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LICENSURE VIOLATIONS

300.1210a)
300.1210b)6)
300.1220b)3)
300.3240a)

Section 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 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.

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.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the 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

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orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. 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. The plan shall be reviewed at least every three months.

Section 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 Regulations were not met as evidenced by:

Based on record review, interviews, and observation, the facility failed to follow care plan interventions, failed to re-evaluated for the effectiveness of interventions, failed to have clearly defined interventions in place for staff to follow, and failed to supervise residents to minimize the risks for recurring falls and serious injuries for 4 of 6 sampled residents wearing body alarm monitors (R1, 2, 4, and 5). This resulted that R1 sustained a subdural hematoma after a fall and was hospitalized. R1 was returned to the facility three days later and within five days died as a result of the subdural hematoma received from the fall.

Findings include:

1. The Physicians Order Sheet for R1 dated 03/03/09 stated diagnoses including Congestive

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Heart Failure, Legally Blind, and Diabetes Mellitus. The MDS (Minimum Data Set) dated 02/11/09 documents R1 has short term memory problems, difficulty making decisions in new situations, and needs limited assistance of 2 persons for transferring and ambulation. Facility Fall Risk Assessment form dated 02/11/09 identifies R1 as a high risk for falls. Care plan for R1 dated 01/20/09 states, "Resident at risk for fall related to daily use of Xanax and poor balance." Intervention dated 01/28/09 stated "Frequent monitoring; bed alarm; and toileting schedule." This intervention did not identify what frequent monitoring entails nor did it specify a toileting schedule.

R1's nurses notes from 01/12/09 through 02/29/09 provide the following information about R1's falls:

Fall #1: 01/12/09 at 10:45PM "Certified Nurse Aide (CNA) was giving bedtime care. Resident went to the bathroom with walker. Resident is legally blind. Resident was backing up to the toilet and went to sit down. Resident missed and fell on buttocks. Resident was assisted with gait belt back to bed. Call light in reach and resident was encouraged to use the call light and maintain a safe environment."

Facility Incident Investigation Quality Improvement Process form dated 01/13/09 states resident toileted self without assistance and received bruises and scrapes to back. This is in conflict with the nurses notes which stated the CNA was giving R1 bedtime cares when R1 went into the bathroom and fell.

Care Plan Approaches/Interventions for R1 dated

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F9999	Continued From page 18 01/13/09 stated "Fall-Frequent monitoring; Physical Therapy to screen; and patient education regarding safety and assistance. Care plan does not clarify "frequent monitoring" nor do facility nurses notes for subsequent days after R1's fall document frequency of monitoring done. R1's record from 01/13/09 through 01/16/09 did not reflect any education provided to R1. Fall #2: 01/16/09 at 3:10PM "Resident observed to be on floor. States (R1) slid down from bed." Care plan does not indicate new interventions related to this fall. Facility Investigation Report Log for January 2009 does not list R1's fall on 01/16/09. Facility Incident Investigation was not provided for this fall. Fall #3: 01/17/09 "Resident yelling for help. Upon entering room (R1) is in sitting position leaning against the bed facing the bathroom. Complained of pain on the right side of back where there is a 6 centimeter scrape under the shoulder blade. On the right side of back there is a 10 centimeter scrape." Facility Investigation Quality Improvement form dated 01/17/09 states, "Resident was using walker to go to bathroom when the walker hit the metal divider in the doorway. Resident lost his balance falling back against his bed and scraping his back on the side rail." Facility Incident Investigation form dated 01/17/09 states "frequent monitoring" as a short term intervention and "encourage resident to ask for assistance" as a long term approach. Investigation does not clarify what staff are to do to accomplish frequent monitoring.	F9999		

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F9999	Continued From page 19 Facility Post Fall Assessment dated 01/17/09 states R1 is " forgetful." Care plan intervention for R1 dated 01/17/09 states "Fall: frequent monitoring; Physical Therapy to screen; patient education regarding safety and assistance." Care plan does not include parameters for frequent monitoring. Nurses notes for R1 from 01/17/09 through 01/27/09 do not indicate any frequent monitoring or education and addresses encouraging R1 to use call light one time on 01/20/09. Fall #4: 01/28/09 at 9:30AM "I was called to resident's room. Resident was sitting on the floor next to bed. Resident stated he was trying to walk to bathroom, stood up, turned, lost balance and sat on floor." Care plan intervention for R1 dated 01/28/09 states, "Fall: Frequent monitoring; bed alarm; frequent toileting; Physical Therapy to screen." Care plan does not indicate parameters for frequent monitoring or frequent toileting. Facility Post Fall Assessment for R1 dated 01/28/09 states "Resident is at risk for falls due to decreased vision and strength and has confusion at times." Assessment also states interventions as "frequent monitoring" and encourage resident to ask for assistance but does not clarify parameters for frequent monitoring. Fall #5: 02/20/09 "Saw resident by the window in resident's room. Resident stepped back with walker then went down on buttocks. Resident stated I was trying to go to the bathroom. Resident did not use call light." R1's record did not indicate an alarm was sounding.	F9999		

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F9999	Continued From page 20 Care plan intervention for R1 dated 02/20/09 states, "Fall: Bed alarm and scheduled toileting." Care plan does not indicate parameters for scheduled toileting. Nurses notes from 02/20/09 through 02/24/09 do not indicate any scheduled toileting. Facility Investigation Report Log for January 2009 does not list fall on 02/20/09 for R1. No Falls Investigation was provided. On 04/26/09 at 1:30PM E3 (Corporate Nurse Consultant) stated "I see it was not done on 02/20/09 for (R1)." Fall #6: 02/25/09 at 5:00AM "Resident was reaching over to the bedside table. The bed rolled out from the resident. Heard resident yell for help and came into the room. Resident was flat face down. Resident denies discomfort except for left cheek bone. Cheek bone swelling and dark bluish. Ice applied." On 04/24/09 at 2:05PM E5 (Licensed Practical Nurse) stated referring to fall of 02/25/09, "I was 2 or 3 rooms down the hall and heard R1 scream. He was on the floor face down. I don't remember hearing an alarm go off. I checked the bed and the wheels were not in locked position." Care plan intervention for R1 dated 02/25/09 states "bed kept in low position and locked." No explanation was stated on the care plan for the staff regarding "low position." Facility Investigation Report Log for February 2009 does not list fall of 02/25/09 for R1. No Falls Investigation was provided. Fall #7: 02/28/09 (no time documented) "I heard resident screaming. I went in to the room.	F9999		

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Resident is trying to walk to bathroom with walker and does not think he can make it. I slide (R1) to the floor. I told (R1) to make sure call light is used."

Facility Incident Investigation form for R1 dated 02/28/09 states at 1:00AM "I heard resident scream. I went to room and I saw that Resident is walking to bathroom but can't make it. I slide him down to the floor." Under section III of facility Incident Investigation form states "What would you do to prevent future occurrences of this nature?" Documentation in this sections states "putting on bed alarm." Bed alarm had already been added to care plan for R1 on 01/28/09.

Facility Post Fall Assessment for fall dated 02/28/09 at 1:00AM states R1 is at risk for falls due to decreased vision and strength and that resident is disoriented or confused.

Fall #8: 02/28/09 at 2:00PM "At 12:00PM (R1) was observed on the floor next to bed on knees with forehead on the floor. (R1) had got up to walk to the bathroom. Does not know how fall occurred. (R1) assisted up and on to bed. (R1) has quarter sized raised area to mid forehead. Ice applied. Resident was talking to the nurse after the fall and was acting normal. At 1:20PM 911 was called due to respirations slightly labored. Pulse oximetry was 77 percent. 1:45PM: resident leaving by ambulance. 2:30PM Hospital called back saying resident has massive head injuries with internal bleeding." Late entry in nurses note for R1 dated 03/01/09 for 02/28/09 states "Resident unresponsive upon transfer." Unresponsiveness was noted at 1:10PM.

Facility Post Fall assessment dated 02/28/09 at

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F9999	Continued From page 22 12:00PM states that R1 is confused or disoriented. Facility Incident Investigation Form dated 02/28/09 at 12:00PM states, "resident got up on own." Under section III of facility Incident Investigation form states "What would you do to prevent future occurrences of this nature? " Documentation in this sections states "bed alarm possibly." Bed alarm had already been added to care plan for R1 as an intervention on 01/28/09. Hospital History and Physical for R1 dated 02/28/09 stated "(R1) was brought into the emergency room from the nursing home after apparently falling approximately an hour and a half earlier and became unresponsive. Upon presentation (R1) had a Glasgow Coma Scale of 3 (indicates no response in the areas of eye opening, verbal response and motor response). (R1) had agonal respirations (periods of apnea) and pupils are pinpoint. Assessment: the patient with a devastating subdural hematoma with a midline shift, status post fall." Hospital Radiology Report for R1 dated 02/28/09 at 3:00PM states "Closed head injury from fall. Large acute left subdural hematoma in the frontoparietal, occipital, and temporal area measuring 2.4 centimeters in thickness, causing shift in the midline structures from left to right by about 2 centimeters." Nurses note dated 03/03/09 states, "Returned to facility at 7:30PM. Using accessory muscles and mouth to breathe." Nurses note for R1 dated 03/04/09 at 10:30AM state "Resting in bed at this time. No response to verbal stimuli. Unable to turn head. Shows no signs or symptoms of pain.	F9999		

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Unable to get response if resident is in pain at this time. Respirations shallow. Doctor notified that resident does not respond to staff. New order for hospice given."

Care plan for R1 dated 03/03/09 states, "Recent decline in condition. Resident is comatose from recent falls. Hospice picked up on 03/04/09."

Nurses notes for R1 dated 03/04/09 at 9:10PM state, "Hospice here. Resident to be picked up by hospice. Medications all discontinued. Roxanol 20 milligrams every 2 hours ordered for moderate pain." Nurses notes for R1 dated 03/05/09 at 4:00AM state. "Resting quietly. Comforted by touch. Respirations using accessory muscles noted. Bilateral upper extremities with 2+ pitting edema." Nurses note for R1 dated 03/07/09 at 5:30AM state, "No signs or symptoms of respiratory distress. Resident unresponsive to verbal and tactile stimuli. Color pale." Nurses note for R1 dated 03/08/09 at 8:30PM state, "Resident showing signs and symptoms of pain. Roxanol 2 milliliters given by mouth at 8:45PM. At 9:15PM resident's respirations zero. No pulse. Pulse oximetry zero. No apical pulse. Call to hospice. Coroner notified by hospice."

On 05/06/09 at 1:05PM Z1 (Attending Physician) for R1 stated, "Basically it was decided (R1) was not a candidate for surgery and was put on hospice as a result of the Subdural Hematoma. The Subdural Hematoma was a result of the fall and caused (R1's) decline."

Interviews regarding Fall of 02/28/09 at 12:00PM:

On 05/06/09 at 12:15PM E8 (Licensed Practical Nurse) stated, "The housekeeper was cleaning

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and noticed (R1) on the floor and came and got me. I went to the room. (R1) was sitting on the floor leaning to the right. He had a quarter sized hematoma on forehead. I got ice and applied the ice and sat with (R1) until (R1's) nurse came. (R1) told me he was getting out of bed. There was no alarm sounding when the housekeeper found (R1). The housekeeper was walking by the room when she saw (R1)."

On 05/10/09 at 11:50AM E7 (Licensed Practical Nurse) stated, "I got to (R1's) room after the other nurse found him. I began neurological checks like we were supposed to then he was transferred to the hospital. I did the incident investigation and made the following suggestions: Keep tread socks on; reinforce the use of call light; and possibly use a bed alarm. I was not aware bed alarm was on care plan."

On 05/07/08 direct care givers were interviewed regarding the definition of "frequent monitoring" when used as an intervention on resident care plans. Responses received were:

9:50AM E14 (Certified Nurse Aide) stated, "When they say frequent monitoring it means to me to check monitors and body alarms. I only work down my hall and try to check them often."

10:10AM E15 (Certified Nurse Aide) stated, "When it says frequent monitoring it means to keep checking them maybe every 30 minutes."

10:30AM E17 (Certified Nurse Aide) stated, "Frequent monitoring means you keep watching them (residents). They might be at risk."

10:15AM E16 (Certified Nurse Aide) stated,

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"Frequent monitoring usually means every 15 minutes or so and to check body alarms."

04/26/09 at 1:55PM E6 (Care Plan Coordinator) stated, "The Rehab nurse and I meet after falls and discuss new interventions. Then if it is a fall the Rehab Nurse updates the care plan."

On 04/26/09 at 1:30PM E3 (Corporate Nurse Consultant) states, "Yes, we are to do falls risk assessments within 24 hours after each fall."

On 40/26/09 at 2:00PM E4 (Rehab Nurse) states, "After each of (R1's) falls I would add a new intervention. (R1) was very independent but needed assistance. The staff has access to the care plans."

Facility Policy titled Accident/Incident Investigation provided on 04/26/09 states: "The Director of Nursing is responsible for the initiation of an investigation within 24 hours of the incident. All investigations are to be conducted by the interdisciplinary team and are to be documented and logged."

2. Facility Physicians Order Sheet for R4 dated 05/01/09 state diagnoses of Parkinson"s Disease, Chronic Obstructive Pulmonary Disease, and Dementia. Minimum Data Set dated 11/17/08 state R4 has severely impaired cognitive status and is totally dependent on staff for transfers.

On 05/06/09 at 2:40PM, R4 was in room lying on a mat on the floor next to the bed. Facility staff was not present in room. Neither R4's body alarm nor motion detector alarm were sounding.

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E10 (Certified Nurse Aide) was taken to room. E10 stated, "I just came on duty. There are no alarms sounding." E10 then picked up the body alarm off the floor underneath R4's bed. E10 stated, "I don't know about the motion detector."

At 2:45PM E4 (Rehab Nurse) was taken to R4's room. E4 stated, "There is no alarm on and I don't see the motion detector in place." E4 then searched R4's room for the motion detector and stated, "Oh, here it is lying on (R4's) bedside table. It is supposed to be attached to the bed. I'll call maintenance and let the Administrator know." R4's bedside table is at the opposite corner of the room.

Nurses notes for R4 dated 04/27/09 (no time documented) state "Certified Nurse Aide went to resident's room and found resident on the floor and came and got nurse. We put resident on the bed and did neurological checks. Resident had the floor mattress to the side of the bed." Nurses notes do not indicate that motion detector was alarming.

Facility care plan for R4 dated 11/10/08 states: "Fall risk related to mobility impairment, poor decision making ability and decreased judgment and safety awareness. Recent history of falls." Intervention for R4 dated 03/03/09 states: "Fall: toileting program, make sure staff is following program; motion sensor on bed." Intervention for R4 dated 04/27/09 states: "Frequent monitoring at night; motion sensor on at all times while in bed."

3. The Physician's Order Sheet for R5 dated 05/01/09 states diagnoses of Congestive Heart Failure, Syncope, Chronic Obstructive Pulmonary

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Disease, and Dementia. Minimum Data Set for R5 dated 01/26/09 states limited assistance one person assist for transfers and ambulation.

On 05/07/09 at 8:15AM, R5 was wheeling down hallway towards room. Body alarm was on the back of R5's wheelchair but was not attached to R5's clothing. R5 then entered room and transferred independently to bed. Mattress pressure sensor was sitting on bedside table next to R5's bed. E19 (Assistant Director of Nursing) was taken to R5's room. E19 stated, "(R5) should have pressure sensor on mattress. Staff had not made bed yet so they sat it on bedside table. They should have left it on the bed."

Care plan for R5 dated 11/10/08 does not address the need for pressure monitor on R5's bed.

On 05/07/09 at 9:30AM E4 (Rehab Nurse) stated, "He has a pressure alarm on his bed as a precaution. I guess I didn't put it on the care plan. I'm not sure if he is supposed to have a body alarm in wheelchair, I'd have to check the chart."

4. The Physicians Order Sheet for R2 dated 05/01/09 states diagnosis of Dementia. The Minimum Data Set for R2 dated 01/26/09 states has moderately impaired cognition and requires one person assistance for transfers and ambulation.

Falls Resident Assessment Protocol dated 10/27/08 states "Resident is at risk for falls. Keep bed in the low position, call light within reach, and non-skid footwear. Resident has body alarm to notify staff of resident attempting to get up on own."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146041	A. BUILDING ______ B. WING ______	C 05/15/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW TERRACE	430 SOUTH 30TH AVENUE EAST MOLINE, IL 61244

(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
F9999	Continued From page 28	F9999		

Care plan intervention for R2 dated 11/10/08 states "Monitor resident closely; check to assure body alarm in place." Care plan intervention for R2 dated 03/03/09 states "Motion sensor on bed."

On 05/06/09 at 9:35AM R2 was lying in bed. No facility staff was present. Bed was not in low position. Body alarm was attached to R2's wheelchair and disconnected from R2. Motion detector was not alarming and was not visible in R2's room. E9 (Certified Nurse Aide) was brought to R2's room. E9 stated, "(R2) is supposed to have an alarm on in bed. (R2) must have transferred self. (R2) is supposed to have assistance but gets independent. The alarm didn't go off. (R2) must have un-hooked it and then put self to bed. I don't see a motion detector."

On 05/06/09 at 10:20AM E4 (Rehab Nurse) stated, "Sometimes (R2) takes the body alarm off. The motion detector should have sounded. I'll have maintenance check it."

On 05/06/09 at 3:00PM E10 (Maintenance Supervisor) stated, "I set the motion detectors up and attach them to either the bed or the wall near the bed to make sure they pick up motion. I don't like them (motion detectors) because they don't catch everything that moves or they get bumped and knocked out of range. I like the body alarms because they seem to work better.

On 05/07/09 at 10:30AM E17 (Certified Nurse Aide) stated, "I like the body alarms better than the motion detectors because they go off quicker and you can hear them better."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146041	A. BUILDING ______ B. WING ______	C 05/15/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW TERRACE	**430 SOUTH 30TH AVENUE EAST MOLINE, IL 61244**

(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
F9999	Continued From page 29 On 05/07/09 at 10:10AM E15 (Certified Nurse Aide) stated, "I have found the motion detectors not working and I have to get maintenance. " On 05/06/09 at 3:10PM E13 (Licensed Practical Nurse) stated, "Sometimes when I find the motion detectors are not working I have to let maintenance know. Sometimes they (motion sensors) drive us nuts but they are good for the residents." (A)	F9999		