STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145630	A. BUILDING ____ B. WING ____	C 02/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST VILLA NSG & REHAB, LLC	**6840 WEST TOUHY AVENUE** **NILES, IL 60714**

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F9999	FINAL OBSERVATIONS	F9999		

LICENSURE VIOLATIONS

300.1210a)
300.1210b)5)
300.1210c)
300.1210d)2)6)
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 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

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F9999	Continued From page 13 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 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 300.3240 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 Requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to supervise 2 residents	F9999		

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(R3 and R2) reviewed for falls. R3 has a diagnosis of blindness and was not supervised in an area near a stairwell. On 2/4/12 at around 12:15 PM, R3 was observed unsupervised in his wheelchair by the stairwell area that leads to the basement. R3 fell down the stairwell (15 steps) and was sent to the hospital via 911. R3 sustained a C7 cervical fracture, 6 x 4 inch laceration to the head, anterior left scalp hematoma, and subarachnoid hemorrhage. R3 expired at the hospital on 2/6/12, after life support was removed.

Findings include :

A) R3 was admitted to the facility on 1/15/12 with diagnoses of Left Hip Fracture, Diabetes Mellitus, End Stage Renal Failure, Left Above the Knee Amputation, Right Foot Metatarsal Amputation, Anxiety, Depression, Diabetic Retinopathy, Left Eye Blindness, and Poor Vision of the Right Eye.

R3's hospital History and Physical (H & P) dated 1/12/12, indicated that R3 was initially from another facility where he sustained a Non - Displaced Left Intertrochanteric Fracture, after falling from his wheelchair. R3 feel asleep in the wheelchair and fell out of his wheelchair sustaining this injury. At the hospital, no surgery was done because of R3's medical issues and instead, R3's left lower extremity was placed on Non-Weight Bearing Status, to allow healing. This H & P also indicated that Z2 said that in the last month and a half prior to the hospitalization, that R3's mental status has been declining significantly, that he had significant change in cognition, and had some level of delirium. At the hospital, Z2 functioned as R3's agent, as R3 was

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not able to engage in meaningful informed consent for himself.

R3's progress note dated 1/18/12 at 8:52 AM indicated that although R3 appears alert and oriented x 2-3, R3 has periods of forgetfulness and confusion. R3's 2/1/12 Progress note at 8:12 AM, also mentioned that R3 has periods of confusion, and needs 2 staff assistance for bed mobility. R3's Minimum data Set (MDS) dated 1/24/12, also coded R3 as moderately impaired (decisions poor, cues/supervision required) in Cognitive Skills for Daily Decision Making. R3's 1/24/12 Care plan also indicated that R3 has impaired decision making due to cognitive deficits.

On 2/9/12 at 10:20 AM, E8 (nurse) said that she took care of R3 when he was at another unit of the facility. E8 thinks R3 has periods of confusion. E8 explained that R3 would yell a lot, but when E8 came to see what R3 needed, R3 would become quiet and would respond that nothing is wrong. Then as soon as she stepped out, E8 said that R3 would start yelling again. Similarly, according to E7 (nurse) on 2/8/12 at 3:02 PM, R3 was demanding, confused at times, and was always shouting in his room when he wants to smoke. E7 said that one time R3 asked her if it was lunch time, when it was only breakfast time. E7 continued that one time, R3 insisted that his wallet with $30 was missing, and insisted that it was just in his pocket. It turned out, Z2 said that his wallet had been left home since R3 was admitted to the facility. On 2/8/12 at 2:05 PM, E6 (certified nurse aide/CNA) also said that R3 would scream in bed, would become quiet when E6 was in the room, and would start screaming

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again afterwards.

R3's hospital Physical Therapy Evaluation dated 1/6/12 indicated that R3 is blind in his left eye and has poor vision on the right eye. R3's 1/16/12 Nurses Notes entry at 4:00 AM, also indicated that R3 cannot see in his left eye. R3's care plan dated 1/24/12 however, erroneously listed R3 only as with decreased vision in the left eye rather than being blind as per hospital record, and did not mention vision impairment in the right eye. R3 had no vision test or assessment while at the facility to determine the extent of his vision impairment.

On 2/10/12 at 2:25 PM, Z1 (R3's attending physician) said that she is aware that R3 is blind in the left eye and has blurry vision in the right eye, but does not know the extent of his vision impairment. Z1 said that she did not test R3's vision.

R3's Physician Order Sheet indicated that on 1/24/12, R3 was placed on Bed Rest for 6 weeks. This order was revised on the same day to Bed Rest except on Hemodialysis.

Z1 wrote on R3's Physician Progress Notes dated 1/16/12 that R3 has left Hip Fracture, and is non-weight bearing for at least 6 weeks. On 2/2/12, Z1 wrote in R3's Physician Progress notes that at this time, R3 is now on complete bed rest.

On 2/9/12 at 2:05 PM, Z1 said that there was no surgery done on R3's fractured Left Hip, so R3 was placed on bed rest for 6 weeks. Z1 said that she is aware that R3 would scream when he was on bed rest, so the facility had him get out of bed

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to smoke once a day.

E10 (Social Worker) said on 2/9/12 at 1:55 PM, that when R3 came to the facility, he was placed on bed rest, but R3 would howl and complain that he wants to get out of bed and smoke. E10 added that Z2 and R3 made a compromise with the facility, that R3 would be allowed to smoke once a day at 3:00 PM, even though it was against physician orders.

On 2/8/12 at 2:27 PM, E3 (nurse) said that she was R3's nurse on 2/4/12. E3 said that R3 came back to the unit after his inhouse dialysis at around 11:30 AM. E3 continued that she came to R3's room after hearing R3 yelling. E3 said that R3 was in the dialysis chair, and said that he wanted to go back to bed. E3 continued that she told R3 she is going to get help, and R3 responded by saying " Hurry up." E3 said that as soon as she got in the hallway, R3 screamed again that he needed help. E3 said that when she came back to his room, R3 was already sitting at the edge of his bed and apparently transferred himself to bed without assistance and despite her instruction not to. E3 continued that she told R3 not to do that again, and as soon as R3 layed his his head down in bed, R3 said he wanted to get out of bed again. E3 said that she saw E6, and E6 together with E5 (CNA), helped R3 out of bed. E3 said that she saw E5 wheel R3 to the Dining Room afterwards. E3 further said that R3 did not stay in the Dining Room and propelled himself to E3, and asked E3 if E3 could take R3 outside for a smoke. E3 said she told R3 to wait after lunch time, which was in 30 minutes. E3 said this was the last time she saw R3, which was between 11:55 AM to 12:00 PM. E3 said that R3 was

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supposed to be on bed rest for 6 weeks because of his hip fracture, but was up in his wheelchair because R3 was screaming, shouting, and insisting to get out of bed. E3 said that she only took care of R3 once before, and did not remember him screaming or trying to get out of bed during that time. E3 continued that she is aware that R3 had vision problems in his right eye, but does not know to what extent. E3 also said that R3 was unsafe, as he transferred himself without assistance despite of her (E3's) direction to wait for staff.

E6 (CNA) said on 2/8/12 at 2:05 PM, that R3 was a very demanding guy, and was screaming and yelling all the time. E6 said that R3 never listened to anyone, wanted to smoke anytime he wants, would not stay in one place and would wheel himself in his wheelchair. E6 said that she was aware R3 has a schedule to smoke at 3:00 PM. E6 said that on 2/4/12, she was not assigned to R3, and had taken care of R3 only once before. E6 said that when she first took care of R3, R3 screamed and yelled while in bed, but E6 said she did not get him up until it was close to 3:00 PM, his smoking schedule. Even though R3 screamed and yelled, E6 said she checked R3 frequently and he did not fall while in bed that day. E6 said she was not aware he wa supposed to be on bed rest at all. E6 added that on 2/4/12, R3 went back to bed from his chair without any assistance. E6 said she stayed with him until E5 (who was assigned to R3 that day) came in and helped E6 place R3 in his wheelchair from bed. E6 said that was the last time she saw R3, as she left R3 with E5 after that.

Aside from E6, E7 (R3's regular nurse) also said

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F9999	Continued From page 19 that although R3 would always want to get out of bed and smoke, E7 would leave R3 in bed until it was time for him to smoke at 3:00 PM. E7 said that R3 would yell, and distraction and his prn medication (Xanax) were given to address his yelling. E7 said that R3 never tried to get out of bed, and was immobile in bed. E7 continued that she left R3 in bed because R3 has an order for bedrest for 6 weeks, except when he went to dialysis. After dialysis, E7 said that R3 was put back in bed. E7 said that there was only one time when R3 was gotten out of bed while E7 was working which was when R3's family were there to watch R3. E7 added that R3 would demand to smoke at times, but that she would just explain to him why he needs to stay in bed, and R3 stayed in bed. E7 said that she is aware R3 could not see from his left eye. On 2/9/12 at 11:00 AM, E5 (CNA) said that on 2/4/12, around 11:45 PM, she passed by R3's room, and saw R3 talking to E6. E5 said that R3 verbalized that he did not want to stay in bed, he was in pain, and he wanted to smoke. E5 said that E6 and she had no choice, but to put R3 in his wheelchair from his bed. E5 said that she wheeled him to the dining room afterwards, but he refused to stay there, and went to the nurses station instead. E5 said that she next saw R3 in the hallway wheeling towards room 137, when she came out of room 137 to assist another resident in room 139. E5 said that she saw R3 in the hallway and told him to go back to the dining room, but does not know if R3 did. E5 said that that was the last time she saw R3 prior to his accident. E5 said that she did not know R3 was supposed to be on bed rest when E6 and she got him out of bed to the wheelchair on 2/4/12.	F9999		

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F9999	Continued From page 20 Finally, E5 said that if she knew R3 was supposed to stay in bed, she would have left him in bed, and would have asked the nurse for direction regarding R3's desire to get out of bed. Per E4 (nurse) during 2/8/12 interview at 3:30 PM, she came to work at 11:00 AM on 2/4/12. E4 said also that she was not really familiar with R3, did not know he had an order for bedrest, and did not know R3 was blind in one eye and had vision impairment in the other eye. E4 said that on 2/4/12, she last saw R3 sitting in his wheelchair by the nurses station. R3's Nurses Note dated 2/4/12 indicate that at 12:15 PM, R3 was noted supine on the floor at the bottom of the stairs, near the employee stairwell. R3's wheelchair was on top of his upper torso, and he was bleeding from the head. R3 was sent to the hospital via 911. On 2/8/12 at 1:43 PM, E9 (second floor nurse) said that she was walking in the 1st floor hallway on 2/4/12 at around 12:15 PM, when she saw R3 on the top of the stairwell. E9 continued that she yelled for R3 to hold on, but is not sure if R3 heard her. E9 said that she saw R3's hand on the wheelchair wheels, and that R3 propelled forward down the stairs. E9 said that there were no staff in that area supervising R3 during this time. E9 said that R3 must have moved the unlatched stair guard on the side, otherwise he would not have been able to go down the stairs. On 2/8/12 at around 12:05 PM, the stairs where R3 fell were observed to have 15 steps. The stairwell was next to the alarmed door exit leading to the outside of the facility, where	F9999		

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F9999	Continued From page 21 residents normally smoke under staff supervision. The hallway where R3 was last seen is separated from this stairwell area by a double swing door, which was not alarmed prior to 2/4/12 per E11 (falls nurse). The back of the stairwell area is an alarmed door leading to another hallway. On 2/8/12 at 2:27 PM, E3 said that this double swing door is usually closed at all times, but is opened during meal time for the trays from the kitchen, which is also in the stairwell area. Facility's investigation did not explain why R3 was left unsupervised in an area that is hazardous to residents like R3, who had a recent history of falling from his wheelchair, an amputee of the left leg, someone with periods of confusion and was initially care planned as having cognitive deficit, was blind in the left eye and had impaired vision in the other eye, and who had poor safety judgment and poor impulse control as evidenced by transferring himself from a dialysis chair to bed unassisted despite staff direction not to. R3 also had an order for bedrest for 6 weeks except during dialysis, yet was allowed to be out of bed just because R3 was screaming and demanding to get out of bed and smoke. As above, R3 during other times stayed in bed as ordered without any incident of trying to get out of bed, or without any incident of falls from bed. Instead of redirection, prn medication, or distraction to address R3's yelling, anxiety and demands to get out of bed so he could smoke, E3 allowed R3 to be transferred from bed to chair despite physician order of bedrest. Furthermore, per R3's Falls Care Plan dated 1/24/12, R3 was supposed to be observed frequently and placed in supervised area when out of bed.	F9999		

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F9999	Continued From page 22 R3's hospital CT (Computer Tomography) Scan on 2/4/12 showed a non-displaced fracture of the superior articular facet on the right at C7. Other trauma were also noted on 2/4/12: ER's Trauma Flowsheet indicated a 6 x 4 inch laceration; R3's Xray of the pelvis showed a transverse fracture through the lower trochanteric region and an oblique fracture through the intertrochanteric region of the left femur. It cannot be determined if these were the same left hip fractures R3 sustained from a fall from another facility recently, or new ones sustained from the 2/4/12 fall down the stairs. R3's hospital History & Physical also indicated that he sustained an anterior left scalp hematoma. Added to this, R3's hospital Consultation report dated 2/5/12, indicated that the CT scan of the brain also showed a very minimal traumatic subarachnoid hemorrhage, and soft tissue swelling of the left parietal frontal region extracranially. R3's 2/5/12 repeat CT indicated a new swelling of the left hemisphere, either from ischemia or contusion. R3 was extubated on 2/6/12 and expired at the hospital. B) R2 has diagnosis of Dementia and Osteoporosis. R2 was initially admitted to the facility on 10/7/11. R2's incident report dated 1/14/12 indicated that at 4:00 PM, R2 was found in the hallway laying on the floor next to her wheelchair. R2 said that she was trying to get up from her wheelchair, lost her balance and fell. R2 was sent to the hospital and was diagnosed with Left Hip Fracture. On 2/10/12 at 1:30 PM, E11 (falls nurse) said that on 1/14/12, R2 stood up without her walker, and	F9999		

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fell for the first time. E11 said that R2 broke her hip from this fall. E11 said that when R2 was readmitted to the facility after this, R2 was placed on alarms, her room was placed closer to the nurses station, and R2 was placed on therapy.

R2's 2/2/12 incident report indicated that at 6:00 PM, R2 was found on the floor inside the resident's bathroom. R2 said per facility's investigation that she was trying to transfer from the toilet to the wheelchair when she fell.

E11 said on 2/10/12 at 1:30 PM that during her investigation, E12 (CNA) assigned to R2 did not turn R2's wheelchair pad alarm on, thus there was no alarm heard when R2 stood up and walked to the bathroom at around 6:00 PM. E11 said that E12 placed her in the dining room around 4:15 PM.

R2's care plan dated 10/13/11 indicated that aside from the use of mobility alarms, R2 is also supposed to be placed in a supervised area when up and awake, and is supposed to be observed frequently.

(A)