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F9999	FINAL OBSERVATIONS	F9999		

LICENSURE VIOLATIONS

LICENSURE VIOLATIONS

300.1210a)
300.1210b)3)
300.1210b)6)
300.3240a)

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.

6) 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

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F9999	Continued From page 14 that each resident receives adequate supervision and assistance to prevent accidents. 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident (Section 2-107 of the Act). These requirements are not met as evidenced by: Based on interview, and record review the facility failed to supervise a resident at high risk for falls (R3), by leaving R3 unattended. The facility failed to follow facility policy by repeatedly failing to assess the ongoing fall risk (after multiple and repeated falls) or make changes to the plan of care for R3. R3 is one of 13 residents sampled for falls and injuries. This failure resulted in R3 falling from an upright position after standing up from his wheelchair. The fall caused multiple facial fractures and head injuries to R3. The facial fractures resulted in the death of R3. Findings include: The most recent Physician's Orders dated March of 2007 showed R3 was a resident with diagnoses of Dementia/Alzheimer's Type, Cerebral Vascular Accident, Degenerative Joint Disease, and Glaucoma. The Minimum Data Set (MDS) dated 2/26/07 showed R3 was cognitively impaired and had periods of altered perception or awareness of surroundings. The MDS also indicated R3 was an extensive assist of two for transfer and needed the extensive assist of two people for ambulation. R3 was an extensive to total assist for all Activities of Daily Living	F9999		

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(ADL'S). Further, the MDS indicated R3 was not able to attempt the standing or sitting balance test.

An Incident Report dated 3/20/07 at 5:00 PM indicated R3 sustained a fall from his wheelchair. The report stated, "...Heard alarm sounding responded in direction of alarm. Found resident (R3) sitting on floor in front of nurses station. Resident in upright position nose bleeding. Noted with puncture site under bottom lip..." A Physician's Order dated 3/20/07 stated, "Transport to (the hospital) for (treatment and evaluation per ambulance)."

A hospital Radiology Report dated 3/20/07 showed R3 with multiple facial fractures and a subdural hematoma. The report stated, "...Status post-fall in an 88 year old male. Patient struck his nose when he fell. There are multiple lacerations on his face. Findings: CT (Computerized Tomography) Head: ...There is a 7mm (millimeter) right subdural hematoma. This appears subacute... CT Facial Bones: There are comminuted fractures of the maxillary sinuses bilaterally. This includes all the sinus walls including the orbital floors... There is a fracture of the pterygoid plates. The left zygoma appears fractured. The nasal septum is fractured. Fluid fills the entire maxillary sinuses. There is fluid seen in the ethmoid sinuses and sphenoid sinuses with a very small amount seen in the frontal sinuses...."

Z2, Emergency Room Physician, on 3/29/07 at approximately 7:15 AM, described the extent of R3's injuries. Z2 stated, "He (R3) came in with facial fractures. He had an old (sub-acute) sub-dural hematoma. Older than 3-4 days...The

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subdural hematoma was probably about 30 days old...That is why he was sent (out). Subdural hematomas come only from trauma - significant trauma. He (R3) had a Broken Nose - a La Forte Fracture - some teeth were knocked out. A La Forte Fracture is a significant facial injury. You get it (usually) by an MVA (Motor Vehicle Accident) or by getting hit in the face with a baseball bat...To receive that type of a fracture (the patient) would have had to fall a long way..."

Z1, Primary Care Physician, on 4/4/07 at approximately 1:00 PM, per telephone, indicated R3 had been the victim of numerous falls over a long period of time. Z1 stated, "I was notified of a number of falls. He (R3) had one in February of 2006, one in March of 2006, one in April 2006, one in May of 2006, two in June of 2006, two in August of 2006, one in October of 2006 and he was found on the floor in February of 2007." Z1 indicated the facility reported the falls but did not seek consultation. Z1 stated, "I don't remember them asking what they should do, they were just reporting the falls..."

A "Falls Risk Assessment" dated 2/26/07 showed R3 was at a high risk for falls.

A facility policy was reviewed, dated January of 2007. This policy was identified by E2, Director of Nurses (DON), as the policy in effect when R3 suffered a fall that resulted in facial fractures and ultimately his death. The policy titled, "Accident Prevention Program" stated "residents will be assessed upon admission to determine their susceptibility to falling." The policy further stated, "...If a resident is considered at high risk for potential falls, this assessment will be documented on the care plan and goals

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F9999	Continued From page 17 developed to reduce/prevent falls. These goals will be reviewed at least every 90 days and as necessary to determine progress..." Also, within the same policy it is stated, "...Fall/Incidence Report:...5. Incident/Accident Reports will be reviewed during the monthly Safety Committee Meeting . Appropriate action and/or recommendations will be taken/made as needed..." A review of R3's Falls Care Plan dated 3/1/07, showed R3 did not have any new interventions to address falls when out of bed, since April of 2006. Review of the Care Plan demonstrated R3's last intervention to address falls when out of bed was "Restraint Free Personal Alarm" added in April of 2006. Interview with E2, the Director of Nurses (DON), on 4/6/07 at approximately 1:00 PM, confirmed new interventions were not added. E2 stated, "No, we did not make any changes to his care plan after April of (2006) - none were needed. Yes, he had numerous falls but we were doing everything we could do. No, I did not consult the Physician or Physical Therapy, or Occupational Therapy about any new or different interventions. We did discuss his falls in the falls meetings but we did not keep minutes. We made no recommendations for changes in his care plan based on the falls meetings... (R3) had a decline in August of 2006, he started spending most of his time in a wheelchair..." Review of Incident reports showed a series of falls from August of 2006, at least four from the wheelchair, the fourth culminating in the fatal injuries. Reports showed falls on 8/15/06, 8/16/06, 8/17/06, 9/17/06, 10/31/06, 2/6/07,	F9999		

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2/16/07, and the final fall on 3/20/07. The reports showed the 9/17/06 fall was from a wheelchair with injuries to the forehead and nose, the 10/31/06 fall was from a wheelchair with a laceration to the left eyebrow and a bump on the left cheek. The 2/6/07 fall was from a wheelchair when R3 was found on the floor. On 2/16/07 R3 was found with a 1.5 cm round hematoma on the right cheek just below his eye with no credible explanation of the origin of the injury. On 3/20/07 R3 suffered the fall that resulted in facial fractures that resulted in his death.

Interviews with Certified Nurses Assistants (CNAs) on 4/4/07 showed the following:

E3 - at approximately 9:30 AM - "...He (R3) would not follow directions. I always put him in a recliner, it was safer..."

E4 - at approximately 10:00 AM - "...He (R3) should have been in a lounge chair. He was not safe to leave in a wheelchair. He would not follow directions he was demented..."

E7 - at approximately 10:15 AM - "...he (R3) would not always do what you told him. I think he would be safer in a recliner than in a wheelchair, I would not leave him in a wheelchair..."

E8 - at approximately 9:40 AM - "...he (R3) was safe in a wheelchair 15 minutes or less. Personally I would be watching him all the time..."

E5 - at approximately 10:30 AM - "...I would feel better laying him (R3) down or putting him in a recliner. He would not do what you told him to do..."

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F9999	Continued From page 19 E9 - at approximately 9:45 AM - "...We didn't leave him unattended. We would leave him in a recliner or in bed for safety reasons. He could get out of a wheelchair easier than he could get out of a recliner..." Interview with E11 CNA on 3/26/07 at approximately 1:20 PM showed R3 was left at the nurses station in a wheelchair on the evening of 3/20/07. E11 stated, "...Me and (E12) went in to (R3's) room to get him up (for supper). He would not stand - so we put him in the wheelchair. We put him at the desk (nurses station) for supervision - because his wife was coming to feed him. We put his alarm on him. We were depending on (E13, CNA) to stay there (until E11and E12 returned). She (E13) was waiting on a resident who was on the phone. (R3) does not remember to stay seated..." Interview with E13 CNA on 3/26/07 at approximately 2:45 PM confirmed R3 had been left alone at the nurses station. E13 stated, "...I was at the nurses station helping (a resident) use the phone. I had been standing there about three and one-half minutes. I don't remember whether (R3) was sitting there or not. Then (another CNA) asked me to help him transfer someone, so I went to the main dining room... I was coming back from the dining room and I heard an alarm go off. I ran to where the alarm was sounding and found (R3) on the floor. There was blood on the floor and on (R3's) face. There was no staff around. (R3) was by himself (no staff) at the nurses station. I hollered for help twice. Finally, I peeked around the other hallway and saw (the nurse). I told her to come quick , she ran to help..."	F9999		

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F9999	Continued From page 20 Interview with E12 CNA on 4/4/07 indicated the CNA'S were in a hurry the night of 3/20/07. E12 stated, "...ordinarily we would not have left him (R3) up in the wheelchair. We would have put him in the recliner with his feet up. We were rushed, we still had three more people to get up. We took a chance, he was not as safe in the wheelchair as in the reclining chair..." A Physician's Progress Note dated 3/21/07 at 11:52 AM and signed by Z3, Physician, stated: "...on inspection patient (R3) was not displaying any signs of respiration. Pupils fixed and dilated. Carotids not palpable. No heart / lung sounds heard. Patient unresponsive to pain. At 11:52 AM on 3/21/07 I declared the patient dead. The cause of death seems to be resp. (respiratory) distress due to multiple facial fx (fractures) sec (secondary) to fall in nursing home." (A)	F9999		