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F 520	Continued From page 32 initiated an intervention of conducting hourly safety checks 6 months ago. E1 said that they have not evaluated the effectiveness of that intervention. During the survey, concerns were identified with frequent resident falls and injuries. For example, R1 had multiple falls and sustained a subdural hematoma; R2 sustained a hip fracture and continued to have multiple falls after surgery to repair the fracture; R5 sustained a hematoma following a fall and was sent to the hospital. The facility's Resident Safety Check log (June 2012) lacks documentation that R2 was checked every hour on 6/12/12 between 7:00 AM and 3:00 PM. (R2 sustained a fall on 6/12/12 at 11:00 AM). On 6/13/12 at 2:15 PM, R2's Resident Safety Check log was reviewed. There was no documentation regarding R2's safety checks for the hours between 7:00 AM and 2:00 PM. On 6/13/12 at 2:30 PM, E2 (DON) stated that staff should document at the time that they checked the resident, not at the end of the shift.	F 520		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care	F9999		

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F9999	Continued From page 33 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. 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. 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 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.	F9999		

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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:

A. Based on observations, interviews and record reviews, the facility failed to:
-Identify and analyze all the risk factors and causes of residents' falls;
-Monitor the effectiveness of the interventions and change the interventions as necessary to prevent recurrence of falls;
-Provide adequate supervision/monitoring to prevent further falls.

This applies to three of five residents (R1, R2 and R5) reviewed for falls in the sample 20.

These failures resulted in R1 sustaining a subdural hematoma after experiencing a fall on 4/26/12.
R2 sustained a hip fracture after a fall on 4/4/12 and,
R5 was sent to the emergency room for evaluation of swelling about 9cm x 9cm with pain to the back of head after she fell backward on 3/11/12.

Findings include:

1. R1's diagnosis includes Pre-senile dementia and osteoarthritis. R1 is ambulatory. The fall risk evaluation dated 12/25/11 assesses R1 as "at risk for falls."

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Review of facility incident reports denote R1 having the following multiple falls:
On 3/18/12-R1 noted sitting on the floor outside of her room. On the left side of her head was a "laceration 6 centimeters x 4 cm with moderate amount of bleeding from her head, bruise on bridge of nose and forehead." R1 alert and verbally responsive. R1 was sent to hospital and returned with staples to head. Care Plan interventions included: Hourly checks.

On 4/6/12 at 7:55 AM "R 1 was found lying on the floor on her left side. Roommate stated she tripped on the roommates walker. Sustained a bruise on left cheek bone. R1 physician/family notified. Neuro checks were done.
Corrective actions: Will monitor."

On 4/6/12 at 9:00 AM, "R1 was found lying on the floor in the north hallway with slight nosebleed. Pressure applied and ice compress applied. Facility investigation denotes R1 was in dining room after breakfast and followed another resident out of the dining room. On 4/7/12 corrective actions chair alarm."

Also on 4/6/12 at 9:20 AM, "R1 while being toileted by the staff, R1 stood up from the toilet and CNA was unable to catch her. R1 was sent out to hospital for evaluation and was admitted for hypotension and leukocytosis."

Nurse notes dated 4/26/12 at 5:45 PM denote R1 was found walking in hallway by nurses station with hand behind head. Laceration noted back of head 4 cm long oozing blood. Taken to room. Pressure applied. Neuro checks taken PERL (pupils equal and reactive). Body check done skin

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F9999	Continued From page 36 intact, no bruises noted. Blood Pressure 130/70, heart rate 100, respiration 20. Motrin given for pain. R1 complain of pain to head in R1's native language. R1's physician was notified and R1 was sent out to hospital for evaluation and R1 was admitted to hospital with diagnosis of subdural hematoma. R1 was readmitted back to facility on 4/27/12 and was placed on 1:1 supervision, and use of soft lap restraint while up in wheelchair and use of chair and bed alarm. Incident report of 5/6/12, R1 was found laying on floor side of bed on right side. Bump noted right side of forehead. R1 did not require hospitalization. Incident report did not denote if bed alarm was on or sounded. Corrective actions included close monitoring of resident and Keep Bed/Chair monitor on at all times. On 6/11/12 at 11:15 AM, R1 was observed sitting in a chair off on the side of the dining room. There was no chair alarm in place, and only 1 staff member was present in the room during activities with 12 other residents. R1 was not in direct visual view of the staff person. 2. R2 is deaf and mute and has difficulty understanding, and is difficult to understand according to the 4/4/12 Minimum Data Sets (MDS) assessments. R2 also has poor vision according to the Vision Function care plan dated 4/7/12. R2 sustained a hip fracture following a fall at the facility on 4/4/12, according to documentation in the nursing notes dated 4/19/12. R2 was re-admitted to the facility on 4/23/12 status post right hip pinning. R2 fell again on 5/3/12 according to the nursing notes. R2 was sent to the hospital and admitted with	F9999		

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Syncope according to the nursing notes dated 5/4/12. R2 was re-admitted to the facility on 5/8/12 at 2:45 PM, and fell again at 3:20 PM, according to the nursing notes dated 5/8/12 (timed 2:45 PM and 3:20 PM). R2 fell again on 5/9/12 at 6:00 PM, according to the nursing notes dated 5/9/12. R2 fell again on 6/12/12 at 11:00 AM and sustained a cut to the bridge of his nose, according to the nursing notes.

On 6/11/12 at 3:08 PM, R2 was sitting in his wheelchair in his room. R2's chair alarm was not attached to him. On 6/11/12 at 3:10 PM, E9 (CNA) stated that R2 knows how to un-clip his alarm.

R2's Fall Risk care plan dated 4/7/12 denotes an intervention to apply chair-bed alarm. The care plan does not address R2's behavior of removing his chair alarm. The care plan also lists an intervention to conduct safety checks every hour. The facility's Resident Safety Check log (June 2012) lacks documentation that R2 was checked every hour on 6/12/12 between 7:00 AM and 3:00 PM. (R2 sustained a fall on 6/12/12 at 11:00 AM).

On 6/13/12 at 2:15 PM, R2's Resident Safety Check log was reviewed. There was no documentation regarding R2's safety checks for the hours between 7:00 AM and 2:00 PM. On 6/13/12 at 2:30 PM, E2 (DON) stated that staff should document at the time that they checked R2 to insure his safety, not at the end of the shift.

On 6/12/12 at 9:17 AM, R2 was in the physical therapy room in the lower level. R2 was seated on a chair and was using the pulley machine. Two other residents were using equipment in the

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room. No staff were present in the room.

3) R5 is a 75 year-old with diagnoses including Dementia, anemia, CVA (cerebral vascular accident) and hepatic encephalopathy.

The Occurrence Log listed R5 was noted with following incidents:
- 1/16/2012 at 6:30 PM - R5 in her room, reported falling to the floor by R25 (R5's husband and roommate). Staff encouraged R5 to ask for assistance for ambulation .
- 3/11/12 at 8:55 A.M. - R5 while in her room, felt dizzy and fell backwards. " (R5) lying on the floor on her left side facing closet and close to the sofa. (R5) complaint of pain to back of her head. Noted swelling about 9 cm x 9 cm (size of a baseball) to the right side back of head with redness and purple color. " R5 sent to the hospital's emergency room precipitated by the fall incident . R5 was later returned to facility on same day.
- 3/17/12 at 1:45 P.M. - R5 reported fall by the nurse' station. "(R5) got up from wheelchair and slowly bend down to the floor and lay down."
- 3/20/2012 at 2 A.M. - R5 reported found sitting on the floor. "(R5) found on the floor, positioned right by the bed. (R5) alert, confused, no injury. Probable cause of fall: (R5) confused , try to get up. (R5) was sent to the hospital."

The plan of care for falls indicated the following interventions :
-"7/11/2011 - instruct resident in proper use of any appliance or device to aid balance. Encourage the resident to use the appliance /device as instructed."

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F9999	Continued From page 39 - "Instruct resident to ask for assistance prior to attempting to transfer or walk." -" Provide ambulation and strengthening exercise" -"Implement fall precautions procedures per protocol" Added interventions were as follows: 1/16/2012- " Every hour check" 1/17/2012 - " Rehab program for safety transfer" There were no revised interventions or modification for fall interventions when R5 had further falls on 3/11, 3/17 and 3/20/2012. E6(Registered Nurse) and E7 (CNA - certified nurse assistant) stated on 6/13/2012 at 12:30 P.M. that R5 stays in her room with R25 and do not go out of the room for activity except for meals. E2 (Director of Nursing) stated on 6/13/2012 at 12:35 P.M. that there was no documentation for rehab program because most likely R5 had refused and will not leave room without R25. The Facility policy titled, " Resident Fall Protocol" requires that with each fall the care plan interventions will be reviewed for their effectiveness and modified as appropriate to reduce hazards and risk to the residents. R5 MDS (minimum Data Set) dated 1/19/2012 and 4/19/2012 indicated that R5 was assessed requiring supervision for transfer and ambulation. During lunch observation on 6/12/2012, R5 got up unassisted from the dining room chair, ambulated	F9999		

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without staff assistance and supervision. R5 ambulated without assistive device, R5 walked towards the hallway to catch up with R25. R5 finally caught up with R25 and then proceeded to propel R25's wheelchair towards their room.

On 6/13/2012 at around 12:35 A.M., R5 was observed ambulating and also propelling R25's wheelchair. There was no staff supervision as observed.

B. Based on observation and interview the facility failed to ensure a safe environment for residents. This failure has the potential to affect most of the 96 residents residing at the facility.

The findings include:

There are no grab bars in either of the 2 women's bathrooms in the lower level per observations on 6/13/12. On 6/13/12 at 10:30 AM, E12 (Restorative CNA) stated that female residents use the women's washroom when they come down to the physical therapy room to receive therapy. E12 said that most of the residents are brought down to the therapy room for restorative therapy.

On 6/13/12 the soiled utility room located on the 2nd floor was unlocked. An unlocked laundry chute is located in this room. Ambulatory confused residents with Dementia reside on the second floor.

On 6/11/12 at 10:55 AM, R28 was sitting in his room. R28 stated that he hit his shin on the bed crank and he was in pain. The bed crank was noted sticking out into the room. A CNA entered

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F9999	Continued From page 41 the room at this time and adjusted the bed crank so that it was not sticking out. The CNA said that the bed crank should have been pushed in after the bed was adjusted. (B)	F9999		