8/18/04 documents that R1 has short and long term memory deficits and is severely impaired in her decision making skills. The assessment further documents that R1 displays wandering behavior and is resistive to care. R1 currently resides in the facility's secured Alzheimer's Unit for supervision.	F9999		

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F9999	Continued From page 32	F9999		

During entrance tour on 11/16/04 at approximately 9:15 a.m., surveyor was made aware of R1's bruises. E9 (CNA) expressed concerns to the surveyor that these injuries were very extensive and happened over a very short period of time.

R1's injuries were observed on 11/16/04 at approximately 9:30 a.m. in her room. R1 was observed to have large bruises covering her entire sternum and bilateral breasts, left and right hip to include the flank, chin, forearm, wrist forehead, bilateral knees and inner thigh.

Nurse's Notes dated 11/16/04 document that R1 had extensive bruising to include the following: a 3.7 cm bruise on the right side of the forehead; a 1.2 cm bruise on the right chin; a 1.2 cm x 1.8 cm bruise on the right knee; a 1.3 cm bruise on the left knee; a 6.1 cm x 11 cm bruise on the left flank; a 4.2 cm bruise on the left side of the chin; a 1.3 cm bruise behind the left ear; a 43 cm x 23 cm x 20 cm x 22 cm bruise over the right flank; and a large bruise covering the entire sternum and both lower aspects of the breasts. R1 also was noted to have bruises on her right forearm, left inner thigh and left hand.

During interviews conducted on 11/16/04 at approximately 9:15 a.m. E1 (Administrator) and E2 (Director of Nurses) said that the cause of these injuries had not been determined. E2 (DON) said that the staff she had talked to was not sure how the injuries occurred.

Review of the facility's Incident/Accident Reports for R1 showed that the following incidents occurred on the Alzheimer's unit:

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F9999	Continued From page 33 1. on 7/20/04 a bruise was found on R1's upper left ear; 2. on 7/24/04 R1 was observed to have lower lip swelling with discoloration origin unknown; 3. on 7/29/04 during R1's shower a CNA observed reddened areas on her shoulders, back, buttocks and right hip origin unknown; 4. on 8/3/04 R1 fell to the floor while walking in the hallway and staff were not able to intervene; 5. on 9/21/04 R1 was observed to have discoloration on the left side of her face and swelling in her left hand origin of injury unknown; 6. on 9/30/04 R1 suffered a laceration on the posterior side of her head origin of injury unknown; 7. on 10/31/04 R1 was found on the floor in her room; R1 had a total of 9 incidents in a 5 month period while housed on the secured Alzheimer's Unit R1's care plan dated 10/5/04 states, "Resident represents a reasonable risk for elopement related to current attempt to leave the facility without a responsible escort." The care plan approaches state that staff are to monitor R1's were-abouts from time to time and place resident in high traffic areas when possible. Staff are to respond to door alarms as quickly as possible and have all residents accounted for immediately. 2. R10 has the following diagnoses Parkinson's Disease, Organic Brain Syndrome, Asthma and Alzheimer's Disease per physicians's orders for November 2004. The nursing assessment of 8/12/04 documents that R10 has short and long	F9999		

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F9999	Continued From page 34 term memory deficits and is moderately impaired in his decision making skills. Review of the facility's Incident Accident Reports for R10 showed that the following incidents occurred while on the Alzheimer's unit: 1. on 6/1/04 R10 was found on the floor; 2. on 7/7/04 R10 was noted to have an injury to his mouth with several teeth found on a counter injury unknown; 3. on 8/2/04 R10 fell to floor while leaving the activity/dining room; 4. on 9/3/04 R10 fell to the floor while attempting to go to the bathroom independently; 5. on 10/13/04 R10 fell while in his bathroom striking his head leaving a baseball size hole in the wall underneath the sink; 6. on 10/18/04 R10 was found to have a laceration to his left eyebrow origin of injury unknown; 7. on 10/19/04 found on floor at 6:30 a.m.; 8. on 11/2/04 R10 was observed to have bruising on on his groin, thigh and left buttock origin unknown; 9. on 11/15/04 R10 was observed to have a 3 inch round bruise on the back aspect of his left calf origin of injury unknown; 10. on 11/16/04 R10 was resistive to staff redirection and fell on another resident resulting in the other resident sustaining a hip fracture. R10 had a total of 12 incidents in a 6 month period. Review of R10's care plan dated 7/8/04 states that R10 is at high risk for falls and injury related to cognitive loss and poor balance. The care plan approaches/interventions state, "check where-	F9999		

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F9999	Continued From page 35	F9999		

abouts every hour; intervene to prevent further or future falls; staff is to supervise when patient is ambulatory."

3. a.) Review of the the facility's Accident/Incident Reports for the previous 6 months documents that R8 had a bright red area to his nose. This injury was classified by the facility as an injury of unknown origin.

b.)R11 was pushed to the floor by another resident.

c.)R15 had 2 unwitnessed falls while on the Alzheimer's unit.

d.)R18 had to 2 unwitnessed falls and 1 incident were another resident repeatedly ran his wheel chair into her legs.

e.)R19 was found laying on the floor in the hallway with blood covering his face. A second fall occurred when R19 was leaving the dining room requiring him to be sent to the emergency room for sutures to close a laceration on his left forehead.

f.)R20 stood from his chair to follow a staff member and fell hitting his knee and left hip. R20 was found laying in the hallway. The time of this incident could not be determined as no time was documented on the incident report.

Review of the facility's Nursing Floor Assignments from June 2004 to November 15th 2004 showed that there was only 1 staff member assigned to work on the Alzheimer's unit for each shift. The only exception was on the p.m. shift on 11/13/04 and 11/14/04 where 2 CNA's worked.

During an interview conducted on 11/19/04 at approximately 10:00 a.m. E2 (Director of Nurses) verified that prior to 11/16/04 there was only 1

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F9999	Continued From page 36 staff member assigned on the Alzheimer's unit. The daily census was reviewed and showed that on average the daily census of the unit remained between 9 to 14 residents. E2 verified that the census breakdown was accurate. During a phone interview conducted on 11/23/04 ,E1 (Administrator) was asked if the staff assigned to the Alzheimer's unit had received any additional training to work with this population and E1 responded "no".	F9999		