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LICENSURE VIOLATIONS

LICENSURE VIOLATIONS

300.1210 a)
300.1210 b)3)
300.1220 b)3)
300.1220 b)7)
300.3240 a)

300.1210 General Requirements for Nursing and Personal Care

a) 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.

b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the

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nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition.

7) Coordinating the care and services provided to residents in the nursing facility.

300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not neglect a resident. (Section 2-107 of the Act)

These requirements are not met as evidenced by :

Based on record review, and interview the facility failed to ensure that care provided to residents with a history of falls and significant injury included measures to minimize further falls to assure residents safety.
1. R20 fell multiple times prior to a fall on 9/15/05 . R20 sustained a head injury in a 9/15/05 fall which resulted in a large Subdural Hematoma. R 20 expired on 9/15/05.
2. R18 had 6 documented falls in 51days. This resulted in R18 sustaining multiple injuries including a head laceration, right wrist fracture on 5/13/06, and decreased ability to ambulate.
3. R12 experienced 12 falls in 5 months, three of these falls resulted in injuries and one fall on 05/

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21/06 resulted in a broken nose.

The facility also failed to assess R20's neurological status after she fell on 9/15/2005 at 6:50am, striking her head on the floor. The facility failed to monitor R20's level of consciousness after the fall. These failures resulted in R20 being discovered unresponsive 40 minutes later when the nursing assistant entered R20's room. R20 suffered a large Subdural Hematoma and expired on 9/15/05.

The findings include:

1. R20's Physician Order Sheet of September, 2005 documents that R20's diagnoses include Congestive Heart Failure, Coronary Artery Bypass Graft, Cerebrovascular Accident, Anxiety Disorder, Osteoporosis and Osteoarthritis.

R20's Nursing Notes dated 2/15/05 document that R20's left shoulder had dark purple bruising 2 centimeters round, left outer abdomen 2 areas of purple bruises, left parietal lobe bump. R20 said she went to fill a glass of water and when she turned she fell on the floor.

R20's Fall Risk Assessment dated 3/18/05 assessed R20 as having a score of 9. (Score of 10 or more is high risk). Fall Assessment dated 6/8/05 assessed a score of 7.

R20's Annual Minimum Data Set (MDS) dated 6/8/05 assessed R20's standing balance and documents that R20 required partial physical support. The Fall Resident Assessment Protocol (RAP) dated 6/8/05 has a care plan decision of " do not proceed" and there is no rationale

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documented.

Facility Incident Report dated 7/31/05 documented that R20 stated she was "dizzy," fell to the floor, and was sent to the emergency room . R20 was admitted with a fractured left wrist.

R20's Nursing Notes for 7/31/05 at 9:50 PM documented that a Certified Nursing Assistant (CNA) found resident laying on the floor on her back. R20 said she had to go the bathroom and got dizzy and fell. R20 stated I must of hit my roommate's bed rail with my head. Noted to have a large hematoma on the right side of eye, eye swollen shut, ice pack applied. R20 had an abrasion to the top of the right knee. R20 voices she hurts very bad all over especially side of face on the right side, right knee, left hip, and back. Nursing Note for 8/1/05 documents that R20 was admitted to hospital with a fractured left wrist.

R20's Hospital Operative Report dated for 8/4/05 documents that R20 had recurrent presyncopal and syncopal episodes with a head contusion leading to facial ecchymoses. (bruising). Hospital Report History Report of 8/4/05 documents that R 20 is to have a work up for Syncope, and that R 20 has had multiple falls over the last year.

R20's Minimum Data Set Assessment of 8/29/05 assessed R20 as requiring limited assistance of one person for toileting. Standing balance was assessed as requiring partial physical support.

R20's Minimum Data Set (MDS) assessment of 9 /8/05 assessed R20 as requiring limited assistance of one person for transfer and walking in room. Standing balance was assessed as

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partial physical support required.

The facility Incident Report shows that on 9/15/05 R20 lost her balance fell to the floor, and was sent to the Emergency Room. R20's admitting diagnosis was Subdural Hematoma.

Nursing Notes dated 9/15/05 document at 6:50 AM R20 was found on the floor by a Certified Nursing Assistant (CNA). R20 was on the floor between the bed and the bathroom. It is documented that R20 had a .5 centimeter laceration to the right eyebrow with small amount of bleeding. Right eyebrow was cleansed, Band-Aid and ice applied for puffiness, and R20 was transferred into her recliner. There were no neurological signs documented at the time of injury.

At 7:30 AM R20 was found sitting in the recliner, eyes closed, head down, and unable to be aroused. There are no neurological signs or level of consciousness recorded initially or up until the time that R20 was transported to the hospital emergency room by emergency rescue personnel at 8:00 AM.

E11 Licensed Practical Nurse (LPN) was interviewed on 6/22/06 at 9:35 AM. E11 was asked about the incident of 9/15/05. E11 said " I remember when (R20) fell, an aide got me, the resident told us what happened, she had a cut on her eye with swelling. I put the neurological signs on scrap paper. I don't know what to tell you, the neuro signs are probably on a piece of scratch paper somewhere, don't know."

E2 Director of Nursing was interviewed at 9:40

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AM on 6/22/06. E2 said "I walked into (R20's) room, saw what kind of condition she was in, and said get me oxygen and call 911. I have told the nurses that specific times should be written in the nursing notes, and all assessment information."

Hospital Admission Note of 9/15/05 documents that R20 was sent to the emergency room after trying to get up to the washroom and fell with the development of significant confusion. R20 underwent a Computerized Tomography (CT) scan of the forehead which revealed a large acute right subdural hematoma, possible minimal left subdural hematoma, significant soft tissue swelling right periorbital and right temporal regions. She was comatose on presentation to the emergency room.

Hospital Nursing Admission Assessment dated 9/15/05 documents that R20 expired at 11:23 AM.

Review of facility Head Injury Protocol document shows:

Paragraph 1) Initial assessment and documentation, followed by assessment and documentation every thirty minutes for 4 hours.

Paragraph 2) documents: Assessment and documentation are to include the following: Neuro's consciousness -mental changes, pupils, or findings, hand grips, able to move extremities.

On 6/22/06 at 11:00 AM E16 Assistant Director of Nursing said "We are changing our neuro policy and procedure now."

Review of R20's Fall Care Plan for Fall Risk

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dated 8/9/05 through 9/15/05 documents R20 is at risk for falls related to an unsteady gait and history of falls, and not calling for assistance . The care plan does not address R20's specific risk factors of syncope, the need for frequent monitoring, and frequent toileting assistance to prevent falls. The last date of a new approach to R20's care plan is dated 9/15/05 for a electronic monitoring device to be placed on bed and recliner.

2. On 6/21/06 at 12:05pm R18 was observed sitting in a wheelchair in the activity area on wing B1. R18 was observed to be wearing a splint to her right arm. R18 was observed taking both of her feet off the foot pedals on her wheelchair and placing them on the floor. R18 then started to push herself up out of the chair. The activity aide was in the room alone with R18 and eleven other residents with cognitive impairment. The activity aide turned around from facing the television and placed R18's feet back on her foot rests.

R18's physician order sheet dated 6/1/06 showed diagnoses including Alzheimer's and Dementia. Minimum Data Set (MDS) dated 4/30/06 assessed R18 as having cognitive impairment, short term memory loss and needing limited assistance of one person for ambulation.

R18's nurses notes showed, 4/9/06, "(R18) has a bruised right upper shoulder and a bruised right hip.... Bruises measure: right shoulder 10cm long by 8cm wide. Right hip 18cm long by 10cm wide."; 4/10/06, "Certified Nursing Assistant (CNA) reports that (R18) told her that she fell (4/9/06) in her room."; 4/30/06, "(R18) found lying on the floor in front of her bathroom.... (R18) has a

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F9999	Continued From page 44 red mark to the left side of spine.... (R18) was placed in the recliner chair." R18's nurses notes showed, "5/5/06 at 12:30am, Staff called nurse to the room to assess (R18's) left foot...left foot dark purplish in color, increased edema noted past the ankle bone. Tender to the touch. Unable to explain how it happened. Left upper thigh very large bruise of dark purple noted . 1:50am, (R18) found on the floor between her bed and the wall. Tabs monitor still attached to gown but not going off. (R18) unable to tell what happened. She is very confused. (R18) denies striking her head. Right shoulder slightly red.... Staff assist (R18) back to bed.... 1:45pm, Out to the hospital X-ray department for left hip and ankle." Review of R18's record showed no neurological checks or flow sheet were initiated after R18 fell on 5/5/06. R18's nurses notes showed, On 5/10/06, "(R18) slid out of the recliner chair...."; 5/13/06 at 9:10 pm, "Found (R18) on the floor in B1 lounge area lying on her right side in a pool of blood from her head...." 9:50pm, "All the time (R18) was in the recliner chair (R18) had tabs monitor on. Tabs monitor did not sound when (R18) got up. Fall was unwitnessed." 5/14/06 at 12:10am." (R18) returned to the facility, neurological checks started. Redness noted to right lower arm...." R 18's emergency room discharge instructions dated 5/13/06 showed, "You have sterile strips holding your wound together...." R18's nurses notes showed, On 5/14/06 at 9:30 pm, "(R18) up in wheelchair, keeps bending forward to pick something up from floor. Upon moving (R18's) right wrist she cried out in pain.	F9999		

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Right wrist edematous bruised and warm to touch . Bruise to right wrist is an old bruise." 11:30pm, "(R18) unable to grasp nurse's hand without experiencing pain." R18's X-ray dated 5/15/06 showed, "Nondisplaced minimally impacted fracture distal metaphysis of the right radius." On 5/29/06 R18's notes showed another fall. This is a total of 6 falls in 51 days.

R18's risk for falls care plan dated 3/21/06 was revised 5/4/06. No revisions were made to R18's risk for falls care plan after 5/4/06.

On 6/21/06 at 12:15pm, E14 (Certified Nursing Assistant - CNA) was asked why R18 was currently in a wheelchair and if R18 was able to ambulate? E14 replied, "(R18) fell out of bed and every since she fell she has been different. (R18) doesn't walk like she used to. (R18) used to walk all over and liked to sweep."

3. Physician's Order Sheet dated 6/06 listed R12 's diagnoses to include Parkinson's Disease, Chronic Back Pain, Edema and Dementia.

Minimum Data Set (MDS) dated 4/6/06 assessed R12 as moderately impaired for decision-making with short term memory loss. MDS assessed R 12 as needing extensive assistance of two staff to walk in room/corridor. R12 requires partial physical support for sitting balance.

Falls Risk Assessment documents R12 is a high risk for falls.

Documentation shows R12 had 12 falls in 5 months. Nurse's notes document the following falls for R12:

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F9999	Continued From page 46 2/19/06 (5-3), "Resident found in hall bathroom on the floor lying on right side...wheelchair (w/c) beside him in upright position with lap buddy in place." 2/21/06 (7:45pm), "Found sitting on floor on buttocks with w/c nearby." 2/27/06 (9:30pm), "Found on floor in room next to bed in puddle of urine." 3/10/06 (3-11), "Resident fell between hallway by break room-resident was found hanging onto rails on wall sitting on floor in front of wheelchair." 3/19/06 (6:15pm), "Slipped in urine and BM (bowel movement)...skin tear to right knee." 3/28/06 (7pm), "In NW bathroom on A wing-door closed- resident found on floor next to bench in shower room...w/c over by toilet." 3/29/06 (8pm), Resident found on floor on right side, in room 121. Small hematoma on right side of head." 4/2/06 (10am), "Resident in dining room for breakfast, attempted to stand, lost balance and fell." 4/10/06 (4:15pm), "Resident stood up from wheelchair and sat back down, brakes were not locked, fell to the floor." 4/13/06 (3pm), "Resident fell on C wing down hall, resident stood up at handrail, twisted top left, slid to floor."	F9999		

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5/21/06 (4:15am), "Resident laying on right side next to the bed. Blood on the floor coming from laceration to bridge of nose and laceration on his forehead and right elbow has skin tear...sent to hospital." Incident report dated 5/21/06 documents that R12 returned from hospital with diagnosis of a fractured nose.

6/7/06 (3pm), "Resident fell in room, got out of bed by himself..."

On 6/22/06 at 10:05am, E12 (Physical Therapist) stated, R12 has episodes of leaning and is not able to wheel self because of body posture so a tray is used on his wheelchair."

On 6/22/06 at 11am, E5 (LPN) was interviewed about what the facility has done to decrease R12 's falls. E5 stated, "We put him in a recliner at the nurse's station, used bed and chair alarms and a breakway lap cushion device which he could remove. Because of leaning, we put a tray in front of him. It helps keep him sitting up in the wheelchair."

R12's care plan dated 5/22/06 documents, " Resident is at risk for falls related to poor safety awareness, history of falls, attempts to get up without assist. Resident ambulates with hand over hand assist and gait belt. APPROACHES include: Keep resident out of room for staff to monitor while awake, staff to ambulate resident from employees lounge into dining room to sit in dining room chair, bed alarm on when in bed, chair alarm on when in chair."

R12's care plan does not address leaning as a

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F9999	Continued From page 48 problem for R12, nor does it address the use of the tray table as an approach. It does not show risk factors or interventions to reduce the number of falls for R12. On 6/19/06 at 12:20pm, R12 was in wheelchair with tray table attached. R12 propelled himself into another resident's room. Dietary staff saw resident but did not remove him from the room. On 6/22/06 at 10:40am, R12 was observed in the A wing bathroom alone. R12 was seated in wheelchair with tray table attached. Surveyor notified E11 (LPN) of R12's whereabouts. R12 was observed on all days of the survey propelling self with feet in the wheelchair with a tray table attached. (A)	F9999		