STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001101	A. BUILDING: _____ B. WING _____	12/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREESE NURSING HOME	1155 NORTH FIRST STREET BREESE, IL 62230

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S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) 300.3240a) 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	S9999		

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S9999	Continued From page 1 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. 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 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 REGULATIONS WERE NOT MET AS EVIDENCED BY: A. Based on observation, record review and interview, the Facility failed to implement fall interventions and provide safe transfers for 2 of 5 residents (R1, R3) reviewed for falls in the sample of 15. This failure resulted in R3 sustaining a fracture of the right proximal femur that required emergency treatment. Findings include: 1. R3's current Cumulative Diagnoses Sheet documents diagnoses, in part, as "Alzheimer's	S9999		

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Disease, History of Fall, History of Right Hip Fracture, Abnormality of Gait and Osteoporosis".

R3's Minimum Data Set (MDS), dated 1/18/2014 and 9/23/2014 documents that R3 is severely cognitively impaired in decision making, requires extensive assistance for transfers, and has unsteady balance from sitting to standing and surface to surface transfers.

The Incident/Accident Report, dated 12/31/2013 at 5:20 AM, documents, in part, that R3 was "found on the floor between the recliner and over bed table. Staff heard the noise when (R3) fell. Checked sensor pad which was on, but cord was malfunctioning and would not sound at times until moved cord around. Complained of pain to right upper thigh, with right foot rotating outward."

The Report of Investigation for R3, dated 12/31/2013 documents, in part, "(R3) sent to the (local emergency department) for further evaluation and treatment. (R3) was being admitted to the hospital for pneumonia and fracture of the right hip".

The X-Ray Report, dated 12/31/2013, documents R3 suffered a "Moderate displaced comminuted intertrochanteric fracture of the right proximal femur".

The Incident/Accident Report for R3 dated 5/17/2014 at 9:50 AM, documents R3 "slid off of the commode after defecating very large BM (bowel movement), lying on left side, laceration noted to left eye, left arm and elbow. Staff (E7, CNA) in bathroom with (R3)." The statement from E7 documented on the Report was, "I had the resident (R3) on the stool in the restroom. I went to turn around to get a washcloth. When I was

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S9999	Continued From page 3 turning back around she started falling. I couldn't get to her in time." Additional comments documented on the Incident/Accident Report for 5/17/2014 are, "Staff was instructed to keep supplies in front of them so they do not have to turn around to get them. (R3) has episodes of non-responsiveness and they usually occur on the toilet. Staff instructed to stay with (R3) entire time she is in the bathroom. This is the second occurrence, did occur one other time in February on BSC (bedside commode), did not fall, went unresponsive after large BM." The Incident/Accident Report, dated 11/11/2014 at 6:50 AM, documents, in part, "This nurse (E8, Registered Nurse) was called down to (R3's) room by CNA (E7). Upon entering room, (R3) observed to be sitting on floor against chair. Two red marks visible on back". The Investigation of Incident, dated 11/11/2014 documents, in part, "Type of safety device/care planned: Use 2 people to transfer, as well as gait belt." The investigation documents E7 transferred R3 with one assist, without a gait belt and R3's knees gave out. E7 reported she never transfers R3 with 2 assist using a gait belt, and was unaware where to find out what type of assistance R3 required. R3's Care Plan, updated 11/11/2014, documents, in part, "has history of falls, would always transfer without assist. Does not remember to use the call light, is confused and forgetful. Has bouts of unresponsiveness." The interventions documented, in part; "Sensor pad to bed and wheelchair. Check placement and function every shift. Do not leave on toilet unattended. Have all	S9999		

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supplies gathered before care. Continue to remind CNA's (R3) is a 2 assist and gait belt with all transfers."

On 11/25/2014, at 1:15 PM, R3 was transferred with the assist of E5 and E6, CNA's with the use of a gait belt. R3 was very confused and required extensive assistance during the transfer with minimal weight bearing to the lower extremities.

On 11/26/2014, at 2:00 PM E2, Director of Nursing (DON) was interviewed about R3's falls. E2 stated, "Well, it is what it is."

The facility's policy and procedure revised 4/2014, entitled, "Resident and Staff Safety Policy' documents, in part, "the facility identifies each resident for accidents and/or falls; and adequately plans care and implements procedures to prevent accidents. ALARMS: Make sure that the unit is turned on and functioning properly prior to each use. Check the battery indicator light if the unit has one and change batteries as needed. All residents who require weight bearing or hands on assistance with transfers and/or ambulation will be transferred and/or ambulated with the use of a safety (gait) belt, unless it is medically contraindicated."

2. The current Cumulative Diagnoses Sheet for R1 documents diagnoses, in part, as "Abnormal Gait and Posture and Personal History of Fall". The Minimum Data Set (MDS) dated 12/09/2013 and 8/26/2014 documents R1 is severely impaired with cognition, requires assistance with transfers and has an unsteady balance from sitting to standing, walking and surface to surface transfers.

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The Incident/Accident Reports for R1 documents falls on 1/19/2014, 2/28/2014, 3/30/2014 and 8/16/2014, as R1 was trying to transfer himself or attempting to stand up without assistance.

The Incident/Accident Report for R1 dated 8/16/2014 documents "(R1) was standing in doorway, fell back onto buttocks before (E5, Certified Nurses Aide) could get to him, landed on buttocks, then rolled onto back. No apparent injury at this time. Was the alarm present and intact? Yes. Sounding? No. Why not? Not on. Must double check all alarms are on. Staff counseled on importance of ensuring alarms are on and functioning before leaving the room."

B. Based on observation, record review and interview, the Facility failed to maintain equipment in good condition to prevent accidents for 1 of 15 residents (R12) reviewed for equipment safety in the sample of 15.

Findings include:

1. On 11/25/14 and 11/26/14, R12 was observed lying in bed with raised, bilateral 1/2 side rails at the top of his bed. On 11/26/14 at 1:30 PM, it was noted that the 1/2 rail located on the right side of R12's bed was very loose and wiggled from side-to-side and front-to-back at least 5 inches. E1, Administrator, was present in the room and stated that the rail should not be able to move that much.

E9, CNA, stated in an interview on 12/3/14 that R12 only uses his siderails to assist the staff when they turn and reposition him. E9 said that R12 never uses the rails independently and only with staff present. E9 said that R12's condition is

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declining and he only grabs the rails to assist in turning and repositioning "once in awhile now".

R12's current Physician Order Sheet (POS) documents diagnoses, in part, of Diabetes, Kidney Disease and Congestive Heart Failure. R12's POS documents: "11/7/14, Top 1/2 siderail up while staff is present and providing care, to maintain side position".

R12's "Restraints: Side Rail Utilization Assessment", dated 7/3/14, documents "resident states he had side rails on his bed at home and he needs them to move around".

R12's MDS, dated 10/2/14, documents a BIMS score of 10, with 15 being the highest cognitive level of functioning. The MDS further documents that R12 requires the extensive assistance of two or more staff members for transfers and toilet usage; and the extensive assistance of one staff member for bed mobility.

The Facility policy entitled "Resident and Staff Safety Policy", documents "General Guidelines for Resident Safety: report all faulty equipment to maintenance and remove from use".

(B)