| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145502 | A. BUILDING _____ B. WING _____ | 06/29/2012 |

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| TAYLORVILLE CARE CENTER | 600 SOUTH HOUSTON TAYLORVILLE, IL 62568 |

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| F 516 | Continued From page 25 | F 516 | | |
| F9999 | FINAL OBSERVATIONS<br><br>LICENSURE VIOLATIONS<br><br>300.1210b<br>300.1210d)6)<br>300.3240a)<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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.<br><br>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:<br><br>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.<br><br>These requirments were not met as evidenced by: | F9999 | | |

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Based on record review, observation and interview, the facility failed to safely transfer a resident, ensure resident alarm(s) were properly functioning and ensure a resident was safely toileted and ambulated for 3 of 9 residents (R1, R5 and R11) reviewed for falls in the sample of 16. This failure resulted in R1 incurring a right tibial tuberosity fracture during improperly assisted toileting and ambulation.

Findings include

1. R1's Occurrence Report, dated 2-12-12, documented "resident (R1) walking back to bed from bathroom and lost her balance." R1' Nurse's Notes, dated 2-12-12, documented R1 was transferred to an emergency room for evaluation. R1's Radiology Department Report, dated 2-12-12,documented "fracture of the tibial tuberosity with minimal avulsion and soft tissue swelling."

In an interview of E23, Licensed Practical Nurse (LPN), on 6-29-12 at 10:30a.m., E23 stated R1's walking device "got tangled in a bed side table" when she ambulated R1 from the bathroom to her bed. E23 also stated she assisted and ambulated R1 by herself.

R1's Falls Care Plan, target date 8-6-12, documented R1 was at risk for falls d/t (due to), in part, poor balance and dementia.

R1's Minimum Data Set (MDS), dated 11-28-11, documented urinary incontinency, extensive assistance of two plus persons physical assistance with mobility transfer and toileting and

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| F9999 | Continued From page 27<br>impaired moving, walking and turning balance.<br><br>2. Per R5's Physician Order Sheet of 6-12, R5 has a diagnosis, in part, osteoarthritides and generalized muscle weakness. The MDS dated 10/28/11 and 4/23/12 both document that R5 requires extensive assistance with transfers, has poor balance and is non-ambulatory. The same MDS documents that R5 is moderately cognitively impaired and has poor safety awareness. Review of the facility Resident Care Plan interventions column, with a start date of 3/10/12 documents, "assist of 2 with transfers."<br><br>On 2/5/12 wheelchair brakes were not checked before the transfer, and during the transfer E16, Certified Nurse Aid (CNA) realized the brakes were not working properly resulting in the wheelchair moving out from under the resident and resulting in a fall.<br><br>On 3/10 and 3/12 E16 transferred R5 by himself. The Occurrance Report documents that R 5 either "lost her balance, or her legs gave out," resulting in a fall. E16 did not have a second assistant, as required for the transfers. Review of the Facility Occurrence Log for 2012 documents that on all three occasions E16 was the person transferring R5 when she fell.<br><br>R5 was observed during a transfer on 6/26/12 at 12:50 PM from her wheelchair to the toilet. R5 required the assist of two CNA's and the use of a standing transfer device. During the transfer R5 yelled out that her knees were rolling and were going to give out and stated she was not able to go up any further in the device tolerating it poorly. | F9999 | | |

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R5 was not able to assist in supporting her weight during the transfer.

E20 CNA stated, she has been this way for a while, she can't help and gets impatient."
In an interview with E16 the CNA involved in the falls with R5, stated, "In February, I did not check the chair before I transferred (R5) I just figured the brakes were OK. In March, I looked at the board next to her bed and it still said 1 assist, but after the first fall on 3/10, it did cross my mind that I should have gone and gotten a second person, but I was the new guy and didn't want anyone to think I couldn't do my job. I should have gone to get help."

3. The MDS dated 4/20/12 identifies R11 to require extensive assist of two staff for transfers and ambulation. The MDS also indicates R11 has deficits with standing balance and moving between surfaces. The June 2012 Physician's Order Sheet (POS) indicates R11 is to have a sensor alarm at all times. According to the care plan dated 4/20/12 identifies R11 to be at risk for falls due to wanting to be able to toilet/walk herself, confusion/forgetfulness, weakness and unsteadiness in addition to receiving an antipsychotic medication. The interventions also indicate R11 is to have a sensor alarm at all times.

An Occurrence Report dated 2/4/12, indicates R11 was found on the floor. Her alarm was documented as "not sounding." No explanation was given for the alarm not sounding.

On 5/14/12 at 3:06am, the Occurrence Report documents R11 having another fall from her chair

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which was not witnessed. The incident details recorded indicate the alarm was not working properly and was replaced. R11 was transferred to the emergency room for evaluation and returned with no injuries noted.

An Incident Detail dated 5/23/12 at 6:30pm again documents R11 on the floor falling from her chair. The investigation documents R11 slid out the wheelchair to the floor and the alarm was half way out of the chair. The report documents the alarm was not sounding. No injuries were reported.

On 5/24/12 at 5:51 am, R11 is again documented as falling from the chair in the dining room. The alarm was sounding but staff were unable to reach her before she slid to the floor. Dycem was placed in the seat of the chair to prevent further sliding.

On 6/24/12 at 8:50 pm, R11 was again found on the floor only beside her bed. The alarm was not sounding as it was "close to the edge".

On 6/28/12 at 11:50 am, E 21 and E 22 CNA's applied a gait belt on R11 and cued her to stand from her recliner chair at bedside encouraging her to "push off" from the arm of the chair. R11 was slightly unsteady then slowly began to take steps toward the bathroom. The gait belt slid up over her breasts and under her arms. R11 had a sensor alarm in the seat of the recliner which did not sound immediately upon R11 lifting up from it.

On 6/28/12 at 11:02 am, E3, LPN, was asked if the facility had a system in place to check if the alarms are functional. E3 stated no but thought

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| F9999 | Continued From page 30<br>they probably needed one. E3 added in interview that the CNA's are suppose to check their own alarms but agreed that several of R11's falls occurred when the alarms were not sounding appropriately.<br><br>(B) | F9999 | | |