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F 329	Continued From page 15 for the reduction or discontinuation of her antipsychotic medication.	F 329		
F9999	FINAL OBSERVATIONS Licensure Violations: 300.610a) 300.610c)2) 300.1210a) 300.1210b) 300.1210d)3)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. c) The written policies shall include, at a minimum the following provisions: 2) Resident care services, including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary	F9999		

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F9999	Continued From page 16 services, social services, clinical records, dental services, and diagnostic services (including laboratory and x-ray); 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 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:	F9999		

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3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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. (A, B) (Section 2-107 of the Act)

These requirements are not met as evidenced by:
Based on observation, record review and interview, the facility failed to provide assistance/supervision to residents at risk for falls. failed to implement effective fall precautions on admission for a resident at high risk for falls and failed to correctly assess residents at high risk for falls. The facility failed to implement specific interventions to prevent falls and failed to analyze circumstances to identify the reasons for resident's falls. The facility also failed to re-evaluate the effectiveness of their interventions in order to prevent further falls. This applies to three (R 3, R2, R22) of nine residents in the sample of 24 resident reviewed

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for supervision.
As a result of this failure R22 fell and sustained a displaced fracture to her left hip and R2 sustained a nasal fracture.
The findings include:
(1) Review of R22's admission face sheet showed R22 was admitted to the facility on 7/25/10 with diagnoses including history of falls, difficulty walking, abnormal gait, and dementia.
Review of the facility's incident reports showed R22 had 7 falls from 3/3/13 to 8/7/13. The falls dates included 3/3, 3/6, 3/31, 4/17, 5/16, 8/1 and 8/7/13. The incident report documentation for 8/1/13 at 1:47 p.m. showed R22 was observed on the floor near her bed. At this time R22 complained of pain to her left hip and leg. The incident documentation showed R22 was sent to a nearby hospital where she was admitted and diagnosed with a displaced left hip fracture.
Review of a quarterly fall assessment done for R22 dated 6/4/13 scored R22 at a " 4 " (low risk). Further review of this fall assessment showed many of R22's risk factors had not been identified and added to R22's fall score. These factors omitted included " Intermittent Confusion " (on 4/17/13- R4 had been hospitalized for lethargy/confusion and for neurological evaluation.) Factors omitted also included " Confined to wheel chair. " The Fall CAA (care area assessment) for Falls dated 6/4/13 showed documentation R22 " now uses a wheel chair. "
Other omitted factors included the incorrect number of falls identified and R22's Dementia diagnosis not identified.
When all of R22's fall factors were identified; R22's scored a " 15. " The fall assessment denotes a score of 10 or higher represents a high risk for falls.
Another fall assessment done for R22 on 8/2/13

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showed R22's fall risk scored at an " 8. " The fall assessment again did not correctly identify all of R22's fall risk factors. Review of this fall assessment showed R22 should have scored a " 14 " - high risk.
Toward the end of the fall assessment there is a section for referrals. Neither of the fall assessments showed R22 should be referred to the Fall Prevention Program.
Review of the facility's Fall Prevention Program policy showed:
A score of 10 or more places the resident on a High Risk.
In addition to the use of Standard and Moderate Fall Precautions, the following interventions will be implemented for resident identified at High Risk.
1. The resident will be checked approximately every two hours or as according to the care plan, to assure they are in a safe position.
2. In the event safety monitoring is initiated for 15-30 minute periods, a documentation record will be used to validate observations.
Review of R22's fall plan of care showed no approaches that R22 had interventions initiated for interventions for high risk fall residents as noted on the facility's Fall Prevention Program.
On 8/30/13 at 11:00 a.m. E7 (Restorative Nurse) stated, " R22's fall assessments for 6/4/13 and 8/2/13 were not completed correctly. They should have been scored with all of R22's fall risk factors included and should have scored her at high risk. When residents are scored at high risk for falls the staff are made aware the resident is at high risk for falls and the staff monitors the resident more closely. "
At this time E7 also stated R22 should have a wheel chair alarm and R22 is encouraged to ask for assistance/use call light before going to the

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F9999	Continued From page 20 bathroom. Review of R22's plan of care showed neither of these interventions were addressed on R22's fall care plan. When E7 was asked why R22 was having falls and/or what were the circumstances surrounding her falls; no answer was given. Observation of R22 on 8/30/13 at 9:00 a.m. noted R22 to be up and ambulating per wheel chair in her room. R22 had a wheel chair alarm attached to her wheel chair but the alarm was not attached to R22's clothing making the alarm non-functional if R22 stood up from her wheel chair. At this time R22 stated, " They tell me to use the call light and call for help before I go to the bathroom, but they don't answer the call light so I go to the toilet myself. I fell a little while ago and fractured my left hip. I was trying to put some items away. They don't watch me. " (2) R3 is an 85 year old female admitted to the facility on 7/17/13 at 6:30 pm. R3's diagnoses include compression fracture of the lumbar vertebra, fracture of the distal phalanx and osteoporosis. R3 speaks Serbian, but her care plan of 8/12/13 states R3 is able to understand English and is able to make her needs known in English. Her Admission Fall Risk Assessment dated 5/17/2013 timed at 7:34 pm is incomplete. It scores R3 with 4 points for intermittent confusion and also with 4 points for being on 3 or more medications which can contribute to falls. The section entitled " Evaluation " is to calculate the number of points in order to determine the resident's fall risk score. There is no number in this section. This assessment makes a referral for R3 for PT and TO (Physical and Occupational therapy). It also indicates to initiate a plan of care. On 8/30/13 at 10:40 am, E1 (Administrator)	F9999		

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stated fall risk assessments are to be done on admission and quarterly, as well as upon a change in condition, including after every fall. E1 agreed that R3 ' s initial fall risk assessment was incomplete.

Admission nursing note on 5/17/13 timed at 6:30 pm indicates R3 needs maximum assistance of 2 people for ADLs (activities of daily living), and R3 ambulates with a walker. On 5/18/13 at 1:42 pm, nursing note indicates R3 is at high risk for falls, and " all safety precautions to be put in place " . There is no documentation of what specific interventions were applied or put in place, or what time safety precautions were initiated.

A nursing note from 5/18/13 at 10:01 pm reflects R3 was observed lying on the floor on her side after getting out of the low bed. A mobility alarm was in place. R3 sustained a wrist injury and was sent to the hospital. A nursing note from 5/19/13 timed at 7:00 am indicates R3 sustained a non-displaced fracture of the distal radius.

R3's fall care plan was dated 5/24/13, with the following interventions dated 5/25/13: analyze resident's falls to determine patterns/trends; clip alarm to alert staff of unassisted transfers; keep bed in low position with brakes locked; observe frequently and place in supervised area when out of bed; occupy resident with meaningful distractions, with music or conversation; place resident in fall prevention program; keep resident invisible area when up in wheel chair; provide proper, well-maintained footwear; provide toileting assistance when needed.

At 12:25 pm on 8/30/13, E1 stated she had staff looking to see if they could find an initial care plan for falls for R3, as R3's current falls care plan started on 5/24/13. No additional care plan was presented by facility staff for review. E1 also stated she had been unable to locate

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documentation which shows what specific interventions were put in place for R3 upon admission.

A facility incident report dated 6/17/13 at 8:25 pm reflects R3's safety alarm was heard and upon entering room. The safety alarm noted clipped on bottom of privacy curtain. R3 was observed lying on her back on the floor, with no apparent injury. R3 was described as restless and agitated and she was taken to the nurse's station for increased monitoring. R3's 6/18/13 fall care plan intervention is to obtain a urinalysis and culture and report any abnormal findings. There were no additional interventions put in place at this time and the tests ordered would not stop R3 from falling.

An incident report dated 8/1/13 timed at 10:22 pm indicates R3 observed self-transferring in the washroom and she fell. This was witnessed by staff, but staff were unable to reach R3 in time to stop her from falling. The report indicates again R3 was able to remove her alarms and has not been compliant with safety precautions. Fall interventions for this 8/1/12 fall include changing to a pad alarm to be in her wheel chair and again, to assist R3 to visible areas when restless. (This intervention was already in place from 5/24/13 care plan, which stated R3 was to be placed in supervised areas when out of bed). R3 sustained 3 falls (6/17/13, 7/22/13 and 8/1/13) after removing her safety alarm, before the type of alarm was changed to a pad type of alarm, after her fall on 8/1/13.) The use of a clip alarm was ineffective as R3 was able to repeatedly remove this type of alarm. Her alarm type was not changed until after 3 falls, when a pad alarm was placed.

R3 had an initial fall risk assessment begun on admission on 5/17/13, which was incomplete. Her

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next fall risk assessment was completed on 8/2/13, after her 8/1/13 fall. This assessment scored R3 at high risk for falls, with a score of 23. There was no fall risk assessment completed after her 6/17/13 and 7/22/13 falls.
Facility Fall Prevention Program states that a Fall Risk Assessment will be performed by a nurse at the time of admission, and that this assessment tool will incorporate current clinical practice guidelines. A Fall Risk Assessment will be performed at least quarterly and with each significant change in mental or functional condition, and after any fall incident. It also states that the admitting nurse and assigned CNA (certified nursing assistant) are responsible for initiating safety precautions at the time of admission.
On 8/27/13 at 11:30 a.m., R2 was observed seated in a reclining chair outside her room. R2 resides on the memory support unit due to her need for supervision, diagnosis of Dementia and extensive assistance needed in activities of daily living (ADLs) said E2 (director of nurses) on 8/27/13 at 10:30 a.m. R2 ' s MDS (Minimum Data Set) dated 11/22/12 and 8/9/12, shows R2 requires extensive assistance in all ADLs.
R2 has a history of falling from the bed onto the floor as shown in the incident reports on the following days:
On 11/21/12 at 6:45 a.m. fell from bed,
On 1/11/13, 4:50 a.m. on the floor on left side on top of floor mat,
On 1/15/13 at, 12:45 a.m. lying on the floor on top of her bed cover beside her bed on the left side lying position,
On 1/17/13 at 3:35 p.m. found on the floor mat, wrapped up in covers,
On 2/5/13 in the bumper pad, sitting position on the floor mat at bedside with back against,

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On 2/4/13, 6:25 a.m. Hit head on the floor, fell from wheelchair in dining room during mealtime, was not witnessed due to staff feeding other residents,
On 2/18/13 at 4 a.m., found on the floor, bed alarm off,
On 3/25/13 at 6:45 p.m. fell from wheelchair onto floor,
On 4/15/13at 7 p.m. next to her bed on the floor,
On 4/17/13 at 3:15 p.m. laying on the floor with head toward window on left lateral position on the floor mat,4/29/13 at 3:30 a.m. fell from the bed, hit head on chest, sustained a nasal fracture,
On 5/18/13 at 3:15 p.m. sitting on the floor next to right side of bed, incontinent pad with soft stools, appears resistant had been trying to take it off),
On 5/25/13 at 2:10 p.m. fell out of bed, found on the floor mat,
On 6/28/13 at 10:15 p.m., on the floor next to floor mat, lying on the floor,
A summary of R2 ' s incidents show R2, had ten falls from the bed before sustaining a nasal fracture on 4/29/13. The nursing notes (observation) dated 4/29/13 show R2, hit her face on the chest next to her bed and was found on the floor and sustained a nasal fracture. Neither the fall assessment nor nurse notes showed the facility analyzed why R2 was falling. E2 (director of nurses) on 8/28/12 said she was responsible for analysis of the falls in the facility. R2 was unable to present any additional information regarding R2 ' s fall upon request on 8/29/13. The changes and interventions are generalized and not specific for R2's falling. An example of the approaches and interventions the facility developed on 11/16/12 are , " to give verbal reminders, keep call light in reach at all times, re-educated resident on safety prevention measures. R2 ' s Minimum Data Set 11/22/12

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F9999	Continued From page 25 shows a score of 7 for the Brief Interview of Mental Status (BIMS) showing moderate cognition impairment and inability to make decisions. R2 was evaluated for fall risk on 5/14/13 to have a score of 17 and on 8/28/13 a score of 18. The facility ' s fall risk observation assessment calculates any resident above a score of 10 to be at high risk for falls. The fall care plan was reviewed with E2 (director of nurses) on 8/29/13. The care plan and fall assessment did not reflect R2's comprehensive evaluation and the intervention for the prevention of her falling.	F9999		