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	146134	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALINE CARE CENTER	120 SOUTH LAND STREET, PO BOX 468 HARRISBURG, IL 62946

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F 458	Continued From page 17 on side II only provide 72 square feet of floor space per resident bed #s 3,6, 8, 9, 11, 12, 15-20,22-27,29-31,34 ,35, 38. 39, 41,,42,44-48. These rooms are provided with 2 beds each.. E1 (Executive Director) confirmed at approximately 2:00 P.M. on 2/6/12, that Room#s 108 and 109 on Side I are Medicare/Medicaid certified and that all of the rooms on Side II are Medicaid certified. At the time of the survey the space provided in these room was adequate to meet the needs of residents.	F 458		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.1210a) 300.1210b)6) 300.1220b)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care	F9999		

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needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)
b) The facility shall 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 resident care plan. 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:
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 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

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F9999	Continued From page 19 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. These Requirements are NOT MET as evidenced by: Based on observation, interview and record review the facility failed to protect residents from avoidable accidents resulting in injuries for 2 residents (R7, R24) reviewed for falls/injuries in the sample of 27. These failures resulted in R7 being taken to the local emergency room and received 12 sutures to her right hand on 12-09-11 as a result of a fall. Also R24 was taken to the local emergency room and was treated for contusions to the hip and a sprain on 01-23-12 as result of a fall.. Findings include: 1. R7 is a 92 year old woman residing in the facility since 5/27/2011 according to facility admission records of that date. The Physician Order Sheet dated 2/1/2012 lists R7's diagnoses to include Alzheimer's Disease, Cardiomyopathy, Restless Leg Syndrome, Rheumatoid Arthritis and Polymyalgia. A review of R7's record on 2/5/2012 notes documentation on the facility's Occurrence Reports of 19 falls occurring from 6/5/2011 thru 12/22/2011.	F9999		

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A review on 2/5/2012 of nurses notes for 6/5/2011 thru 1/25/2012 identifies notations of 21 incidents/accidents including; 6/5/2011 found in floor in bathroom, sent to local hospital emergency room for x-ray and complaint of knee pain and hitting head on floor, 6/9/2011 noted lying on left side on bedroom floor, stated she hit her head on the floor, 6/13/2011 found in bathroom on the floor, 6/13/2011 noted lying on floor on stomach, (wheelchair alarm applied, placed at nurses station), 6/15/2011 noted in floor on left side (moved to a room to be closer to nurses station), 6/17/2011 found on floor in front of recliner, 6/27/2011 found on floor in dining room beside the table, 7/4/2011 found lying on floor on left side(laceration to back of head), 8/7/2011 found sitting on buttock in middle of the room 8/22/2011 found sitting on floor , 9/17/2011 fell standing from table (laceration to head, sent to local hospital emergency room for treatment), 10/1/2011 found on floor between wheelchair and recliner, 10/11/2011 found on floor leaning on recliner chair, 10/13/2011 found lying on floor on right side 10/30/2011 found sitting on floor at end of bed, 12/8/2011 found on bottom in room, 12/9/2011 found lying on floor on stomach in front of bathroom door (sent to local hospital emergency room 12 sutures to right hand), 12/15/2011 found lying on floor face down, 12/22/2011 found lying on bathroom floor on left side, 1/21/2012 found on floor.

The Fall Risk Assessment of 11/20/11 with a score of 17 indicates R7 is high risk for falls. The Functional Status on the Minimum Data Set/MDS of 11/20/2011 notes R7 is extensive physical assistance of one person for transfers, limited

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assist of one person using a wheelchair for travel about the facility, has unsteady balance during transition and walking, and is occasionally incontinent of urine. The Care Plan updated 11/23/2011 has a goal for R7 to avoid future falls, 5 falls occurred since this care plan was last revised. Interventions identified on the care plan of 11/23/2011 list having R7 rise slowly from sitting to standing or lying to upright position, assess environment to prevent recurrent falls, perform assessments and evaluation of R7 post fall, observe for 48-72 hours after falls, refer to physical therapy for evaluation, and remind R7 to ask for assistance. Also added to the care plan are notations on 6/9/2011 to add personal alarm, 6/13/2011 1 hour checks, 6/15/2011 moved to room 104 (closer to nurses station), 8/7/2011 remind to ask staff for help, 8/22/2011 reeducate R7 on standing and transferring without assistance. The Care Plan fails to monitor effectiveness of the interventions and modify the interventions accordingly. The Quarterly Functional Assessment Transfer/Bed Mobility notes R7 is alert, confused, cooperative, uncooperative, and follows cues, and requires moderate-maximal assist of 2 with transfers.

During an interview on 2/8/2012 at 10:30 am with E1 (Executive Director) and E2 (Administrator) about plans to prevent falls/injuries to R7, E1 stated "we have tried everything and we don't know what else to do, she has a right to fall and I spoke with her this morning and asked her if she knew she would probably fall if she kept getting out of the chair without asking for help and she replied "I know but I am going to keep getting up." E1 continued talking and asked "what do you want me to do tie her down in the chair I won't do

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that." E2 stated "we have tried everything I know without restraining her, I don't know what else to do." E2 added she has spoken with R7's family and they were not able to offer any suggestions on how to prevent R7 from falling. Both E1 and E2 stated the family does not want her restrained.

On 2/09/2012 at 9:45 am R7 was observed sitting slumped down in a wheelchair in the dining room waiting for activities to begin. R7 was not wearing a self releasing belt or personal body alarm and no alarm was noted attached to the wheelchair. At this time R7 was interviewed about falls, injuries, and about asking for assistance from staff when needed. R7 was noted to be pleasant and confused and was not able to explain risks and benefits of consenting to fall, or her right to do so. R7 denied falling or getting out of the chair without asking for help. R7 denies falling and being injured. When asked about using the call light to alert staff she needs help R7 stated "that's what they say that is for but I don't know about that". R7 was able to state her birthday is next month and on the 15th, she was unable to tell her correct age, she first stated she was 90, then said 95. R7 is actually 92 years old. When R7 was asked about her knees/legs hurting she denied pain, when asked about the injury to her hand, R1 picked at a old scab and denied an injury.

2. R 24 is a 63 year old woman residing in the facility since 7/29/1986 according to facility admission records of that date. The Physician Order Sheet dated 2/1/2012 lists R24's diagnoses to include; Hypoxemia, Polydipsia, Iron Deficiency Anemia, Psychosis, and Acute Mental Illness. A review of R24's record on 2/5/2012 notes documentation on the facility's Occurrence

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F9999	Continued From page 23 Reports of 10 falls occurring from 8/11/2011 thru 1/23/2012. A review on 2/5/2012 of nurses notes for this period identified occurrences/accidents including; 10/21/2011 found sitting on floor in room, 11/4/2011 found sitting on floor, 11/12/2011 found on the floor,(complaining of left hip pain) 12/8/2011 found lying on floor on left side (complaining of face hurting), 1/10/2012 observed sitting on floor in room, 1/23/2012 (sent to local hospital emergency room treated for contusion, sprain of ribs, contusion of hip). The Fall Risk Assessment dated 12/11/2011 notes a score of 21 indicating high risk for falls. The Functional Status on the Minimum Data Set/MDS of 12/11/2011 notes R24 is limited physical assistance of one person for transfers, limited assist of one person using a wheelchair for travel about the facility, has impairment of the upper extremity, and is occasionally incontinent of urine. The Care Plan updated 12/15/2011 has an identified problem with falls, at risk due to diagnoses of Hemiplegia and History of Falls. The goal for this problem is falls will be avoided and safety will be maintained. R24 has sustained 2 additional falls since the care plan was updated. Interventions for the fall problem include check to ensure the mobility/transfer device works properly, check environment for risk factors, encourage wearing rubber sole and non skid slippers, ensure clothing does not cause tripping, ensure lighting is adequate, put to bed when sleeping in wheelchair, remind to use call light, assist when incontinent. The Quarterly Functional Assessment for Transfer/Bed Mobility of 12/26/2011 identified R24 to be alert, cooperative,	F9999		

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F9999	Continued From page 24 uncooperative and severely hard of hearing. On 2/9/2012 at 11:00 am an interview with R24 was attempted. The interview noted R24 to be extremely hard of hearing and speech was difficult to impossible to understand. R24 was asked if she had been falling and R24 nodded yes. When asked if she had fallen out of bed R24 nodded yes. When asked if she could tell why she was falling or if she asked staff for help R24 did not respond. It is unclear and difficult to determine which questions R24 heard or understood and how accurate or appropriate her answers are. (A)	F9999		