STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146119	A. BUILDING _____ B. WING _____	03/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWOOD	320 SECOND STREET GRAYVILLE, IL 62844

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F 323	Continued From page 27 E10 stated the chair alarm was discontinued 6-7 months ago and was replaced with the electronic monitoring bractlet. 3. The Incident and Accident log and Incident Reports dated 05/09/11 , 06/13/11, and 07/09/11 note R-2 was found in the floor near his bed on the evening and night shifts. The only intervention attempted was a personal alarm.. The Incident Report dated 09/07/11 at 2:30 AM notes R-2 fell from bed and would be in a low bed with a personal alarm. During an observation on 03/12/12 at 2:15 PM , R-2 was in bed. It was not in the lowest position.. At 10 :00 AM on 03/13/12, R-2 was in bed. It was not in the lowest position and both side rails were up.	F 323		
F9999	FINAL OBSERVATIONS Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies	F9999		

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F9999	Continued From page 28 a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care 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: 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: 6) All necessary precautions shall be taken	F9999		

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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 regulation were not met as evidenced by:

Based on observation, interview and record review the facility failed to assess, identify causative factors, implement interventions based on identified hazards, and monitor and modify those interventions when falls reoccurred for 4 residents (R13, R6, R2, R9). This failure resulted in R13 fracturing her left clavicle, right hip, and left hip.

Findings include:

1. R13 a 84 year old woman resided in this facility from 3/24/2011 until 2/7/2012, according to facility admission records of this date. R13's Physician Order Sheet dated 2/1/2012 lists as diagnoses Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Hypoxemia, Dyspnea, and Acute Respiratory Failure.

A review on 3/14/2012 of R13's record notes documentation of R13 falling on 5/7/2011, 5/21/2011, 5/27/2011, 10/3/2011, 10/4/2011,

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11/102011, 12/27/2011, and 2/7/2012. A review on 3/14/2012 of the facility's Incident Log notes R13 fell on 5/7/2011 and sustained a hematoma to her forehead. R13 fell on 5/21/2011 sustaining a laceration and hematoma and was sent to the local hospital for treatment. On 5/27/2011 R13 fell again and sustained a fractured left clavicle. The Incident Log notes R13 fell again on 10/3/2011, and 10/4 2011. On 10/4/2011 R13 sustained a fractured right hip from that fall and received treatment at the local hospital. R13 fell on 11/10/2011 again injuring her right hip, bruising, and a received a hematoma to her right eye. On 2/7/2012 R13 fell and sustained a fracture to her left hip.

A review on 3/14/2012 of the facility's Incident Reports notes recommended steps to prevent recurrence of the fall of 5/7/2011 is "possibly increasing the number of accuchecks, encourage the resident to ask for help." The Incident Report for the fall of 5/27/2011 fails to note recommended steps to prevent recurrences. The Incident Report of the fall of 10/3/2011 lists as recommended steps to prevent recurrence as "1:1 with resident reminded to ask for assist." There are no noted recommendations for the fall of 10/4/2011. The Incident Report of 11/10/2011 notes as recommendation to prevent recurrence "resident did not use call light." The Incident Report of the fall of 2/7/2012 notes recommended steps to prevent recurrence as "we might need to use personal alarm to alert staff resident getting out of bed, check more frequently." No Incident Reports were submitted for review for incidents of 5/21/2011, or 12/27/2011.

Review of an x-ray report dated 6/21/2011 notes

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a non displaced fracture of the left distal clavicle. The Discharge Summary from the local hospital dated 10/5/2011 notes fall with Right Hip Fracture. Review of an x-ray report dated 2/7/2012 notes left hip fracture.

The Minimum Data Set/MDS dated 12/23/2011 Section J - Health Condition fails to identify any falls since admission or prior assessment. This review of 3/14/2012 fails to note a Care Plan, Fall Risk Assessment, Assessment of Cognitive Status, or any other documentation to address causes of falls and appropriate interventions to prevent recurrences of falls.

2. R6 is a 72 year old woman residing in this facility since 6/5/09 according to facility admission records of this date. R6's Physician's Order Sheet dated 3/1/2012 lists her diagnoses to include Tardive Dyskinesia, Recurrent Falls, Bipolar Depression, Dementia with Hallucinations, Parkinson's Disease and Tremors.

A review on 3/12/2012 of R6's record notes 17 falls occurring on 4/20/2011, 5/5/2011, 6/8/2011, 6/21/2011, 7/4/2011, 7/9/2011, 8/27/2011, 8/31/2011, 9/4/2011, 9/6/2011, 9/8/2011, 9/12/2011, 9/24/2011, 9/29/2011, 10/1/2011, 10/3/2011, and 12/7/2011. These 17 falls are also identified on the facility's Incident Log.

A review of the facility's Incident Reports notes observation of occurrence and recommended steps to prevent recurrences for the 4/40/2011 fall "resident found sitting on floor on buttock, chair alarm". Recommendations for the fall of 5/5/2011 " resident observed on mat beside bed, CNA needs to stay with resident while in bathroom, she

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also needed to put alarm on wheelchair". 5/13/2011 " bed alarm went off resident observed sitting on floor, continue with alarm use." 6/8/2011 " resident observed on the floor, resident will not use call light gets up to go to bathroom by self, alarm in use at this time, resident temp 100.4, Tylenol Extra Strength two tabs was given, this may help with sleep". 6/21/2011 " bed alarm sounded resident found on floor, frequent checks on resident, and take to bathroom as needed." 7/4/2011 "got up unassisted and fell, remind resident not to rise unassisted." 7/9/2011 " resident stood up from wheelchair, stumbled and fell, lap belt for resident". 8/27/2011 "alarm sounded resident climbed out of bed and lost her balance, more frequent checks." 8/31/2011 " resident bumped her head on headboard of bed, monitor bed alarm report incidents right away." 9/4/2011 "resident hit head on 1/2 side rail on left side of bed, more frequent checks, resident trying to get up self numerous times during the night, staff alerted to check more often than every 2 hours." 9/6/2011 "got up from wheelchair tried to walk and fell, continue to use chair alarm, remind resident to not be up without assist." 9/8/2011 "found sitting on floor, promptly react to alarm when sounded, lap belt to be used if needed." 9/12/2011 "attempting to get into another resident's bed, lap belt for safety, assessment for restraint to be completed." 9/24/2011 " observed on floor, I was unable to find alarm in room for bed pad, we are also working short staffed, 2 CNAs." 9/29/2011 "resident sitting on mat on floor, resident has bed alarm, was not on, make sure alarm on." 10/06/2011 " resident observed on floor, bed alarm missing battery, replace battery." 12/7/2011 "observed on floor urine on floor, neuro check within normal limit, range of

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motion within normal limit, monitor."

Fall Risk Assessment dated 2/13/2012 indicates with a score of 15 that R6 is high risk for falls. Care Plan dated 5/30/2011 identifies problems with falls but does not address the use of lap belt or bed alarm. Observation of R6 on 3/14/2012 at 1:45 am in the facility beauty shop noted R6 sitting in her wheelchair, no chair alarm was noted, R6 was wearing a non self releasing seat belt. The seat belt was across R6's lap and was tied around and fastened behind and at the bottom of the wheelchair. Observation of R6's bedroom on 3/14/2012 at 2:00 pm noted a body alarm device attached to the head of the bed. Observation on 3/15/2012 at 11:00 am of R6 noted her self propelling in wheelchair in front lobby area of the facility no chair alarm was noted. During an interview at this time 3/15/2012 11:00 am with E10 (Certified Nurse Aide/CNA), E10 stated the chair alarm was discontinued 6-7 months ago and was replaced with the electronic monitoring bractlet.

3. The Incident and Accident log and Incident Reports dated 05/09/11 , 06/13/11, and 07/09/11 note R-2 was found in the floor near his bed on the evening and night shifts. The only intervention attempted was a personal alarm.. The Incident Report dated 09/07/11 at 2:30 AM notes R-2 fell from bed and would be in a low bed with a personal alarm. During an observation on 03/12/12 at 2:15 PM , R-2 was in bed. It was not in the lowest position.. At 10 :00 AM on 03/13/12, R-2 was in bed. It was not in the lowest position and both side rails were up.

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