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F 497	Continued From page 44 training in proper transfer following the incident of 7/5/12. E22 (Assistant Director of Nursing) provided the following in-service Attendance Records for 7 sampled CNA's during 2012: E27 - 45 minutes; E25 - 2.5 hours; E28 - 3.0 hours; E16 - 4 hour 50 minute; E18 - 2.5 hours; E17 - 2.0 hours; E29 - 3.5 hours. E22 said that CNA in-service Attendance Records could not be found for 2011.	F 497		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall within 24 hours after admission of a resident, request a criminal background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender. This requirement was not met as evidenced by:	F9999		

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F9999	Continued From page 45 Based on interview and record review the facility failed to ensure that background checks were requested within 24 hours after admitting a resident, and failed to complete timely website checks of the 2 required web sites: www.isp.state.il.us and www.idoc.state.il.us. This is for 15 residents admitted in September 2012 (R1, R9, R12, R29, R32, R46, R53, R54, R55, R56, R57, R58, R59, R60 and R61). The findings include: During the month of September 2012 the facility admitted R1 (9/20/12), R9 (9/11/12), R12 (9/23/12), R29 (9/14/12), R32 (9/19/12), R46 (9/6/12), R53 (9/18/12), R54 (9/15/12), R55 (9/14/12), R56 (9/8/12), R57 9/7/12), R58 (9/7/12), R59 (9/7/12), R60 (9/6/12) and R61 (9/6/12), according to the Admit/Discharge Report. On 9/26/12 at 4:30 PM, E9 (Receptionists) said, "Since the new company took over, we are behind in getting background checks and website checks done." E9 said that she has not completed any website checks for September admissions. On 9/27/12 at 9:30 AM, E30 (Admissions Coordinator) said she completed all of the September admission background check initiations and website checks on 9/26/12. (AW) 300.610a)	F9999		

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F9999	Continued From page 46 300.1210b) 300.1210c) 300.1220b)3) 300.3240a) Section 300.610 Resident Care Policies 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.	F9999		

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F9999	Continued From page 47 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 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. (Section 2-107 of the Act) THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY: A. Based on observation, interview and record review, the facility failed to follow their plan of care to provide resident specific interventions, reevaluate the effectiveness of interventions and provide adequate supervision to prevent reoccurring falls. The facility also failed to ensure that fall preventions equipment was working properly.	F9999		

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This is for 2 residents (R2 and R3) out of 11 reviewed for falls in the sample of 27 and 1 resident (R47) in the supplemental sample. These failures resulted in R2 falling and sustaining a laceration to the forehead requiring an emergency room visit and sutures, and R3 sustaining rib fractures on 05/29/12 and a blunt trauma of the head on 8/21/12 precipitated by fall incidents.

The findings include:

1. R2 is an 81 year old resident with diagnoses including Anemia and Anxiety Disorder according to the Minimum Data Sets (MDS) dated 6/5/12. R2 has moderate cognitive impairment and requires extensive assistance from staff to perform all activities of daily living, according to the 6/5/12 MDS. R2 receives multiple psychotropic medication, including Haloperidol 1 mg 9:00 AM, Haloperidol 2 mg 9:00 PM, Zoloft 200 mg at 9:00 PM and Trazodone 100 mg at 9:00 PM. R2 is at high risk for falls, according to the fall risk assessment dated 5/30/12. R2's fall risks include weakness, decreased safety awareness and history of falls from leaning forward in her wheelchair, according to the Fall care plan dated 6/1/12. R2 was found face down on the floor in her room on 8/11/12 at 1:20 PM with a laceration and contusion on her right forehead, according to the nursing notes. R2 was calling out for help, and the "chair alarm wasn't working" per documentation in the nursing notes dated 8/11/12. R2 was sent to the emergency room for treatment and received sutures to the right forehead, according to nursing notes. According to review of the Treatment Record and

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nursing notes, no documentation regarding the monitoring of the functioning of the wheelchair alarm was recorded.

On 9/6/12 at 10:25 AM, E4 (Nurse) stated that she responded to R2 yelling out on 8/11/12. E4 said that the chair alarm was not sounding. E4 said that R2 has a history of leaning forward in her wheelchair, and that the alarm would sound so" we could stop her" from falling out of her wheelchair. E4 said that she changed the sensor pad and the batteries in the control unit after R2 fell on 8/11/12. E4 said that she did not know the last time the batteries or sensor pad had been changed. E4 said she could not recall if their was a date on the sensor pad. E4 said that the nurses do not date the sensor pads when they are put in place. E4 said that documentation regarding the functionality of the wheelchair alarm should be in the Treatment Record.

The fall investigation for this incident did not examine the reason that R2's wheelchair alarm was not working, according to review of the incident report dated 8/11/12.

R2 was in her room sitting in a wheelchair on 9/5/12 at 3:25 PM. A control unit (alarm box) was noted attached to the back of the wheelchair. No flashing green light was noted on control unit. A green light should flash every 2 seconds to indicate the system is monitoring, according to the manufacturer's guide. The sensor jack did not fit securely into the control unit; the jack fell out of the control unit when lifted from the back of the wheelchair. E5 (Clinical Coordinator RN) was present and said that the jack should fit securely into the control unit. E5 tried to fit the jack

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F9999	Continued From page 50 securely into the control unit but it fell out again. On 9/5/12 at 3:30 PM, E5 (Clinical Coordinator RN) stated that R2 should have had a treatment order for the monitoring of the wheelchair alarm. E5 said that no documentation could be found for the monitoring of the functioning of the wheelchair alarm. E5 said she initiated an order to check the wheelchair alarm today (9/5/12). The chair sensor pads utilized by the facility are designed for one year of use according to the manufacturer's insert instructions. 2. R3 is a 91 year old with diagnoses that include Dementia, Parkinson's Disease, Hypertension and Depression. R3 was originally admitted to the facility on 1/13/2012 from home. R3 sustained a subdural subarachnoid hemorrhage and fracture of occipital bone due to a fall incident at home on 12/26/11, a recent fall history prior to admission to the facility. Review of MDS (Minimum Data Set) dated 7/7/12 and 9/15/12 showed that R3 requires moderate to extensive assistance with 1 person physical assistance for transfer, mobility, hygiene and toileting needs. R3 had 12 fall incidents at the facility for a period of 7 months. Review of nurse's notes and occurrence reports documented that R3 had falls on the following dates: -01/14/12 at 9:30 P.M., " Heard alarm sounding. (R3) noted lying on floor mat." -01/30/12 at 2:20 P.M., "unwitnessed fall, (R3) lying on floor mat, bed alarm has gone off."	F9999		

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F9999	Continued From page 51 -03/31/12 at 2:28 A.M., "Alarm sounding, CNA (Certified Nurse Assistant) responded, (R3) found on the floor." -04/05/12 at 3:30 A.M., " CNA entered room in response to alarm, (R3) on his knees on mat next to bed." - 04/10/12 at 4:45 A.M., "Alarm sounding, CNA entered room and (R3) was on his knees on floor mat holding on to bed." -04/11/12 at 4:30 P.M., " CNA responded to wheelchair alarm sounding and noted (R3) sitting on the floor in front of wheelchair. Unwitnessed fall." -05/14/12 at 12:15 A.M., "Alarm sounding, (R3)on floor." -05/22/12 at 2:15 P.M., "Found sitting on floor, alarm going off." -05/24/12 at 10:45 P.M., "On floor, skin tear right elbow and laceration to right side of head." -05/29/12 at 5:30 A.M., "(R3) found on floor, in room kneeling. (R3) sustained 4 inch skin tear on left upper arm. At 10:30 A.M., (R3) complained of left rib pain." X-ray result dated 5/29/2012 showed R3 sustained ribs (9th, 10th and 11th) fracture. -06/14/12 , " CNA heard alarm, (R3) fall backward in wheelchair." -08/21/12 at 7:20 P.M., "Nurse outside of (R3's) room and heard a noise, found (R3) on floor on his left side at foot of bed. Unresponsive approximately 5 minutes. 911 called, sent to hospital and was admitted for blunt head trauma." R3 was readmitted back to the facility on 8/24/12. Review of the incident reports showed that quality assurance by nursing department and interdisciplinary team had failed to determine	F9999		

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appropriate interventions and failed to revise the care plan. The incident report also showed no evaluation to determine the cause of the incident to prevent further occurrence of fall.

Review of R3's care plan from original to current admission showed no adjustment/changes in approaches, interventions or goals specific to R3's specific needs in order to prevent further fall.

R3 has a bed/chair alarm monitor since the fall incident of 1/14/2012. Review of current care plan dated 9/6/2012 showed that R3 continued to have bed/chair alarm monitor and no revision of intervention despite of R3 sustaining multiple falls with an alarm sounding off.

On 9/26/12 at 2:00 P.M., E5 (Clinical Coordinator) stated the she did not revise R3's care plan interventions for each fall incidents. E5 also conceded that the interventions were generalized and the care plan approaches were not resident specific.

On 9/25/2012 at 2:20 P.M., R3's alarm monitor was sounding off. R3 was in the bathroom sitting on the toilet. R3's wheelchair was also in the bathroom and the alarm monitor that was attached to the wheelchair was alarming. There were no staff attending R3. E5 stated that R3 did not ask for assistance and had transferred himself to the toilet before a staff came to assist him.

R3 was sitting in his wheelchair in the resident's hallway on 9/26/2012 at 12:30 P.M. R3's alarm monitor cord was not connected to the alarm monitor box. E17 (CNA) was alerted to this

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observation. E17 connected the cord to the unit box of the alarm monitor and stated "this cord should be connected to activate the sound alarm."

3. On 9/24/12 at 10:55 AM, R47 was in her room sitting in her wheelchair. The cord that connects the sensor pad to the wheelchair alarm box was disconnected from the alarm box and hanging down. E3 (Registered Nurse) was present for this observation. E3 stated that R47 is at risk for falls.

B. Based on observation, interview and record review the facility failed to ensure that residents are transferred safely, and according to their policy, and failed to ensure that CNAs are knowledgeable regarding residents' transfer needs. This is for 2 residents (R24, R14) in the sample of 27 and 2 residents (R32, R36) in the supplemental sample.

The findings include:

1. On 9/25/12 at 12:25 PM, E16 (Certified Nursing Assistant [CNA]), was observed using a maximum mechanical lift type device to transfer R24 from a chair to the bed. E16 stated that she was not sure whether R24 required 1 or 2 assists during the transfer using a maximum mechanical lift. E16 said "My understanding is that bigger people need 2 people when transferring."
R24 has diagnoses of Alzheimer's Disease, Parkinson's Disease and Seizure Disorder, according to the 7/17/12 annual MDS assessment. R24 is totally dependent on staff for all transfers according to the MDS. R24 has poor trunk control and safety awareness according to

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the Fall Care Plan (review date 10/16/12). The care plan dictates that R24 is to be transferred using a mechanical lift; however, the care plan does not state whether 1 or 2 people are required.
According to the facility's policy titled Resident Handling - Limited Lift (09/10), 2 staff members are to be present during a transfer using a maximum mechanical lift device. The policy also states "The specified method for transferring...will be communicated to the healthcare providers by ensuring this information is included in their care plan and also is posted on the back of the bathroom door on the Mechanical Lift Assessment form...The information will also be included in Care Tracker and in AOD."
2. During the initial tour with E5 (Clinical Nurse Coordinator) on 9/24/2012 at 10:00 A.M., R14 was transferred from bed to reclining wheelchair by E21(CNA). The total lift mechanical transfer device was next to R14's bed. E21 stated that she transferred R14 by herself. E21 also added that she did not ask for assistance from another staff to transfer R14 because they were short that day, since a CNA had called in.

Review of MDS (Minimum Data Set) dated 1/10/12 and 7/10/12 showed that R14 requires total assistance with 2 person physical assist for transfers.

3. On 9/25/12 at 1:00 PM, E11 (CNA) was observed taking the total mechanical lift out of R32's room.
E11 stated on 9/25/12 at 1:10 PM, she transferred R32 back to bed by herself using the mechanical lift. E11 said that R32 was weak but it was okay. E11 said that R32 was not able to

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F9999	Continued From page 55 stand on his feet so she used the total lift. The admission MDS dated 9/25/12 indicated that for Section G: Function Status, R32 needed extensive assistance with 2 person assist. 4. On 7/5/12, E27 (CNA) did not properly position R36 prior to using a mechanical lift to transfer R36, according to the facilities incident investigation form dated 7/5/12. This caused R36 to exclaim "ouch" when her arm got caught in-between the bed rail and the lift and caused a 4 X 4.5 centimeter bruise to R36's right forearm. E27 did not receive any training in proper transfer technique, according to her in-service Attendance Record. E27 received 45 minutes of in-service training during 2012, according to the Attendance Record. (B)	F9999		