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W 331	Continued From page 16 2. A nighttime toileting schedule will be implemented for R1. In the interim, 15 minute checks will continue during the nighttime hours with incontinence checks when awake. During daytime hours, hourly checks for incontinence will be completed. 3. The IDT will meet to develop a transition plan to acclimate R1 to an alternative room assignment. This will include a formalized program. 4. The IDT will review the need for safety devices which may include audio alarms. Human Rights and Guardian approval will be obtained prior to any rights restrictive measures. Until this time, the individual will remain within eye site at all times during nighttime hours. Although the Immediate Jeopardy was removed, the non-compliance continues at the time of the exit because the facility has not had the opportunity to fully implement their plan or evaluate its effectiveness.	W 331		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATION 350.620a) 350.1230b)2)3)6)7) 350.1230d)1)2) 350.1230e) 350.1230f) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the	W9999		

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facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.

Section 350.1230 Nursing Services
b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in:
2) Evaluation study, program design, and placement of the resident at the time of admission to the facility.
3) Periodic reevaluation of the type, extent, and quality of services and programming.
6) Development of a written plan for each resident to provide for nursing services as part of the total habilitation program.
7) Modification of the resident care plan, in terms of the resident's daily needs, as needed.
c) A registered nurse shall participate, as appropriate, in planning and implementing the training of facility personnel.
d) Direct care personnel shall be trained in, but are not limited to, the following:
1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.
2) Basic skills required to meet the health needs and problems of the residents.
e) Sufficient, appropriately qualified nursing staff shall be available, which may include licensed practical nurses and other supporting personnel, to carry out the various nursing service activities.
f) The individual responsible for providing nursing services shall have knowledge and experience in the field of developmental disabilities.

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Section 350.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These REGULATIONS were not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide nursing services to prevent continuing falls for R1 which resulted in significant injuries, failed to remove sutures and staples for R1 and R2 as ordered by the physician, and failed to adequately assess for neurological compromise in four of four residents (R1 - R4) in the sample who sustained head injuries.

Findings include:

1) R1 is a 50 year old female who functions in the profound range of mental retardation, according to the roster provided by the facility on 08-13-07. R1 has a Psychological Intelligence Quotient of <20 and an adaptive behavior score of one year one month. R1 has a recent diagnosis of Metachromatic Leukodystrophy identified during an MRI (Magnetic Resonance Imaging) on 07-19-07. R1 also has a history of seizure activity, which is controlled with medication at this time. According to a telephone interview on 08-21-07 at 9:52a.m., Z3 stated that R1 had a severe injury to her left eye as a child, and it is questionable that she has any usable vision in that eye.

According to R1's Individual Program Plan (IPP) dated 01-18-07, describing the events of the past

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year, "I had some trouble with my balance." The only intervention mentioned to address this identified need is under Other Services, number 6, "Staff will document, in writing, all unusual incidents observed. Medical Incident Report will be completed for any falls." There is no evidence in the IPP that the IDT (Interdisciplinary Team) had taken steps to prevent falls for R1, nor is there evidence of a fall risk assessment or nursing care plan for fall injuries sustained by R1.

During a review of facility incidents, it was noted that R1 had eight confirmed incidents of falling from 05-28-07 to 08-08-07.

05-28-07 Unwitnessed fall on back patio resulting in abrasion to right knee. Written under, "Why did it happen?" was, "Increase of falls/trips" E2, Nurse, added at the bottom of the form, "(R1) when agitated refuses assistance - trips, falls."

06-10-07 "Bruise left lower back." Under "Why did it happen?" is written "(R1) has increase of unsteadiness; stumbles/falls." An additional notation by E1, Administrator, states, "Staff to report unsteadiness and change in personality. Has been correlated with anti-convul(sant) levels being high."

06-13-07 "1 1/2" laceration to center of forehead." The description of the occurrence is that E3, Direct Care Staff, heard R1 crying, and went to check on her. "(R1) had gotten out of bed, was incontinent in the bathroom. When (R1) left the suite to get assistance, her feet were wet and she slipped and fell hitting head."

06-22-07 "Hit back head on closet - fell to buttocks." An additional notation states, "Staff

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reported that (R1) was upset wanting to get out to the bus. (R1's) A.M. meds had not been given yet and she was detained, trying to get out door when she fell."

07-12-07 "Left side of forehead raised, redden area, no active bleeding. Walking and fell forward. Shuffling gait, toes 'catch' on floor." An additional notation, "Increase in falls. Testing scheduled."

08-01-07 Quarter-sized abrasion to left neck. Unwitnessed, believed to be self-injurious behavior.

08-04-07 "Slid to the floor on her left side when trying to get back to her bed. The floor was wet due to inc(ontinence). Trying to get the bed made before she got back in it." The Supervisory Review states, "Spoke with (E4, Direct Care Staff involved) - (R1) anxious to return to bed, slip before clean up possible."

08-06-07 "Fall (R1) was crawling on the floor on her hands & knees. (R1) was inc(ontinent) and her feet were wet."

08-08-07 "D/T (due to) incontinence slipped on urine on floor, Rt side forehead abrasion 2cm s (without) active bleeding." The responses to the questions, Sent to Medical facility? and MD notified? are marked, No. A notation on 08-09-07 at 5A.M. states, "Individual's Rt eye black from the fall. Acetaminophen 650mg given po (by mouth) for possible discomfort."

On 08-13-07 E1, Administrator, was asked what the facility did following R1's 06-13-07 fall. E1 recalled having an IDT meeting and that staff had

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noticed a big change in her and had asked that R1's mother request an MRI to determine if there were any changes in R1's brain. E1 was asked if R1 has a Fall Risk Assessment, and replied that she does not. E1 was asked if R1 was going to continue to ambulate independently. E1 stated R1 loves to walk and that the IDT did not want to take away her independence by confining her to a wheelchair. E1 continued that the IDT had ruled out putting siderails on R1's bed because there would be a greater danger to R1 attempting to crawl over them. E1 added they may have to put a bed alarm on R1's bed, but the alarms are very loud and would wake others. E1 stated R1's roommate has an audio monitor in the room, and staff would hear if R1 got up, but if they only heard her fall, that would be too late. E1 acknowledged that the monitor was already in place when the other falls occurred, so it is not a preventive measure.

On 08-16-07 at 3:11p.m., E1 was asked when R1 was put into adult diapers. E1 answered that it was on 08-09-07, the day after the fall when it was changed to full time. Prior to that R1 wore adult diapers when she was on community outings or medical appointments. E1 also acknowledged the facility has no policy on neuro checks, and that R1 does not have a program for fall prevention. E1 also stated the residents are not taken to Z2's office for follow-up visits, or acute concerns. The nurses call Z2's office and are referred to the emergency department for those issues.

The IDT Six-Month Review dated 06-28-07 for R1 states, "(R1) has also had several falls. Everything appears fine and (R1) suddenly will fall." " (R1) will not tolerate assistance or staff

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shadowing. This makes it very difficult to prevent a fall." Under recommendations, "If staff note that (R1) is 'off balance' or they see a change in her gait, they will provide necessary safety measures to prevent a fall - if at all possible." There is no evidence of specific safety instructions, evaluation of the times of the falls, and no discussion of safety versus independence for R1.

2)a) A review of R1's Nursing Progress Notes verified that following the fall on 06-13-07, R1 was sent to the hospital for evaluation and treatment of the laceration. At 1:10a.m. on 06-14-07, R1 returned to the facility with five sutures on middle forehead. E5, Nurse, noted, "refused to allow nurse take vital signs or do a neuro check."

Per a review of R1's discharge instructions from the local hospital emergency department dated 06-13-07 at 11:59p.m., it states, "Have your sutures, staples, or steri-strips removed in 05 days as instructed by your caregiver." In two additional places are the Follow-up Instructions with a box around them stating, "suture removal in 05-06 days."

On 06-22-07 at 7:30p.m., E5 wrote, "This nurse attempted to take sutures out on mid forehead - 2 sutures removed - will bring in tweezers from home on Sunday noc (night) to remove the rest of the (done - ?) - indiv(idual) also refused to allow nurse take VS X3 - indiv continues to have bil(ateral) blacken eyes from fall earlier in week."

There are no further entries regarding R1's forehead injury/wound until 07-06-07 at 8:00p.m. in which E6 states, "Order from (Z2) to send out to (hospital) received 2:45p.m. Sent out for

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W9999	Continued From page 23 suture removal." In an interview on 08-16-07 at 12:15p.m., E8, RN, HSS (Health Services Supervisor) was asked who was responsible for removing sutures/staples, and replied that the nurses at the facility usually do it, or the individual is taken to the physician. When asked how the nurses know when to remove them, E8 stated there is usually an order from the emergency department doctor or the facility Medical Director. E8 was asked about R1's sutures from 06-13-07 which were ordered to be removed in 5 days, and were not removed until 07-06-07, 23 days later. E8 was asked if there had been an investigation to determine why it had happened. E8 had no explanation. E8 was asked if there had been any training to ensure prompt removal of staples/sutures in the future, or if there had been any disciplinary action taken? E8 responded, "I don't know of any." During an interview on 08-13-07 at 3:02p.m., E10, LPN, was asked who is responsible for removing sutures/staples. E10 stated the nurses remove the staples/sutures, and they know when to do it because it is written in the discharge instructions from the hospital. E10 added, the nurse who receives the paperwork from the hospital should mark the date of removal in the MAR (Medication Administration Record), usually on the treatment sheet. E10 was asked about R1's sutures not being removed on time and E10 checked the MAR to see if it was marked for when they were to be removed. The order had never been entered. During a telephone interview on 08-15-07 at	W9999		

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9:20a.m., Z1 was asked about the condition of R1's wound and sutures. Z1 stated that usually the nurses remove sutures, but R1's sutures were so imbedded Z1 could not get them out, and had to have the doctor do the last three, and that the doctor had to cut them out. Z1 added, "That, of course, created another wound, but we treated it."

2)b) R2 is a 40 year old female who functions in the profound range of mental retardation, according to the roster provided by the facility on 08-13-07. R2 has additional diagnoses of Cerebral Palsy and Seizure Disorder. Per a review of the facility incidents/accidents from June, 2007 until August, 2007, R2 had a fall when staff was walking her from the staff restroom to her wheelchair at 9:50p.m. on 06-20-07. R2 was not wearing a gait belt at the time of the incident. R2 suffered a 1" laceration to the top of her head with a moderate amount of bleeding. According to the Nursing Progress Notes dated 06-20-07, R2 was sent to the hospital for evaluation and treatment at 10:20p.m. On 06-21-07 at 12:20a.m., R2 returned from the hospital with 4 staples closing the laceration. The Discharge Instructions from the hospital have Follow-Up Instructions boxed in two places. The instructions state suture removal in 07-10 days. Vital signs were completed upon return from the hospital. No neuro checks are documented.

The next mention of the injury is on 07-03-07 at 9:50p.m. when an entry by E10 indicates he removed the staples, (13 days after the injury). In an interview on 08-13-07 at 3:02p.m., E10 was asked about R2's staples. E10 got R2's MAR and saw the order to remove the staples was boxed in for 06-28-07, but it was not initialed as having been done. E10 acknowledged that he removed

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the staples, but did not know why they had not been removed as ordered.

The IDT meeting minutes dated 06-21-07 also state, "The staples can come out in 7-10 days."

3)a) R1 is a 50 year old female who functions in the profound range of mental retardation, according to the roster provided by the facility on 08-13-07. During a review of facility incidents, it was noted that R1 had sustained many falls including a fall on 06-13-07.

A review of R1's Nursing Progress Notes verified that following the fall on 06-13-07, R1 was sent to the hospital for evaluation and treatment of the laceration. At 1:10a.m. on 06-14-07, R1 returned to the facility with five sutures on middle forehead. E5, Nurse noted, "refused to allow nurse take vital signs or do a neuro check."

According to a R1's Nursing Progress Notes, on 06-14-07, the 6:00a.m. entry by E5 states, "no active drainage, sutures intact" as the only assessment of the wound; "No nausea or emesis" as the only assessment for concussion/neuro check; and "No facial expression of pain/discomfort" as the pain assessment.

The 12:00p.m. entry on 06-14-07 by E6, LPN, states, "(R1) refused any type of assessment," but an assessment of the injury was documented. The next entry at 8:00a.m. on 06-15-07 notes, "gait unsteady" "vitals refused X3 by individual." The injury site was assessed and documented.

At 4:35p.m. on 06-15-07, APAP 650mg was given for possible pain/discomfort. The entry also notes

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that R1 has an unsteady gait, spent most of the day in a w/c (wheelchair) and refused vitals X6 throughout the day.

The next entry is on 06-16-07 at 11A.(M.), E7 notes, "Bridge of nose et (and) eyes purple bruising." There is no evidence of pain assessment, vital signs, suture site assessment, neuro checks or observation of gait documented.

The following entries are the only additional documentation regarding the injury:
06-17-07 1:00p.m. eyes remain bruised, also nose
06-19-07 9:10a.m. Unsteady gait, refused vitals , 5 sutures dry et intact, (no) s/s of infection

On 06-22-07 at 9:00a.m., the fall to buttocks hitting head on closet door is documented.

On 07-12-07 at 8:10a.m., it is documented that R1 fell forward et (and) hit her head on the floor. Neuro check completed. A late entry at 3:35pm states the 8:00a.m. neuro check was WNL (within normal limits) but refused vital signs.

On 07-13-07 at 8:40a.m., "Up ad lib c (at liberty with) unsteady gait, refused vitals." There are no further assessments or mentions of this injury sustained in the fall on 07-12-07.

The next entry regarding injuries is a fall to the left side at 8:15a.m. on 08-04-07. Pain medication was given two times on 08-04-07 and one time on 08-05-07 "for possible discomfort" with increased vocalizations and pacing. No other assessments were done.

On 08-06-07 at 10:20p.m. an entry describes

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individual crawling on hands & knees, feet wet due to incontinence, refuses vital signs, started neuro checks - WNL.

On 08-07-07 at 12:00a.m.E5 was able to assess head for hematomas lacerations and redness; none found.

On 08-07-07 9:00a.m. Refused vitals, grips equal, noted by E7

At 11:50p.m. on 08-08-07, "slipped on urine on floor in bedroom D/T incontinence. Rt side of forehead (with) 2 cm abrasion" "Neuro check completed, vitals refused." At 3:00a.m. on 08-09-07, "Rt side of forehead abrasion 2cm bleeding off/on ." At 6:15am, "Neuro check completed. Vitals refused. Rt eye black et edematous."

On 08-09-07 at 9:30a.m., E8, Health Services Supervisor documented, "Called 911 to pick up (R1). (R1's) laceration above her R (right) brow began bleeding, R (right) eye completely shut due to swelling and it's black and blue. Her nose began to bleed." A late entry by E7 follows this entry stating, "8:15 @8A(M) (pain medication) 650mg for eye pain, forehead bleeding epistaxis - steri-strips removed area cleaned et bandaid applied. Notified (E8) HSS need order to send to ER."

According to an entry by E11 on 08-09-07 at 3:50p.m., R1 returned from the hospital at 1:45p.m. Neuro checks WNL (with) exception of R (right) eye unable to open - Dx (Diagnosis): R orbital fx (fracture) per CT scan.

No further assessments of the injury are made

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until 08-10-07 at 7:15pm. There is documentation of R1's loud vocalizations and pain medication being administered. The next mention of the injury is 08-11-07 at 5:30p.m., "face remains black/blue c (with) edema." E5 adds, "remains in w/c for safety c (with) 15 min (checks)."

On 08-12-07 7:15a.m., E12, LPN documents, "facial edema continue black & blue in color - continue to monitor - individual remains unsteady when ambulating."

Documentation notes that pain medication continues to be given for crying and loud vocalizations, but no further mention of neuro checks is noted.

The IDT met on 08-09-07 to discuss the most recent fall on 08-08-07. One of the recommendations was, "Since (R1's) injury was to her 'good eye,' the IDT would like to have (an eye specialist) examine (R1) again...after the fracture is healed."

E8, HSS, was asked what nursing policy/procedure/protocol would require in assessing individuals following an emergency department visit for a head injury, and stated, "My expectations would be a head to toe assessment on return, and charting every shift until the injury is healed." When asked about neuro checks, E8 stated, every shift for at least 24 hours. E8 added the assessments every shift should include vital signs, assessment of the injury site, neuro checks, and pain assessment until healed.

On 08-13-07 at 3:02p.m., E10, LPN was asked about the policy for residents returning from

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	14G056	A. BUILDING _____ B. WING _____	C 08/22/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE FIFTY-THREE	4601 53RD STREET MOLINE, IL 61265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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emergency department visits with injuries. E10 stated there was no specific policy; they just follow the discharge instructions from the hospital. When asked how often and how long assessments should be done, E10 replied, "At least once every shift for a day or two after the staples/sutures are removed to make sure there are no signs/symptoms of infection and that the wound is well approximated."

There is no evidence that the IDT or nursing addressed R1's multiple refusals of assessments.

3)b) R2 is a 40 year old female who functions in the profound range of mental retardation, according to the roster provided by the facility on 08-13-07. R2 has additional diagnoses of Cerebral Palsy and Seizure Disorder. Per a review of the facility incidents/accidents from June, 2007 until August, 2007, R2 had a fall when staff was walking her from the staff restroom to her wheelchair at 9:50p.m. on 06-20-07. R2 was not wearing a gait belt at the time of the incident. R2 suffered a 1" laceration to the top of her head with a moderate amount of bleeding. According to the Nursing Progress Notes dated 06-20-07, R2 was sent to the hospital for evaluation and treatment at 10:20p.m. On 06-21-07 at 12:20a.m., R2 returned from the hospital with 4 staples closing the laceration. Vital signs were completed upon return from the hospital. No neuro checks are documented.

On 06-21-07 at 11:20a.m., neuro checks were completed. No further neuro checks were documented. The wound was assessed only two times following the 06-21-07 assessment, once on 06-22-07 at 3:00a.m., and once on 06-24-07 at

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10:00p.m. Both assessments were by E5.

A further review of R2's Nursing Progress Notes state R2 had a previous fall on 05-25-07 at 6:40p.m., hitting her head on the edge of the wall. R2's head was bleeding from a small cut on the top right side of her head. Neuro checks were done three times in the next 14 hours, and then R2 went on a home visit with family. There is no documentation that family was instructed on signs/symptoms to watch for. There is no further documentation of any kind regarding this injury.

3)c) R3 is a 21 year old male who functions in the profound range of mental retardation, according to the roster provided by the facility on 08-13-07. R3 is also diagnosed with Seizure Disorder.

During a review of incidents on 08-13-07, an incident dated 07-06-07 at 3:30p.m. reported that R3 had fallen from the shower chair and suffered a large laceration to his right forehead approximately 3 inches long. This information is verified in the Nursing Progress Notes, which also state R3 was sent to the hospital for evaluation and treatment.

On 07-06-07 at 10:00p.m. an entry states, R3's wound was glued and assessments and neuro checks were done. The next entry was for neuro checks and vital signs on 07-07-07 at 5:53p.m. No further mention of the injury is made.

On 07-15-07 at 10:00a.m. an entry states R3's Right eye swollen with purple bruising and red mark on outer aspect of upper lid. Neuro checks and vital signs completed. At 10:00pm the right eye remained edematous with purple bruising,

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vital signs and neuro checks done. On 07-16-07 at 10:20p.m, neuro checks and vital signs again completed, and right eye edematous with purple bruising. There are no additional entries regarding this injury.

On 07-25-07, R3 slid out of his wheelchair to the floor while reaching for a book. There were no apparent injuries as a result of this fall.

On 08-01-07 at 8:00a.m., R3 flinched when nurse touched his right leg. At 11:00a.m. the entry by E6 states R3 had flipped out of a recliner at day training yesterday. E6 and E9, both nurses, assessed R3's right foot and leg and noted it was reddened, warm to touch and visibly swollen. E6 called the doctor and got an order to send to the hospital for evaluation and treatment. R3 was diagnosed at the hospital with ankle sprain and bruising. E6 documented APAP 650mg for pain at 4:40p.m. and noted "bruising very visible at this time." There is no further documentation regarding this injury.

On 08-07-07 there is a late entry for 08-03-07 stating R3 had again slipped forward off the seat of his wheelchair and went to the floor with staff assist. There were no injuries noted at that time. There is no further documentation regarding additional assessments following this fall.

3)d) R4 is a 50 year old male who functions in the profound range of mental retardation, according to the roster provided by the facility on 08-13-07. R4 is ambulatory and has a diagnosis of seizure disorder, but has not had any seizures for over two years.

According to a review of incident reports and

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Nursing Progress Notes, R4 had a fall with a laceration to the left forehead on 06-13-07. There is no further documentation regarding this injury or follow-up assessment.

On 08-02-07 R4 fell and hit the back of his head. Neuro checks and vital signs were done three times in next 24 hours. No further mention of this injury or assessments.

On 08-08-07 at 11:50a.m., R4 fell at workshop and sustained a laceration to left forehead. R4 was taken to the hospital where the wound was closed with adhesive. Neuro checks and vital signs were done three times until 9:35pm that night, for only seven hours. There is no further documentation regarding this injury. No assessments of any kind are noted.

The facility failed to produce evidence of any specific policies and procedures regarding assessments and documentation of head injuries.

(A)