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	IL6002190	A. BUILDING: _____ B. WING _____	C 01/03/2020

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COUNTRYSIDE NURSING & REHAB CTR	1635 EAST 154TH STREET DOLTON, IL 60419

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S 000	Initial Comments Complaint Investigation: 1999325/IL118530	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b)5) 300.1210d)6) 300.1220b)3) 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. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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.

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 300.1220 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.

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These requirements were not met as evidenced by:

Based on observation, interview, and record review, the facility failed to follow their policy titled, "Falls-Clinical Protocol," by not implementing any new interventions after a fall for a resident with episodes of syncope and failed to monitor the effectiveness of current fall interventions for one (R1) of three residents reviewed for falls in a total sample of five. This failure resulted in R1 having a second episode of syncope , falling and being transported to the local hospital to be treated for a laceration to the back of the head , requiring three staples.

Findings Include:

Per the Face-sheet, R1 is a 58 year old with the following diagnosis: syncope and collapse, type 2 diabetes, lack of coordination, and abnormalities of gait and mobility.

A Nursing note dated 6/3/19 documents R1 stood up to get R1's weight taken and fell backwards hitting R1's head. Injury noted to the back of R1's head and a dry pressure dressing applied to control the bleeding. R1 sent to the hospital and was admitted for syncope. A Nursing note dated 6/4/19 documents R1 returned to the facility with a dry dressing to the right side of R1's head and seven staples to the head.

The Hospital Records dated 6/4/19 document R1 passed out and reports feeling lightheaded before falling. R1 developed a laceration which was sutured in the emergency room.

The Facility Incident Report dated 6/5/19

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documents R1 fell due to an episode of syncope and returned to the facility with seven staples to the head.

A Nursing note dated 7/3/19 documents R1 became faint and the nurse caught R1. R1 assisted back to bed and the doctor was notified.

A Nursing note dated 12/18/19 documents R1 was ambulating to the nurse station when R1 fell backwards. An assessment was performed on R1 and blood noted coming from the back of R1's head. R1 sent to the hospital per the doctor's order.

The Facility Incident Report dated 12/18/19 documents R1 collapsed to the floor, striking the back of R1's head. R1 received three stitches (sic) to the back of the head and the fall is believed to be related to R1's syncope. Care Plan to be updated upon R1's readmission.

A Nursing note dated 12/19/19 documents R1 admitted to the hospital for syncope, receiving two stitches to the back of the head. A Nursing note dated 12/20/19, R1 readmitted to the facility from the hospital with three staples to the right side of the head (sic). R1 reported getting dizzy at the nurse's station and passed out, causing the cut to R1's head. R1 instructed to sit on the side of the bed three to five minutes before getting up to help blood pressure from dropping.

The Hospital Records dated 12/20/19 document R1 found with profound orthostasis and was admitted for the same. R1 started on a blood pressure support medication.

On 1/2/2020 at 1:13PM, no interventions noted in R1's room for falls. R1 ambulating the halls

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freely.

On 1/2/2020 at 1:42PM, R1 ambulating with no assistive devices or supervision. R1 with three sutures to the back of the right side of the head that are healing. R1 stated, "I fainted twice actually going to get my medication, so I think I am scared to get up to get it or something. I was walking to the nurse's station both times and right before I was lying down in my bed. I got up and went to go get my medicine and I fell on the floor. No, I didn't sit on the side of the bed for a couple minutes before I got up first. I think I just forgot I had to do that and got up. Sometimes I get dizzy and things go black, but sometimes it happens so fast I can't even tell it is coming. Both times I busted my head open and had to go to the hospital to get staples. The first time I got seven staples and this time I got three, I think. No one told me anything or did anything after either fall. I still walk around when I want and stuff like that. In the hospital, they told me I need to sit at the side of my bed before I stand up for five minutes, so I don't pass out. When I came back the only person to tell me to do that was the nurse {V4, LPN} I didn't have any meetings or anything with someone telling me what they are going to do now that I fell twice. Yes, I was started on another medication but I don't remember what it was or what it is for. No, I don't get my blood pressure checked every day. I don't remember how often I get it done but it's less than once a week. I don't know what they are doing to keep me from falling again. Sometimes I don't remember to sit on the side of my bed and I get dizzy when I start walking but I haven't fell yet again."

On 1/2/2020 at 2:14PM, V3 (CNA) stated, "No high fall risks on the D wing. I guess we find out

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who is high fall risk through hearsay. I haven't seen anybody with any fall interventions in place that I know of. On D wing, everybody can walk. No one needs supervision when they walk on D wing. I never heard about R1's fall from anybody. This is my first time hearing about it. There is a look back on the computer system we use and it will tell you there if the person is a high fall risk or not. I have never looked in R1's chart. I think because of HIPAA policy."

On 1/2/2020 at 2:46PM, V4 (LPN) stated, "The management will let us know if something happened that makes them a high fall risk. I went to get R1 before lunch time and R1 was coming up to the nurse's station. I was getting the accu-check machine ready to test R1's blood sugar and I had my back turned. I heard a boom and turned around and R1 was on the floor. No, I don't know what fall interventions R1 has in place. I know they changed some of R1's insulin when R1 came back from the hospital. R1 has some stitches to the back of the head. I think R1's admitting diagnosis was syncope, but they don't know what caused it. I don't know who is in charge of falls here. We have a stand up meeting every morning and they let us know when new interventions are put in place. I know R1 was just admitted from the hospital with fainting and R1 has some insulin changes but that is all I know."

On 1/3/2020 at 11:25AM, V5 (LPN) stated, "R1 was walking up to the nurse's station to come get R1's blood sugar checked I think. R1 was in the doorway and R1 just fell back. We weren't able to catch R1 before R1 hit the floor. R1 hit her head and we sent R1 out to the hospital. She came back with some stitches or staples. This was the first time R1 fell like this for me. We just

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tell R1 to dangle first, before R1 starts walking. I can't tell you if R1 does it or not. R1 is independent, so we don't really need to monitor if R1 is doing that. We take her blood pressure every day and every shift to monitor it. No, we don't do a meeting or anything here after a fall. We do 72 hour charting once they come back from the hospital to see how they are adjusting to post fall. It would probably be a doctor's order that is an intervention. If they come back from the hospital with new orders, then we follow those. We just watched R1 more closely for 72 hours."

On 1/3/2020 at 12:45PM, V6 (DON) stated, "We put an immediate intervention in immediately so they don't fall again. We send them out to the hospital if they hit their head. The Fall Committee meeting happens the next day and we discuss the fall and we come up with an intervention. We then talk about the fall after they come back from the hospital and follow up with the recommendation from the hospital and use those in our interventions. We also do the reportable, if it results in any injury. This was intrinsic because we can't control it. R1's fall was due to a medical reason. The hospital started midodrine for R1 when R1 came back and that has been the only intervention that was put in place. We are also monitoring her blood pressures and blood sugars every day. With midodrine, a blood pressure should be taken before giving it every time."

On 1/3/2020 at 1:05PM, V6 stated, "Yes, the vital signs should have been being taken every shift. Midodrine is a medication where you need to do that and it wasn't being done. The ADON and myself just went and changed the order so it will start being taken once a shift now. I understand your concern with R1's falls. Seizures are a

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medical condition that can cause falls as well and we have to put interventions in place for those residents, so I see what you mean."

The Physician Order Sheet (POS) dated 12/3/2019 to 1/3/2020 documents an order was placed on 12/20/19 for monthly blood pressures for R1 to be taken on the 7th of every month and a blood pressure support medication (midodrine) to be taken three times a day. The Care Plan dated 6/5/19 documents R1 is at risk for falling related to diabetes mellitus, acute kidney failure, and syncope and collapse. No interventions put into place after the fall on 12/18/19. The Medication Administration Record dated 12/2019 reviewed and documents no blood pressures being taken with blood pressure support medication. The blood pressures for R1 reviewed from 06/2019 to 12/2019. Blood pressures only being taken on the 7th of every month.

The policy titled, "Falls- Clinical Protocol," dated 08/2008 documents, "The staff will document risk factors for falling in the resident's record and discuss the resident's fall risk. Risk factors for subsequent falling include lightheadedness or dizziness, ... Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent fall and to address risks of serious consequences of falling. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling."

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