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	145911	A. BUILDING ______ B. WING ______	C 04/11/2006

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HERITAGE MANOR-GIBSON CITY	**620 EAST FIRST STREET** **GIBSON CITY, IL 60936**

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F9999	FINAL OBSERVATIONS LICENSURE REPEAT TYPE "A" VIOLATION 300.1010h) 300.1210b)3) 300.3240a) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee	F9999		

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or agent of a facility shall not abuse or neglect a resident.

These requirements are not met as evidenced by :

Based on record review and interview the facility to comply with its Plan of correction from the 8/17/05 survey by failing to ensure that its policies and procedures for physician notification for resident significant changes of condition were followed. Specifically, the facility failed to notify the physician of a fall with a head injury of one (R 3) of six residents sampled for falls and injuries. A certified nurses assistant (CNA) failed to notify the charge nurse that R3 was not responding to stimuli when taking her vital signs post fall. Also, the charge nurse failed to do the complete neurological assessment required by facility policy for all residents with suspected head injury. Failure of staff to notify the physician and to fully monitor R3 resulted in a delay in treatment for the worsening head injury. R3 expired at the hospital from a Subdural Hematoma as the result of the fall.

Findings include:

R3's most recent Physician's Orders dated March of 2006 showed R3 had diagnoses of Paralysis Agitans and Abdominal and Pelvic Pain. Review of R3's most recent Minimum Data Set (MDS) dated 2/23/06 indicated R3 had moderately impaired cognition, was independent or needed supervision for most activities of daily living, and needed supervision for ambulation.

Facility document titled, "(Facility) Occurrence

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F9999	Continued From page 11 Report #30092" dated 3/12/06 showed that R3 had suffered a fall in the early morning hours of 3/12/06. The report stated the fall occurred in R3's room at approximately 12:45 AM on 3/12/06. The report goes on to state R3 sustained "Head Trauma" with a "1.7 cm (Centimeter) laceration to her left periorbital area" and a "2.3 cm jagged laceration to upper lip just left of center..." R3's Nurses Notes dated 3/12/06 at approximately 12:45 AM showed R3, although injured from the fall, was initially conscious and responding to caregivers. The notes stated, "Res (resident) was asked about nausea, lightheadedness et (and) dizziness et (and) denied all. Pupils were reactive et (and) equal at this time." Further review of the notes showed R3 continued to respond. The notes went on, "...Res (resident)...stated she was going to the bathroom (when she fell) et (and) still needed to go - assisted (up) to bathroom for toileting, then stood (with) assistance (and) ambulated back to her bed..." Review of a 1:00 AM note showed "B/P (blood pressure) 142/89 T (temperature) 99.2 pulse 127 R (respirations) 20 Pupils remain equal and reactive - Res (resident) responding appropriately but did not hold ice in place to mouth..." Review of intervening nurses notes (at 1:15 AM and at 1:30AM) showed the resident continuing to respond appropriately. However a nurses note dated 3/12/06 at 3:05 AM showed the resident had become non-responsive. The note stated, "...when this LPN (Licensed Practical Nurse) went to do neuros - was unable to get any response from res (resident)..." Review of Nurse Notes showed the physician was finally notified at 3:40 AM and R3 was sent to the hospital.	F9999		

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F9999	Continued From page 12 A hospital document dated 3/12/06 at 9:29 AM showed R3 had suffered, "... Large right subdural hematoma with extensive subfalcine herniation and extensive left maxillofacial injuries..." The report describes, "...extensive left facial fractures with fractures of the anterior wall and lateral wall of the left maxillary sinus..." A "Medical Examiner's - Coroners Certificate of Death" dated 3/23/06 demonstrated R3 died in the hospital at 12:40 PM on 3/13/06. The certificate stated the cause of death as "(a) SUBDURAL HEMATOMA Due to, or as a consequence of (b) fall." The certificate further stated the injury occurred because the resident " Fell, landing on her face" at the "nursing home." A facility policy dated 8/2005 is titled "Guidelines For Physician Notification Of Change In Resident Condition." The policy was identified by the Director of Nurses (DON) on 3/31/06 at approximately 10:00 AM as the policy in effect at the time of R3's fall. The policy stated..."Staff observe, document and communicate to the physician changes in resident condition promptly. Change in condition may include, but is not limited to the following:...change in mental status ...abnormal or deviation from normal vital signs... falls with or without injury..." A facility document not dated but titled "Head Injuries" indicated vital and neurological signs are to be taken: "a. BP (blood pressure) & P (pulse) q (every) 15 minutes times 4; check pupils b. BP & P q 30 minutes x 2; check pupils c. Complete vital signs and neurological signs q4h (every 4 hours) x 24 hours...4. Utilize neurological Assessment Tool to document findings..."	F9999		

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A facility document titled "Neurological Assessment" with (R3's) name at the bottom documents the times vital signs and neuro assessments were done on R3 on 3/12/06. The listed times that contained data were "12:45 AM, 0100 (1:00 AM), 0115 (1:15 AM), and 0130 (1:30 AM)." The time slots of 0200 (2:00 AM) and 0230 (2:30AM) were blank.

Interview with E3 LPN on 3/31/06 at approximately 9:40 AM confirmed she did not report the fall to the Physician, did not report a change in vital signs to the physician, and did not do a complete neurological assessment as required by facility policy. E3 stated, "...At about 12:30 (AM)-about 45 minutes after she fell I noticed her blood pressure was a little higher. She was still responsive and talking to us. Her blood pressure was about 154 over something and the pulse was 120 something. My judgement at that point was that I wanted to send her to the hospital. We have instructions to call the DON before calling the doctor after hours... I told her (the DON) I was concerned about the resident and I wanted to send her out. She (R3) was chilling and shaking and then I put a blanket on her... She had stated she was cold. I called (the DON) because I felt there was a possibility she (R3) was going into shock...Something inside was telling me something was not right with this resident. When I called the DON I told her twice what the blood pressure and pulse were and that they were elevated and that I needed to send her out (to the hospital). The DON stated, 'we don't want to send them out unless we have to.' (Later) when I talked to the DON she stated she thought I had already called the doctor...This is no longer

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a directive (that the DON must be called before the physician). I took it as a directive not to call the physician...So the Physician was not called... I was on the phone with the DON for a while and I tended to another patient. I sat down to do some paper work and I let time get away from me and I realized I was late by an hour doing the next set of neuros (neurological assessment). When I went in at 3:00 AM R3 was non-responsive. Very shortly about 3:25 (the) ambulance got here and took her to (the) hospital ."

Interview with E2, Director of Nurses (DON) on 3/31/06 at approximately 10:40 AM confirmed a policy that required the nurses call her before calling the Physician. The DON stated, "Yes, the physicians were complaining that the nurses were calling them when they (the nurses) did not have all their ducks in a row. I instituted that policy so I would be able to make sure the nurses were making necessary physician contact. I had a sign posted at the nurses station that stated the nurses had to call me before calling the physician, but emergencies or life threatening events were exempt."

A facility document identified by the DON as the directive posted at the nurses station about physician notification demonstrated the following. "ATTENTION NURSES NO CALLS ARE TO BE MADE TO ANY M.D. DURNING [SIC] OFF HOURS UNTIL [SIC] AFTER SPEAKING TO ME UNLESS LIFE THREATENING NO EXCEPTIONS!!!!! This notice had the DON's name and phone number at the bottom.

Interview with Z1, physician on 3/31/06 at

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approximately 2:30 PM showed he expected to be notified of a fall with a head injury. Z1 stated, " I would certainly have thought they (facility staff) should have called me. For a head injury they should have notified me."

Interview with E6 CNA on 3/31/06 at approximately 10:55 AM confirmed R3 was not responsive at 2:00 AM or at 2:30AM on 3/12/06. E6 stated, "...as she (R3) got into bed she said she was cold and we put an extra blanket on her. We took her VS (vital signs) again. We checked on her every 15 minutes for the first hour or hour and fifteen minutes and then every one-half hour after that. I went to take her vital signs at 2:00 AM and 2:30 AM (and) she slept through these vital signs... When I told the nurse she (R3) had slept through her vital signs she became alarmed. This was about 3:00 AM. We went down and found the resident(R3) non-responsive...I did not realize the nurse missed the neuro checks..."

Interview with E3 LPN on 4/4/06 at approximately 9:30 AM indicated she did not give specific instructions to the CNA. E3 stated, "I did not give (E6 CNA) any specific instructions on what to watch for on R3. I did not tell her to report to me if she found R3 non-responsive. I would have thought E6 would have known to notify me if R3 was non-responsive..."

(A)