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	IL6002778	A. BUILDING _____ B. WING _____	12/20/2018

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INTEGRITY HC OF ALTON	3523 WICKENHAUSER ALTON, IL 62002

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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

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:

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:

Based on observation, record review and interview the facility failed to provide supervision and interventions to prevent falls, and assess siderails for accident hazards for 3 residents (R18, R51, R63) reviewed for falls/accidents. This

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S9999	Continued From page 2	S9999		

failure resulted staff leaving R51 alone on the side of the bed, R51 falling and sustaining a displaced nasal fracture.

Findings include:

1. On 12/18/2018 at 9:04 AM, R51 was seated in a wheelchair. R51 refused to answer or respond. A fall mat was on the floor next to the bed. There were no siderails on the bed.

The Physician's Order Sheet (POS) for R51 documents diagnoses, in part, as Dementia, Syncope and Collapse, Forehead Laceration, Alzheimer's disease and Cerebral Vascular Accident.

R51's Minimum Data Set (MDS) dated 9/12/2018, documents R51 has a Brief Interview for Mental Status (BIMS) score of 5, indicating severely impaired cognition. The MDS documents R51 requires extensive assistance of one staff for transfers, and has unsteady balance with limited range of motion for upper and lower extremities.

R51's Fall Risk Evaluation, dated 4/8/18, score is 10, indicating high risk.

The facility's Fall Log for 11/2018 documents R51 fell from the bed on 11/04/2018.

The facility's investigation of the fall for R51, dated 11/04/2018 at 7:27 AM documents, in part, "Resident reported sitting on side of bed this AM getting dressed. The assistant turned to get the resident's bra. The resident fell forward. Resident encountered a nose bleed and a bruise to the bridge of the nose. Assessed resident as she is lying on floor. Resident lifted per bed by nurse and assistant. A cool wet cloth was used to clean

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S9999	Continued From page 3	S9999		

the face. Examined mouth to ensure no broken teeth, face and head examined for any cuts, or bruises. Body examined overall for any possible breaks, scratches or bruises. Injury type-Abrasion, Injury location-face, Injury type-bruise."

The Investigation Conclusion for R51, dated 11/04/2018, documents, in part, "Alert and oriented X 1. Requires assist of 1-2 staff for all ADL's (activities of daily living). Dependant on staff with mobility through building. Plan of Action to Prevent Reoccurrence: Staff education to ensure all items and supplies are collected prior to the start of care. Staff also educated to maintain close proximity to assist with balance."

R51's X-ray report, dated 11/04/2018, documents a "Mildly displaced nasal fx (fracture), 2 mm (millimeter) of displacement.

On 12/19/18 at 9:09 AM, V19, R51's Power of Attorney, stated, "She (R51) has a tendency to lean to the side. If she is sitting straight up, she will lean forward. She needs support. You don't just turn or walk away. I was really upset about that."

On 12/19/18 at 9:30 AM V18, Certified Nurse's Aide, (CNA) stated, "I was used to getting her up every morning and sat her on the side of the bed. I sat her up and sat her on the side of the bed. She pointed at something. Her bra was in the drawer. I turned around and got it from the drawer of the bedside table. Then she fell. She has good and bad days. I guess she was having a bad day. I have walked away before and she was fine. I yelled at the nurse, (V24, Registered Nurse). (R51) was on the floor and was bleeding. When we turned her over she said she was all right. She

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S9999	Continued From page 4	S9999		

had no loss of consciousness. Me and the nurse picked her up and put her in bed. She was bleeding pretty good. They said they were going to get an X-ray."

On 12/19/18 at 9:44 AM, V20, Physician, stated, "Mostly when I see her (R51) she is in a chair or in bed. Look at the Physical Therapy assessment and see what they think as well. By definition, if she's had a stroke her balance is off. Talk to the Aide as well."

On 12/19/18 at 9:53 AM, V23 Physical Therapy Aide stated, "She needs someone with her for maximum assistance 75% (per cent) of the time, and 25%, she will need CGA (contact guard assistance). She's very weak, unmotivated and requires a lot of encouragement. She previously used a geriatric chair. She can walk with moderate assist of 2. She leans to the right when sitting."

R51's Physical Therapy Evaluation, dated 11/03/18 through 1/28/19, documents, in part, "Diagnoses-Age-related osteoporosis without pathological fracture, abnormal posture, muscle weakness, unspecified lack of coordination. Sitting balance, static sitting poor, unable to maintain balance/requires moderate/maximum support. Standing balance=Poor (requires maximum assist and UE (upper extremity) support to maintain stand without balance loss."

A Progress Note from V16, Nurse Practitioner (NP) dated 11/06/2018, documents, in part, "Chief complaint: Fall. Reported patient fell from bed. Most recent fall resulted in an injury. Patient reports falling once every couple of months."

R51's Care Plan, 12/18/2018, documents, in part,

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S9999	Continued From page 5	S9999		

"(R51) is a high risk for falls related to unaware of safety needs, confusion, wandering, incontinence mobility and unsteadiness on feet, requiring staff assistance to stabilize, She requires extensive assistance for sit to stand and transfers. Has a history of falls, sustaining fractures. (R51) has exhibited poor sitting posture, leaning over to the right and unable to sit safely in her wheelchair. Interventions/Tasks-11/04/2018 staff education to not leave resident unattended during care."

2. The facility's Fall logs documents R18 had two falls on 9/06/2018.

The Incident/Accident Report, dated 9/06/2018 at 6:10 PM documents, in part, "Staff heard loud crash from adjacent room. Found resident on the floor next to bed lying on right side. Alert with noted confusion from earlier seizure activity. Resident has active seizure disorder, benign neoplasm of cerebral meninges, epilepsy with status epilepticus. Concluded that resident (R18) had second seizure from his bed. No injuries noted. Plan of Action to Prevent Reoccurrence: Resident medicated for seizure activity, bed placed in lowest position with mat on floor next to bed."

The Incident/Accident Report, dated 9/6/2018 at 7:00 PM, documents, in part, "CNA noted during rounds resident was on the mattress on floor. During staff rounds, CNA staff noted (R18) lying on mat next to bed. Active Seizure activity noted. Conclusion is that resident's seizure activity caused him to roll off the bed onto mattress on the floor. Plan of Action to Prevent Reoccurrence: 1:1 staff monitoring resident through the night. Resident and family educated that for safety reasons related to seizure activity, resident for the

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S9999	Continued From page 6	S9999		

night is to sleep on the mattress on the floor next to his bed. Keppra (anti-seizure medication) level ordered for next AM. MD (medical doctor) to audit medication on next visit."

On 12/14/18 at 10:46 AM, R18 was in bed asleep. There were 2 half, non-padded siderails raised on the bed. The bed was in the raised position. There was no fall mat or mattress on the floor next to the bed. The bed was against the wall.

R18's Fall Risk Evaluation, dated 4/5/18, documented a score of 12, (10 or above =high risk).

On 12/18/18 at 8:57 AM, R18 was in bed with 2 unpadded half siderails up. The bed was in raised position. There was no fall mat or mattress on the floor next to the bed.

R18's Care Plan, dated as revised 11/06/18, documents, in part, "(R18) has seizure disorder related to brain tumor and takes anti-epileptic medications. His seizures tend to occur at night and will cause him to fall out of bed. He has one side of the bed pushed up against the wall and a fall mat or mattress on the floor on the other side for safety purposes. (R18) is a high risk for falls related to hemiplegia, requires assistance for transfers history of falls, seizure disorder and medication use. Interventions-11/06/18-Bed placed in lowest position, floor mat put on floor next to bed. Resident utilizes mini-siderails to left and right side of bed for bed mobility and positioning.

On 12/19/2018 at 10:00 AM, V2, Director of Nursing (DON) was asked why R18's siderails were not padded and why there was not a fall mat

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S9999	Continued From page 7 on his floor. V2 responded, "I don't know." 3. The MDS, dated 11/9/2018, documents R63 has a BIMS score of 14-cognitively intact and requires extensive assistance of 2 staff with bed mobility and transfers. On 12/12/18 at 10:47 AM, R63 reported recently fell and hit his head and was sent to the ER (emergency room). R63 reported he transferred himself and his wheelchair was not locked. Per resident." R63 stated, "I know I should wait for help. I won't do that anymore. I use the siderails to help myself. Look how loose that one is." R63 pointed to the siderail on the right side of the bed. The padded half siderail to R63's right side was very loose with a large gap posing an entrapment risk. The left siderail was loose without a gap. The gap between the bottom of the right siderail and the mattress measured 2 1/2 inches. The gap between the middle of the siderail and the mattress measured 3 1/4 inches. The gap between the top of the right siderail and the mattress measured 5 inches. The siderail was unstable and moved back and forth easily. On 12/14/18 at 12:47 PM, V8, CNA used a gait belt and transferred R63 to bed from the wheelchair to bed. R63's Care Plan, dated 11/15/2018 documents he is a high risk for falls related to impaired mobility, edema and wounds to bilateral heels and osteomyelitis of the left heel. The Care Plan documents R63 requires a 2 person assist for transfers. The Physical Therapy Evaluation and Plan of Treatment, dated 11/3/2018 documents, in part, "Diagnoses-Acute hematogenous osteomyelitis,	S9999		

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S9999	Continued From page 8 Generalized muscle weakness, abnormalities of gait and mobility, unspecified lack of coordination. Pt. (patient) presents with decreased bed mobility, decreased transfers and decreased balance. Fall risk". On 12/18/18 at 2:09 PM, V17, Regional Nurse stated, "We checked it. The bolt was loose. We fixed it." V17 Reported she can't find the R63's side rail assessment. V17 reported V13, Maintenance Director is responsible for checking the siderails. The facility's policy and procedure, revised 3/2015 and entitled, "Fall Management" documents, in part, "It is the policy of the facility to have a Fall Prevention Program to assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Facility staff are responsible for assuring ongoing precaution are put in place and consistently maintained. Transfer conveyance shall be used to transfer resident in accordance with the care plan." (B)	S9999		