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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE MANOR OF VIRDEN	333 SOUTH WRIGHTSMAN STREET VIRDEN, IL 62690

(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
F 490	Continued From page 72 their use of water at the facility was in place. On 06/16/09 at 5:00 PM, R17 indicated she brushed her teeth in her sink during the boil order. The nursing staff also used the nonpotable water from the sinks in the facility to wash their hands and do mouth care for at least one resident. At 06/18/09 at 10:00 AM, E21 indicated that she used water from the sink for mouth care on R4. E35 (Cook) and E17 (Food Service Supervisor) were interviewed on 06/18/09 at 9:00 AM and confirmed that the kitchen staff did use water directly from the sink to wash their hands and to wash vegetables during the boil order. The facility policies did not address when they would initiate their Emergency Water Agreement, or how water will be stored or distributed for the various needs of the facility. The Emergency Water Agreement was also out of date with a signature dated 09/01/04. The boil order was lifted on 06/16/09 at 9:00 AM when the Z5's office notified the facility that EPA water sample test cleared the water for use.	F 490		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)4) 300.1210b)6) Section 300.1210 General Requirements for Nursing and Personal Care	F9999		

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F9999	Continued From page 73 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: 4) Personal care shall be provided 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 were not met as evidenced by: Based on observation, interview and record review the facility failed to assess, investigate, and analyze the post fall data to determine the root cause of the falls, failed to Care Plan and implement effective interventions, and failed to devise a system of communication for staff to immediately know who is at risk for falls in order to prevent falls for 1 of 15 sampled residents (R2). Findings include: 1. Review of the June 2009 Physician's Order	F9999		

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F9999	Continued From page 74 Sheet (POS) shows that R2 has diagnoses which include Hypertension, Peripheral Vascular Disease with a Vascular Ulcer of the right inner ankle, Anxiety, Depression, Glaucoma, and Dementia with Behavior Disturbance. Review of the Minimum Data Set (MDS) assessment dated 6/1/09 shows that R2 has both long and short term memory problems and is severely impaired for decision making. The MDS has assessed R2 with behaviors associated with delirium including being easily distracted, and having periods of altered perception with restlessness and lethargy. It also shows that R2's mental function varies over the course of the day. R2 has both hearing and visual impairments. R2 also displays mood and behavior problems manifested as anxiety, depression, and displays socially inappropriate behavior in which there has been an overall decline. Review of the MDS also shows that R2 is non-ambulatory and requires extensive assistance with 1 to 2 staff to complete activities of daily living (ADLs). R2 is frequently incontinent of bladder and is dependent upon staff for incontinent care. R2 is 66" tall and weighs 166 pounds. The MDS also shows that R2 has had falls within the last 30 days and also within the past 30 to 180 days. R2 is unable to maintain sitting or standing balance without physical help. R2 has limited range of motion with one arm and both legs with partial loss of voluntary movement. Currently R2 wears a personal alarm when in the wheelchair, recliner and in bed. Random observations on 6/19/09 through 6/30/09 showed that the alarm was attached with a diaper-type pin in the back of R2's shirt. Review of the Resident Incident Reports show that R2 fell on 12/11/08, 1/5/09, 1/18/09, 2/17/09,	F9999		

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F9999	Continued From page 75 2/25/09, 5/13/09 and on 6/14/09. Review of the Resident Incident Report dated 12/11/08 at 4:00 a.m. showed: R2 fell when he was found on the floor next to the bed. The Incident Report and the Investigation Report were not complete. The investigation report identified "dementia" as one of the possible causes. Staff also documented that R2 was incontinent. The origin was stated as "Apparently attempted self transfer." "Make sure he is repositioned frequently, if restless get him up" was documented as approaches to prevent future occurrences. Review of the Incident Report dated 1/5/09 showed that at 7:45 pm R2 slid out of his recliner. The Investigation Report question regarding "Identify any possible factors that could have precipitated the incident" was left blank. The origin of the fall was "slid out of chair." E2, Director of Nursing (DON) documented this fall as an "isolated incident, will continue to monitor." Review of the Incident Report dated 1/18/09 at 10:00 am, showed that R2 experienced a fall when he "slid out of chair reaching for something in the chapel." The origin of the incident stated "reaching for object." E2, Director of Nursing (DON), documented to "encourage to ask for things, attempt to reinforce moving closer to object prior to reaching" to prevent future occurrences. Review of the Incident Report dated 2/17/09 at 6:00 p.m. showed that R2 slid out of the (wheelchair). On the investigation report, "Dementia" was listed as the causal factor. E2 documented the origin of the incident as "slid out	F9999		

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of chair." The approach to "watch closely and put a non-skid (pad) on wheel chair cushion" was listed to prevent future occurrences. Although the Incident Report showed that R2 was wearing a Personal Alarm which did not sound, it was not addressed in the Investigation Report nor on the Care Plan.

Review of the Incident Report dated 2/25/09 at 6:00 p.m. showed that R2 had a fall. The Investigation Report documents "Resident observed to be laying on the floor on his (right) side... .5 cm bruise to (right) elbow. Noted personal alarm pin had been undone. E2 documented the origin of the fall to be "Slid out of wheelchair." The approach "changed cushion out, pommel cushion now in place." Again, although the Incident Report showed that R2 was wearing a Personal Alarm which did not sound, it was not addressed in the Investigation Report nor the Care Plan.

On 6/16/09 at 1:35 p.m., R2 was observed in the hallway of the Special Care Unit. R2 was holding on to the back of another resident's wheelchair. R2 did not have the Personal Alarm attached to the wheelchair. A check of R2's room showed that the Personal Alarm was attached to the side rail on the resident's bed. When questioned, E20, CNA stated that "(R2) is to wear the body alarm at all times because he tries to get up on his own." At 1:40 pm, E20,CNA confirmed that R2's Personal Alarm was attached to the bed stating, "They probably just forgot it "

Review of the Nurse's Notes dated 5/31/09 showed that R2 had a fall at 6:35 pm. Upon request, the facility produced the Incident Report along with the Investigation Report. Nursing staff

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documented "Dementia" as one of the factors that could have precipitated the event. Staff also wrote "(R2) was in recliner (and) slid off foot rest onto floor." E2 documented the origin of the fall as "slid out of chair." E2 commented "see if piece of 'antislid' material can be put in the recliner."

Review of the Resident Incident Report dated 6/14/09 at 3:30 p.m. showed that R2 fell out of the wheelchair causing a hematoma and an abrasion to the right cheek and forehead area. The Investigation Report was incomplete and was blank regarding factors that could have precipitated the event. The incident was described as "wheel of wheelchair went off sidewalk causing chair to turn over. Abrasion and bump received from hitting ground and glasses." The origin of this incident was documented as "ran off sidewalk causing wheelchair to fall over." To prevent future occurrences, E2 wrote "have someone hold onto wheelchair at all times when outside."

None of the Resident Incident Reports and the Investigation Reports for the above falls were filled out completely nor did they contain enough information to determine the root cause of the fall, and there were no resident specific approaches added to the Care Plan to be implemented to prevent future falls.

Interview with E13, RN Restorative Nurse on 6/25/09 at 10:00 a.m. showed that she completes a restorative assessment which would indicate if a resident who is already receiving restorative services needs Fall Risk data collection. E13 stated that she completed this assessment for R2 on 12/18/08, 2/25/09 and on 6/2/09. E13 stated

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that she does not complete a new assessment after each fall and tries to do them every 3 months and not necessarily in response to a specific resident fall occurrence. On the back of the form she does document the falls. None of the forms completed indicate that R2 should have "Fall Risk Data Collection & Assessment as indicated," On the form dated 12/18/08 the falls of 2/17/09 and 2/25/09 are recorded on the back of the form, on the form dated 3/13/09 the fall of 5/31/09 is recorded and on the form dated 6/2/09 the fall of 6/14/09 is recorded. When questioned E13 stated that this is the only assessment that is completed as the facility does not complete any fall risk assessments to determine if a resident is at risk for falls or after a resident has a fall.

The Resident Fall Management Plan documents "It is the policy of this facility that upon the resident's admission/readmission, their transfer and ambulation ability will be addressed." This policy does not address resident fall assessments, care plan updates for falls with interventions, or how to identify residents at risk for falls.

Review of R2's Care Plan dated 6/4/2009 shows that Problem (10) documents "(R2) is at risk for falls (due to) history of falls, impaired judgement, poor safety awareness. He has had a fall in the last six months." The onset date is 12/22/2008. The review date of 6/4/09 is crossed out and 6/14/09 is written in. The falls from the previous quarters are not listed on this current Care Plan. Staff had changed the review date to 5/31/09 but did not indicate that this was the date of a recent fall. Information about the cause and affect were not in the Care Plan and the Care Plan approaches had not been updated. Care

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Plan approaches were broad based and nonspecific. Care Plan approaches included: 2) Encourage (R2) to wait for assistance to transfer, (5) Monitor in Recliner for Sliding, (6) Encourage (R2) not to reach for objects, (7) Encourage (R2) to ask for help to pick things up. The "reminders" approaches were not appropriate for a resident with severe cognitive impairment and long/short term memory loss according to E2, DON.

According to E13, RN Restorative Nurse, the falls are not carried over from one Care Plan to the next Care Plan. And to actually see when R2 fell staff would have to access the North Conference Room and find previous Care Plans in order to see the fall history for this resident. A review of the Care Plan dated 3/18/09 showed that no falls were listed for the quarter from 3/18/09 to 6/4/09. A review of the Care Plan dated 12/22/08 showed that Problem (10), Falls, did not have any information about the falls. The only information added to the Care Plan were the review dates of 1/5/09, 1/18/09, 2/17/09, and 2/25/09. Staff did not indicate that these were dates that represented falls for R2. There was nothing written regarding the falls, the time of day, the circumstances, and what specific directives staff were to follow to prevent falls in the future.

Interview with E19, Special Care Unit Director, on 6/29/09 at 3:20 p.m., and also with E13, Registered Nurse (RN) Restorative Nurse, confirmed that to see the history of a resident's falls, staff would need to see the resident's Care Plan for the quarter in which the falls occurred. It took E13 approximately 10 minutes to find R2's past Care Plan in the file. During this interview, E19 also stated that agency staff is used in the

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F9999	Continued From page 80 Special Care unit stating that all agency staff have had the four hour dementia training. When questioned how staff know when to put an alarm on a resident and how they know what precipitates an aggressive episode, E19 stated that staff can come out to look at the Pre-assessment Form in the medical record which gives a detailed history of the resident's stage of dementia which is more lengthy than the monthly notes. The Special Care resident medical records, Care Plans, and resident card index information is behind the North wing nurses desk which is outside of the Special Care Unit. When questioned, E19 did not know where the CNA Resident card index for the Special Care Unit residents was located. E19 explained that information from shift to shift for CNA's was communicated with the CNA Pass On Sheet, which contained information that occurred during the previous 24 hours. Review of the C.N.A. Report Form showed that it had three columns for each shift with 16 rows where information about falls, Behaviors, Urinary Output and other care needs are listed. E19 stated that these sheets are for one day and are turned in to the DON at the end of each 24 hour period. E2, DON stated that she keeps them for a few weeks and then throws them away. When asked, E19 said she was not sure if R2 had three alarms available for use in the chair, recliner and in bed. E19 stated that if a staff person had not worked for a week or two on the unit that they could look on the treatment sheets to see if a resident was receiving treatments for any falls. During interview E19 indicated that R35 and R12 would be considered at high risk for falls. When questioned about R2, E19 stated "it is hard to determine with him. It depends on his	F9999		

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F9999	Continued From page 81 mood, when he becomes agitated or antsy." When questioned on 6/25/08 at 4:40 p.m. regarding how the nurse would know if a resident was at high risk for falls, E14, Licensed Practical Nurse (LPN) stated, "there would be no immediate way to know." E14 stated that she works the evening shift on the unit 5 days per week and that she could always check the care plans behind the desk at the North nurses station. When asked if any resident on the Special Care Unit was at risk for falls, E14 stated, "(R35), he'd be about the only one for high risk. PT (Physical Therapy) is working with him on that. That's all I know. Most information is by word of mouth and observation." When asked if R2 was at risk for falls, E14 stated, "it just depends on him. You can just tell when he gets in his mood, by his behavior. He does have a personal alarm. His behavior can change right away." Observation on the Special Care Unit on 6/25/09 showed that there are no identifiers, such as a falling star, to alert staff if a resident is at risk for falls. Other staff interviews with staff regularly assigned to the unit, E15, E16, E11 and E27 Certified Nurse Aides (CNAs) who routinely take care of R2 did not identify him as being a high risk for falls. They named R35 and R12 as being at high risk. E15 stated that he knew that R2 could throw the footrest legs down and then could slide between the foot rest and the side of the chair and is aware that R2 has slid out of the chair before. E15 stated that residents with alarms such as R12 were considered to be at risk for falling. Interview with E43, CNA on 6/26/09 at 1:40 p.m. showed that R2 was considered to be at risk for falling as well as any other resident	F9999		

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F9999	Continued From page 82 who had an alarm on. E43 stated that she never knows when R2 will get agitated or how to calm him down as some approaches work at different times. E43 stated that when R2 gets worked up he has more fidgeting with yelling. E43 stated that she did not know what causes agitation but has heard when R2 has 1 to 1 supervision with staff and he does much better . None of the staff interviewed could readily identify R2 as being at high risk for falls or specific care plan approaches for dealing with precipitating factors such as behaviors. Interview with agency staff E42, CNA on 6/29/09 at 6:00 p.m. showed that she has been an agency CNA for the past 10 years and has worked at the facility for 8 years. E42 stated that she had been working on the Special Care unit since it opened in February 2009 stating that she had completed the 12 hour Dementia class. E42 states that if she's been off for a few days then she asks staff "Is there anything new on anyone since I've been there. I'm not afraid to ask about bowel movements, new intake and output records, new residents, falls, eating changes or new hospice residents." E42 stated "you got to have good communication and you can ask the nurses too, or you can observe the residents and their behavior and look for signs of pain or agitation." Speaking of R2, E42 stated he wears a personal alarm in the wheelchair, bed, and recliner. E42 said that if she has been gone for a few days, she could ask any staff if any residents fell while she was off or if a resident was on full vitals she would know if they had experienced a fall. E42 stated that there is a Resident card index on all of the halls. E42 stated that she has not worked on the Special Care unit for approximately 1 1/2 weeks. She stated that she	F9999		

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F9999	Continued From page 83 is not sure if R2 has had any falls in June, however she did recall that R2 fell outside. She did not recall if R2 had any other falls before that. "I don't think he's a fall risk at all. Accidents happen so you just never know." The current Care Plan directs staff to keep the call light within reach. On 6/17/09 R2's call light not within reach. During a random observation on 6/18/09 at 8:40 a.m., R2 was observed seated in the wheelchair in his room. The wheelchair was facing the seat of the roommate's recliner. The call light was observed on R2's bed on the other side of the room and was not within reach of the resident. (A)	F9999		