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| S9999 | Final Observations<br><br>Statement of Licensure Violations<br><br>300.610a)<br>300.1210a)<br>300.1210b)5)<br>300.1210d)6)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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 | S9999 | | |

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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. Restorative measures shall include, at a minimum, the following procedures:

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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.

Section 300.3240 Abuse and Neglect

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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 are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to prevent injury for two of 17 residents (R10 and R16) reviewed for activities of daily living and failed to develop and implement fall interventions for one of six residents (R23) reviewed for falls in the sample of 20. R10 sustained a dislocated shoulder during improper dressing. R16 sustained a bruise during a mechanical lift transfer, and R23 sustained a fractured hip after a fall.

Findings include:

1. On 4/01/14 at 11:00 a.m. and on 4/02/14 at 11:00 a.m., R10 was in the dining room seated in a padded reclining chair attending an activity. R10 was confused and unable to participate in conversation. A MDS (Minimum Data Set) assessment dated 12/03/13 documents R10 has severe cognitive impairment and requires extensive assistance of two staff for dressing. R10's care plan dated 12/04/13 documents R10 is dependent on two staff for dressing

Nurses' notes for R10 written by E8 (RN - Registered Nurse) dated 12/14/13 at 6:10 a.m., states, "CNA (Certified Nursing Assistant - E7) came up to desk and reported that while putting on (right) sleeve of shirt (E7 CNA) had 'heard a pop'. E7 was the only care giver working with R10

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at the time. This nurse entered room and (R10) sitting in recliner and (right) shoulder appears to be out of socket. Appears sleepy and (complains of) some discomfort. Moans occasionally. Went to (Emergency Room) and shoulder put into place." A Resident Occurrence Report dated 12/14/13 at 6:10 a.m., indicates R10 was sent to the local Emergency Room for treatment. A Radiology Report dated 12/14/13 indicates R10 experienced an "anterior inferior dislocation of the humeral head (dislocated shoulder)" on the right shoulder.

A progress note written by Z1 (R10's Attending Physician) dated 12/29/13 states, "In my absence, there was an issue that (R10) had an anterior inferior dislocation of the humeral head (dislocated shoulder). This was discovered on x-ray on 12/14/13. It is not particularly clear exactly what happened because of the nurses' notes stop in November and that was switched over to computer recording and I do not have access to those notes... (R10) was getting dressed and apparently dislocated (R10's) shoulder. While putting on the right sleeve, (R10's) shoulder 'popped out of place'. Apparently this is the first time it has happened... Impression: 1. Dislocation of right shoulder. 2. History is doubtful to (Z3). I do not see, even with Alzheimer's that (R10) dislocated (R10's) shoulder while helping get dressed without any antecedent history of previous dislocation. I suspect there was more trauma then is reported. Shoulder immobilizer - Use full time for six weeks."

On 4/02/14 at 11:50 a.m., Z1 (R10's Attending Physician) stated, "I was trying to find out what happened. Like, did they manually put (R10's) arm into (R10's) shirt? Was it not just (R10) doing

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it by (R10's) self. (R10) is combative. Sometimes with the elderly if it was twisted the wrong way it could have happened but (R10) doesn't have a history of this. I was trying to determine if it was an issue of the nurse or the CNA turned (R10's) arm. Did someone have them role play what happened? That's what I was trying to find out. I wanted to look at what was in the record, the history of the incident. Like, was the nurse or CNA just holding the shirt out for (R10) to put (R10's) arm in the sleeve or did the nurse or CNA physically do it?"

On 4/02/14 at 10:55 a.m., E7 (CNA) stated, "I work for (staffing agency). I have been working at (the facility) on a regular basis 32 to 40 hours a week. I was working the first shift (on 12/14/13). I was getting (R10) dressed in the (geriatric) chair. I was getting (R10's) shirt on. I got the left arm in first and moved (R10) forward and shoved the shirt in the back of the chair and tried to get (R10's) other arm. (R10's right arm) was in flexion and (R10) wouldn't straighten the arm up. I pushed (R10's) elbow up to see if that would straighten (R10's) arm up but it didn't straighten. The shirt was bunched up on the shoulder. I thought (R10) would straighten (R10's) arm. It was a long sleeve shirt. (R10's) shoulder popped and I went and got the nurse (E8 RN - Registered Nurse) immediately. (E8 RN) asked me what happened but nobody else has. Nobody in Administration. It was a weekend. I did write a report."

On 4/02/14 at 2:30 p.m., E1 (Administrator) provided E7 (CNA's) hand written statement concerning R10's care on 12/14/13. (CNA's) hand written statement, dated 12/14/13 at 6:10 a.m., states, "Took (R10) from the (main dining room) to dress (R10) for morning ADL's (Activity

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of Daily Living). I was able to put (R10's) pants and T-shirt on (R10). I was attempting to put (R10's) long sleeve shirt on (R10). At this time was (R10) being combative with this portion of (R10's) ADL's. I was able to put (R10's left) sleeve on, then I struggle(d) with putting on (R10's right) sleeve on. I had (R10's) elbow at a 90 (degree). I raised (R10's) elbow up, when heard a 'pop' on (R10's right) shoulder. (R10) did not yell. I wasn't sure if (R10) was injured. I notified (E8 RN - Registered Nurse) of (R10's) condition."

On 4/02/14 at 10:40 a.m., regarding R10's injury on 12/14/13, E8 (RN - Registered Nurse) stated, "I was the nurse on duty when the shoulder happened. The CNA came to me and said (R10's) arm had popped out of the socket while the CNA was putting on (R10's) shirt. I went down to the room. (R10) was sitting in the (geriatric) chair and all I had to do was look at (R10) and I could see (R10's) shoulder was slumping down and looked like it was out of place." E8 (RN) stated (E8) did not see that R10 had any other injuries. E8 (RN) reported E1 (Administrator) was called and notified of the incident and R10's injury. E8 (RN) verified E7 (CNA) was the only staff person in the room caring for R10 when R10's shoulder was dislocated.

2. On 4-1-14 at 1:10 pm, E5 (Certified Nursing Assistant/CNA) and E6 (CNA) transferred R16 from the wheelchair to the bed, using a mechanical lift. When lowering the mechanical lift, R16's left arm was pinched between the mechanical lift and the arm of R16's wheelchair, causing a bruise to R16's left arm. E5 and E6 did not encourage R16 to cross R16's arms over the chest, before attempting to transfer R16 with

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the mechanical lift.

On 4-1-14 at 2 pm, E4 (Registered Nurse/RN) verified R16 received a bruise measuring 2 (centimeter/cm) x 1.5 cm, due to injury from a transfer.

On 4-2-14 at 11:30 a.m., E2 (Director of Nursing/DON) confirms staff is to at least encourage R16 to cross arms and ensure arms are out of the way of other objects, to prevent injury, while transferring R16 with a mechanical lift. R16's mechanical lift care plan dated 2-26-14, documents R16 should cross arms across the chest during transfers.

Mechanical Lift Policy dated 12/2013, documents staff should always be aware of residents' placement of their extremities before transferring and encourage residents to place their arms over their chest, or hold onto an item, during transfers.

3. A Physician Notification Fax dated 8/12/13, documents R23 was admitted with injuries from a fall prior to admission. A Physician Notification Fax dated 8/12/13, documents R23's injuries included fractured ribs, bruising, skin tears, and abrasions.

An Admission Nurses Note dated 8/12/13 (time unknown), documents R23's Power of Attorney informed the facility that R23 is "likely to get up on own" if not taken to the bathroom promptly; R23's gait is unsteady at times and R23 is too weak to stand independently.

Nurses Notes dated 8/13/13 through 8/24/13, document R23 had an unsteady gait and balance problems. A Fall Risk Assessment dated 8/19/13, documents R23 is at high risk for falls. A

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Minimum Data Set dated 8/19/13, documents R23 scored seven out of fifteen (impaired cognition) on the Brief Interview for Mental Status; requires extensive assist with transfers and ambulation; and had a fall with fracture prior to admission.

A Care Area Assessment Summary dated 8/19/13, documents R23 is at risk for falls due to weakness, de-conditioned state and a fall prior to admission. R23's Care Area Assessment Summary dated 8/19/13, documents fall precautions were implemented upon admission and will be added to R23's plan of care. R23's Plan of Care dated 8/19/13, documents R23 is at risk for falls and staff are to "place call bell and frequently used items in reach; encourage to wait for assistance."

An Incident Report dated 8/24/13 at 11:30 p.m., documents R23 was found on the floor and sent to the hospital emergency room for evaluation.

An Investigation form (TRIP Form) dated 8/25/13, documents R23 attempted to get out of bed independently, attempted to walk independently and fell. An Investigation form (TRIP Form) dated 8/25/13, documents R23 did not have a personal alarm in place or any other device to help to reduce the risk of R23 falling. A Hospital Discharge Summary dated 8/29/13, document R23 sustained a fractured right hip.

A Fall Policy dated 12/2013, documents "ensure resident receives adequate supervision and assistive devices to prevent accident."

On 4/3/14 at 10:35 a.m., E22 (Licensed Practical Nurse) stated R23 had a history of falls when admitted. E22 stated R23 had a poor short term

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| S9999 | Continued From page 8<br>memory and did not remember to use the call light. E22 stated "I do recall (R23) attempting to get up independently from (R23's) wheelchair and bed."<br><br>On 4/3/14 at 10:45 a.m., E23 (Certified Nurse Aide) stated R23 was frequently confused and attempted to get up independently out of bed and wheelchair. E23 stated R23 also attempted to toilet self.<br><br>On 4/3/14 at 11:17 a.m., E2 (Director of Nursing) stated E2 would expect staff to implement safety alarms for a resident with confusion and a known history of falls. E2 verified R23's plan of care interventions were not appropriate for R23 due to R23's known confusion and history of a fall prior to admission.<br><br>(B) | S9999 | | |