STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145660	A. BUILDING ______ B. WING ______	08/28/2007

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WESTCHESTER HEALTH & REHABILITATION	2901 SOUTH WOLF ROAD WESTCHESTER, IL 60154

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F 520	Continued From page 41 a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement appropriate plan of action to correct identified quality deficiencies on facility incident falls since August of 2006. Findings include: Interview of E1 (Administrator) and E2 (Director of Nursing) on 8/22/07 revealed that the facility has implemented the action plan of CNA (certified nurses assistant) to be assigned at certain times in the facility dining rooms from Aug. 2006 to this date in Aug. of 2007. Review of facility incident reports from September 2006 to Aug. 2007 showed that falls in the facility dining rooms have not improved with average of 21 falls per month that occurred in the dining rooms. E2's response to the surveyor when asked about other alternatives to address the frequent falls occurring in the facility dining rooms stated: "We will continue to write them up and ultimately terminate for not following the assignment. "	F 520		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION 300.1210a)5) 300.1210b)6) Section 300.1210 General Requirements for Nursing and Personal Care	F9999		

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a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological 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. Restorative measures shall include at a minimum the following procedures:

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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

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 that each resident receives adequate supervision and assistance to prevent accidents.

These REGULATIONS are not met as evidenced by:

Based on record reviews and interview, the facility failed to supervise 5 of 21 sampled residents all with history of multiple, unwitnessed falls.

The failure to supervise and monitor these

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residents in an unsupervised area resulted in R7, R19, R14, R16, and R18 sustaining unwitnessed falls in the dining room.

In addition, R17 fell during an incorrect transfer technique.

As a result of these falls, R19 sustained a Subdural Hematoma. R14 and R16 required emergency room care for injuries. R18 suffered minor injury post fall. R7 fell without injury. R17 fell during transfer. All of these falls were unwitnessed at different times of the day and in a dining room used for meals and activities that should have ben attended by staff.

Findings include:

1) R19 is a 95 year old female originally admitted to the facility on 4/13/06 with diagnosis of gastric cancer and osteoarthritis. Admission nurses notes on 4/13/06 described R19 to be an alert and oriented female.

Review of facility care plans for falls identified R19 on 5/10/06 to be at risk for falls and she had multiple incidents of falls from this date.

Review of facility incident reports revealed the following :

Date of Fall: 3/7/07
Time of Fall: 9:30 PM
Unwitnessed
If injury occurred, specify: Skin tear and bruise to R (right) elbow.
Description of Fall: Resident observed lying on side with walker on hand.
Location of Fall: Resident room.

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F9999	Continued From page 44 Date of Fall: 3/27/07 Time of Fall: 4:30 PM Unwitnessed Injury: No injury Description of Fall: Patient found sitting up on the floor by the hallway door. Location of Fall: Resident room. Date of Fall: 4/18/07 Time of Fall: 5:45 PM Witnessed Injury: No injury Description of Fall: Resident stood up and then attempted to sit back down, w/c (wheelchair) rolled backwards and resident fell hitting L (left) arm on wall. Date of Fall: 5/17/07 Time of Fall: 2:35 PM Unwitnessed Injury: No injury Description of Fall: Summoned to pt's. (patient's) room, where pt. was on the floor crawling on her knees towards the door. Date of Fall: 6/10/07 Time of Fall: 10:16 AM Unwitnessed Injury: not filled out Description of Fall: Resident got out of bed and walked into the hallway with one shoes on and one off, lost her balance and fell backwards on her buttocks, hitting her head. Date of Fall: 7/19/07 Time of Fall: 6:40 AM Unwitnessed Description of Fall: Resident in w/c in dayroom,	F9999		

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F9999	Continued From page 45 heard noise. Res. (resident) found on floor on L side with bleeding from 2" (inches) laceration on forehead. Nurses notes indicated that R19 returned to the facility with 5 sutures from this incident fall. Date of Fall: 7/28/07 Time of Fall: 11:00 AM Unwitnessed Description of Fall: Found resident face down in Unit 2 dining room, nose bleeding, lacerations on nose and between L hand and middle finger. Nurses notes indicated that 911 was called due to possible head injury. R19 was transferred to the hospital. Further review of following records revealed the following : Hospital Radiology Report of R19's CT Scan of Head dated 7/28/07: Impression: 1. Two moderate-sized intra-axial hematomas are present within the left frontoparietal lobe. The location is not typical for hypertensive hemorrhages. 2. Subarachnoid hemorrhage along the high frontoparietal convexities, likely traumatic in origin. 3. The above CT Scan findings were personally communicated to the ordering physician at 12:56 PM on 7/28/07. Ambulance transport on 8/2/07 Describe the patient's condition at the time of pickup that necessitated utilization of an ambulance: Bedridden S/P (Status Post) fall.	F9999		

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Speech Therapy Evaluation:
Date: 8/2/07
Medical Diagnosis: Cerebral Hemorrhage
Dysphagia
Initial Assessment Summary: Resident re-admitted to this facility following hospitalization for a fall she had off the wheelchair in the nursing home.
Assessment Summary: Cerebral Hemorrhage, H/O (History of Fall) Fall.

Hospice Client Information:
Pt. D/C (discharged) from hospital with cerebral hemorrhage on 8/2/07. She fell on 7/28/07 in SNF (Skilled Nursing Facility).

Review of R19's care plan revealed no re-assessment and update nor revision of R19's care plan to address her multiple falls.

Interview of E2 on 8/21/07 regarding supervision of dining room in Unit 2, the unit R19 resided at the time of the incident: E2's response was "She should have chair and bed alarms on at all times. E2 (DON) stated that she was at the nurses station at the time of R19's incident fall on 7/28, but she did not hear the alarm, and that a CNA (certified nurses assistant) was suppose to be assigned to the dining room. E2 also told surveyor during this interview that it is the responsibility of the nurse on the floor that CNA's are present in the DR (dining room).

Disciplinary Action Review as follows:
On 7/28/07 E13 failed to report to DR at her assigned time. Resident fell causing a severe head injury resulting in hospitalization.

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F9999	Continued From page 47 Employee Statement obtained by the facility: I (stated her name as E13) know that it is a must to be in the DR at your scheduled time, but due to shortness in staff and the fact that I was very busy, I failed to go to the DR at my appropriate time. 2) Review of R14's Incident Report dated 7/19/07 at 6:40 AM indicated R14 was in wheelchair in dayroom when staff heard a noise. R14 was found on floor on the left side with bleeding from 2 inch laceration on forehead resulting in R14 being sent to the hospital for sutures. R14's diagnosis includes Dementia. 3) R16 was an 84 year old resident admitted to the facility on 3/4/07 with a diagnosis of Gastroesophageal Reflux Disease and a history of hip fracture (S/P Open Reduction Internal Fixation). She also had a history of Compression fractures to spine and pelvis, osteoarthritis, and osteoporosis. Since admission to the facility, the resident has had 2 falls in which she was found on the floor (bedside and dining room). In both instances the falls were not witnessed. The post fall review for the fall on 7/7/07 indicated that the team decided to order a pommel cushion. There was no evidence of assessment. On 6/9/07 the resident had a fall. According to the incident report the resident was, "found on the floor at bedside lying on her right side with the wheelchair belt unattached." On 7/7/07, R16 was found on the floor in the	F9999		

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dining room at 5:55pm. According to the incident report, "Resident in dining room. CNAs picking up trays when resident observed on floor. No witness." According to the facility policy, the dining rooms are supposed to be monitored. The resident required sutures to a laceration on her right forehead.

4) Incident/Accident report dated 8/1/07 states at 2:03p.m. R18 was found on dining room floor, face down, still attached to wheelchair with self release restraint. Report states R18 suffered a large knot (tennis ball size) in middle of forehead and skin tear to right wrist.

Review of record revealed there was no physician order for the use of a self release restraint. No assessment for restraint. No consent for the restraint. Use of the self release restraint was not identified as a problem in care plan until 8/6/07.

Surveyors were informed by Administrative staff that a Nurse Aide is assigned to monitor dining room at all times. Incident report states this fall was not witnessed by anyone.

5) R7 was admitted to the facility on 6/7/07 and suffered falls 6/19/07, 7/11/07 and 7/14/07. A physician order was obtained on 7/16/07 for the use of a self release restraint. On 7/28/07 Incident/Accident report states R7 was found on dining room floor at 8:10p.m., restraint was in use, and report states this was an unwitnessed accident.

6) R17's diagnosis includes Syncope, Cerebral

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Vascular Accident, and legally blind. Review of R17's Minimum Data Set of 6/27/07 assessed R17 moderately cognitively impaired and totally dependent on staff for Activities of Daily Living and requires 1 person assist with transfers.

Review of R17's care plan dated 7/24/07 denotes R17 has a history of falls and requires a 2 person assist and a mechanical lift for transfers. Review of nurses notes dated 8/8/07 at 2:00 PM documents that while E10 (CNA) was attempting to transfer R17 from the wheelchair to the bed, R17 and E10 lost balance with R17 landing on E10, neither sustaining an injury. Review of facility interdisciplinary post fall review dated 8/9/07 denoted that E10 will be re-educated on transferring this resident with a gait belt and 2 person extensive assist.

E5 (restorative nurse) stated in interview on 8/21/07 that she had upgraded R17 to a 2 person transfer in July 2007 because she felt that she required more assistance upon transfer. E5 stated that staff are required to review care patient alert system prior to caring for the resident.

Review of disciplinary action record: "E10 caused harm to a resident causing her to fall and was not using a gait belt as he has been instructed many, many times." Corrective Action included E10 to have a gait belt on his person and use it when transferring residents.

(A)