Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001135	A. BUILDING: ______ B. WING ______	C 07/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST CITY REHAB & NRSG CTR	321 ARNOLD AVENUE ROCKFORD, IL 61108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint: 1714033/IL95233-F157, F282, F309, F333 IRI of 7/04/17/IL95404-F323	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c)1)2)3) 300.1210d)6) 300.1630c) 3003210n)o) 300.3220f) 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/07/17

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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 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.

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

2) All treatments and procedures shall be administered as ordered by the physician.

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.

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:

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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 300.1630 Administration of Medication

c) Medications prescribed for one resident shall not be administered to another resident.

Section 300.3210 General

n) The facility shall immediately notify the resident's next of kin, representative and physician of the resident's death or when the resident's death appears to be imminent. (Section 2-208 of the Act)

o) The facility shall also immediately notify the resident's family, guardian, representative, conservator and any private or public agency financially responsible for the resident's care whenever unusual circumstances such as accidents, sudden illness, disease, unexplained absences, extraordinary resident charges, billings, or related administrative matters arise.

Section 300.3220 Medical Care

f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee

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within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)

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 followed as evidenced by:

Based on interview and record review, 1) the facility failed to administer medications in a manner to avoid a significant medication error. This failure resulted in R1 receiving R3, R4, R5, and R6's opioid medications. 2) The Facility failed to provide the necessary care and services by not assessing, documenting vital signs, and monitoring for a decline in condition for a resident that received multiple opioid medications in error. These failures contributed to the resident becoming unresponsive and required an emergent opioid reversal medication. 3) The facility failed to inform a resident's power of attorney (POA) for health care regarding an incident that required physician intervention and a significant change in the resident's condition. 4) The facility failed to follow physician order by not monitoring R1's vital signs every hour after a medication error occurred.

This applies to 1 of 3 residents (R1) reviewed for medications.

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The findings include:

R1's Electronic Medical Record shows R1 was admitted to the facility on July 18, 2001. R1 had diagnoses including: dysphasia, cerebral palsy, epilepsy, bipolar, major depressive disorder, schizoaffective disorder, chronic obstructive pulmonary disease, and chronic respiratory failure.

R1's progress notes show a late entry was created on July 3, 2017 at 5:43 PM (7 days after incident occurred) by E5 LPN (Licensed Practical Nurse) that on June 26, 2017 E5 LPN mistakenly gave R1 morphine 90mg and norco 5/325 two tablets, at approximately 7:45 PM. Upon realizing the medication error, the DON (Director of Nursing) and NP (Nurse Practitioner) was notified. Orders received to monitor resident closely for now and inform Nurse Practioner for any changes in resident's condition. Resident resting in bed at this time, alert and verbally responsive. On July 6, 2017 at 3:20 PM, E5 LPN stated, "I did not notify R1's family. I should have."

On July 6, 2017 at 3:20 PM, E5 LPN stated, "I was preparing medication pass when a CNA (Certified Nursing Assistant) called for my help with another resident. I placed a medication cup that had Morphine 60mg, Morphine 30mg, and two Norco 5/325 tablets into the top drawer in the medication cart. On July 10, 2017 at 2:50 PM, E5 LPN stated the morphine 60mg tablet came from R5's medication card, the morphine 30 mg came from R3's medication card, one Norco 5/325 mg tablet came from R4's medication card, and one Norco 5/325 mg tablet came from R6's medication card. E5 LPN stated R3, R4, R5, and R6 were all asking for pain medications so she put them all in the same medication cup to be

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able to get to the faster before the CNA requested her help in another room.

R3's Medication Administration Record for June 1, 2017-June 30, 2017 shows an order for Morphine Sulfate 30 mg four times per day.

R4's Medication Administration Record for June 1, 2107-June 30, 2017 shows an order for Norco Tablet 5/325 mg one tablet by mouth every six hours as needed.

R5's Medication Administration Record for June 1, 2017-June 30, 2017 shows an order for Morphine Sulfate extended release 60mg every 12 hours.

R6's Medication Administration Record for June 1, 2107-June 30, 2017 shows an order for hydrocodone-acetaminophen (Norco) 5/325mg every six hours as needed.

On July 6, 2017 at 8:08 AM, Z9 RN stated R1 was her normal baseline self prior to the medication error. R1 was eating, propelling herself in her wheel chair, smoking, and socializing. On July 14, 2017 at 8:45 AM, Z9 stated R1 passed away on July 3, 2017. Z9 informed the coroner of the medication error that occurred at the facility on June 26, 2017 because there were concerns. Z9 stated the medication error occurred on June 26, 2017, R1 possibly aspirated on June 29th, then passed away on July 3, 2017.

On July 6, 2017 at 1:00 PM, Z1 NP (Nurse Practitioner) stated she received a phone call notification from E5 LPN in regards to the medication error that occurred with R1. Z1 NP stated she gave orders to monitor the resident's

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vital signs every hour, to monitor for respiratory depression or increased lethargy, and to administer narcan (medication used for opioid overdose) if there were any changes in her vital signs.

On July 17, 2017 at 3:23 PM, E2 DON (Director of Nursing) stated the facility staff did not take any vital signs from May, 2017-June 2017 but hospice care took weekly vital signs. The hospice clinical note provided by the facility shows on May 18, 2017 R1 vital signs were: Blood Pressure 118/72, Pulse 70, respirations 18, and oxygen 94% on room air. R1's vital signs on June 22, 2017 were blood pressure 118/72, pulse 70, respirations 18, and oxygen 94% on room air.

R1's Medication Review Report shows an order for morphine concentrate solution 5mg every two hours as needed was entered on May 24, 2017. R1's medication administration record for June 1, 2017-June 30, 2017 shows R1 received 5 mg of morphine 7 days in the month of June.

According to R1's Electronic Medication Record, R1's vital signs were created into the progress notes between July 3, 2017-July 6, 2017 with the exception of two entries. This is 7-10 days after the medication error incident occurred on June 26, 2017. On July 6, 2017 at 2:53 PM, E2 DON (Director of Nursing) stated the facility staff was documenting vital signs on paper and that is why there is late documentation. She expects the staff to document right away in the computer.

On July 6, 2017 at 2:10 PM, E4 LPN stated, "On the morning of June 26, 2017, R1 was her normal self." (When questioned regarding the medication error that occurred on June 26, 2017) "During change of shift report, E10 RN reported to me

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that there may have been a medication error and to monitor R1's vital signs. At about 7:10AM, R1 was not responsive. Z1 NP gave an order to give narcan. R1 was alert and responsive within a few minutes after the narcan. Narcan reverses the effects of opiates."

R1's vital signs on June 26, 2017 at 7:50 PM were entered into her progress notes on July 5, 2017 (9 days after the incident) by E5 LPN:
Blood pressure (BP)=105/68, pulse(P) 89, respirations(R) 18, oxygen level(02) 95% on room air(RA) and resident was alert and oriented.

R1's vital signs on June 26, 2017 at 8:48 PM that were entered into her progress notes on July 5, 2017 (9 days aftger the incident) also entered by E5 LPN:
Blood Pressure 116/82, pulse 75, respirations 18, oxygen level 96% on room air, and resident remained alert, oriented, and verbally responsive.

R1's vital signs on June 26, 2017 at 9:45 PM that were entered into her progress notes on July 5, 2017 (9 days after the incident) entered by E5 LPN:
Blood Pressure 110/82, pulse 87, respirations 16, oxygen level 94% on room air, resident remains verbally responsive.

R1's vital signs on June 26, 2017 at 10:52 PM that were entered into her progress notes on July 5, 2017 (9 days after the incident) entered by E5 LPN:
Blood Pressure 119/80, pulse 79, respirations 18, oxygen level 95% on room air, no changes in mental status, verbally responsive.

The next progress note was entered on July 6, 2017 (10 days after the incident) by E10 RN

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(Registered Nurse) and only reflects R1's respiratory rate on June 27, 2017 at 12:25 AM: Respirations: 20

R1's vital signs on June 27, 2017 at 3:17 AM that were entered into her progress notes on July 6, 2017 (10 days after the incident) entered by E10 RN:
Blood Pressure 100/66, pulse 74, respirations 22, oxygen level 91%.

R1's vital signs on June 27, 2017 at 5:38 AM that were entered into her progress notes on June 27, 2017 by E10 LPN:
Blood Pressure 104/68, pulse 64, respirations 16, oxygen 91%. Resident very lethargic this am. To remain in bed at this time.

R1's progress note entered by E4 LPN on June 27, 2017 shows at 7:31 AM, R1 was not responsive to a sternal rub. Her pupils were pinpoint/fixed. Blood pressure was 86/65, respirations were 12, and oxygen level was 62%. Orders were received from Z1 NP at this time. On July 12, 2017 at 10:51 AM, E4 LPN stated she did not speak to R1's family at any point during the period of June 26, 2017-July 3, 2017.

The next progress note was created on June 27, 2017 (day after event) and showed at 5:38 AM, R1 was very lethargic. Blood pressure 104/68, pulse 64, respirations 16, oxygen 91% on room air. E4 LPN created a progress note that shows on June 27, 2017 at 7:31 AM, R1 was not responsive to sternal rub. Her pupils were pinpoint/fixed. Blood pressure 86/65, respirations were 12, and oxygen level was 62%. Orders received from Z1 NP to give 1CC (cubic centimeters) of narcan (medication used to

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reverse opioid overdose) immediately. E3 ADON (Assistant Director of Nurses) created a note on July 3, 2017 (7 days after the incident) that shows on June 27, 2017 around 7:00 AM, R1's blood pressure was 103/45, pulse 123, respirations shallow 26, oxygen level 73% on 2 liters of oxygen. R1's pupils were pinpoint, fixed, and not reactive to light. Z1 NP (Nurse Practitioner) was notified and an order for narcan (medication used to reverse opioid overdose) was received. The medication was given and within 10 minutes, R1 began to wake up and was verbalizing. R1 stated she felt tired. Oxygen level increased to upper 80 to lower 90% on 5 liters of oxygen. E4 LPN entered a progress note dated June 27, 2017 that shows at 7:40 AM, R1 was alert and verbally responsive. Blood pressure 89/68, no pulse documented, respirations 18, and oxygen level 98 % with 2 liters of oxygen.

On July 6, 2017 at 2:30 PM, E3 ADON stated, "At about 7:00 AM, E10 RN reported that there was a possible medication error. E4 LPN and I went into R1's room to assess her. Her pupils were pinpoint and she wasn't responding to a sterna rub. E4 LPN administered narcan and within approximately 5-10 minutes later R1 came around.

E3 ADON entered a progress note on July 3, 2017 (7 days after the incident) at 9:53 PM to reflect on June 27, 2017 at 8:47 AM, E3 was alerted that there may have been a medication error on June 26, 2017 during the night. E3 was asked to assess R1 around 7:00 AM. Upon R1's assessment, R1's blood pressure was 103/45, pulse 123, respirations 26 and shallow, and oxygen level was 73% on 2 liters of oxygen via nasal cannula. R1's pupils were pin point and

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fixed, non reactive to light. New order received from Z1 NP for narcan administration. Narcan was administered and within 10 minutes, R1 began to wake up. R1's oxygen level increased to the upper 80, lower 90% on 5 liters of oxygen via nasal cannula. On July 11, 2017 at 11:40 AM, E3 ADON stated he did not notify R1's family in regards to R1's changes in condition and did not know if anyone else has.

Vital Signs Chart documented as the following:
June 26, 2017
7:50 PM=BP 105/68 P89 R18 O2 95% RA-note created on July 5, 2017 at 6:14 PM
8:48 PM=BP 116/82 P75 R18 O2 96% RA-created on July 5, 2017 at 6:22 PM
9:45 PM=BP 110/82 P87 R18 O2 94% RA-created on July 5, 2017 at 6:26 PM
10:52 PM=BP 119/80 P79 R18 O2 95% RA Res alert-created on July 5, 2017 at 6:37 PM
June 27, 2017
12:25 AM=No vital signs. R20-Resident sleeping. Created on July 6, 2017 at 9:12 AM
3:17 AM=BP 100/66 P74 R22 O2 91% RA-created on July 6, 2017 at 9:24 AM
5:38 AM=BP 104/68 P64 R16 O2 91% RA-Resident very lethargic. Created on June 27, 2017 at 5:43 AM.
7:00 AM=BP103/45 P123 R26 O2 73% 2 liters of oxygen. Pupils pinpoint and non reactive. Created on July 3, 2017 at 9:53 PM.
7:31 AM=BP 86/65 No pulse documented R12 O2 62%. Res not responsive. Narcan given.

On July 6, 2017 at 3:20 PM, E5 LPN stated, "Z1 NP said to call Z1 NP back if there were changes in her condition. We were monitoring for lethargy or respiratory depression.

On July 6, 2017 at 2:10 PM, E4 LPN stated, "E10

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RN reported to me that there may have been a medication error. He said to monitor her vital signs."

On July 10, 2017 at 1:45 PM, E3 ADON stated, "A change in condition could include sedation, lethargy, changes in alertness, a decrease in blood pressure, increase in pulse, and decrease in oxygen level, or respiratory rate could increase or decrease. E10 RN should have notified Z1 NP at 3:17 AM."

On July 10, 2017 at 2:55 PM, E2 DON (Director of Nursing) stated, "The physician should be notified with changes in vital signs, altered mental status, or lethargy. Physician should have been notified if R1's blood pressure went down or she became lethargic. I would have called Z1 NP with R1's vital signs at 3:17 AM."

On July 10, 2017 at 3:23 PM, E9 CNA (Certified Nursing Assistant) stated, "My shift started at 10:00 PM on June 26, 2017. At the beginning of my shift, R1 was coherent. At about 4/4:30 AM, R1 wouldn't wake up and wouldn't move, so I told E10 RN. E10 RN assessed R1 and said that we would monitor her. Her eyes weren't open and she wasn't speaking. I think E10 RN was going to notify the doctor."

On July 10, 2017 at 3:33 PM, E10 RN stated, "E5 LPN told me R1 received an overdose of medications but I don't remember which ones. E5 LPN did not tell me how often to monitor R1. I think I took her vital signs twice. I let R1 sleep. R1 was lethargic in the morning of June 27, 2017, I figured she was ok. The CNA came and got me about 5:30 AM. I told the CNA that R1 had too many medications and needed to sleep it off. I would notify the NP with changes in respirations

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or if their vital signs changed." When the day nurse came in at 7:00 AM, she felt R1 was more lethargic." On July 10, 2017 at 3:33 PM, E10 RN stated he did not speak to R1's POA.

On July 11, 2017 at 9:48 AM, Z2 (one of the facility's pharmacy pharmacist) stated, "The peak (time it takes for the drug to reach its highest effective action) of morphine extended release is approximately 10 hours. The patient could be extremely drowsy. The medication error could have made a difference in her condition since R1 needed the Narcan."

On July 12, 2017 at 10:15 AM, E12 RN stated narcan is used for someone that overdoses. If R1 did not receive narcan, she could've stopped breathing or not gotten enough oxygen.

On July 10, 2017 at 2:55 PM, E2 DON (Director of Nursing) stated, "It is not at all ok to put multiple medications for different residents together because a medication error can occur."

The facility's undated Medication Administration Policy shows medications must be administered in accordance with a physician's order, the right resident, right medication, right dosage, right route, and right time ...medications may not be pre-poured ...only prepare and administer medications for one resident at a time.

On July 13, 2017 at 4:32 PM, Z10 (Medical Doctor) stated, "The peak time of morphine extended release is 8-12 hours. Narcan is used for opiate reversal. The first sign of toxicity would be drowsiness. Pin point pupils would also signify opiate toxicity."

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On July 2, 2017 at 8:32 AM, R1's medications were held due to residents mental status, resident is unable to speak and is increasingly weak. Shallow, rapid respirations noted. At 12:52 PM, R1 continues to be lethargic, only opening eyes when repositioning with occasional moaning, resident unable to answer question or speak. Both notes were entered by E12 RN (Registered Nurse). On July 12, 2017 at 10:15 AM, E12 RN stated she did not talk to R1's family.

E13 LPN cared for R1 on June 28 and June 30, 2017. On July 12, 2017 at 10:45 am, E13 LPN said she did not talk to R1's family/power of attorney at any point during the period of June 26-July 3, 2017.

E11 LPN cared for R1 on June 28-30, 2017. E11 LPN stated she has not spoken to R1's family at all.

On July 6, 2017 at 2:53 PM, E2 DON (Director of Nursing) stated, "The medication error and change in condition would get reported to the R1's family/POA. Family was notified, I believe ...I do not know if family was notified. I did not ask E5 LPN if she notified the family."

On July 12, 2017, at 8:50 AM, Z6 (R1's POA) stated, "I was called when R1 went into hospice in April, but I have not received any calls from the facility since then."

On July 13, 2017 at 3:50 PM, E3 ADON stated that Z6 is indeed R1's power of attorney and family member.

On July 14, 2017 at 8:45 AM, Z9 (Hospice Nurse) stated, "I did not notify R1's family. The facility should notify the family, they have an obligation."

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On July 6, 2017 at 1:00 PM, Z1 NP (Nurse Practitioner) stated, "E5 LPN (Licensed Practical Nurse) called on Monday (June 26, 2017) and informed me she may have given R1 Morphine and Norco (not prescribed for R1). I gave orders to monitor her vitals every hour and if there is any change in her vitals, give Narcan (Medication used to treat overdose)."

On July 6, 2017 at 3:20 PM, E5 LPN stated, "Z1 NP stated to monitor R1 for now and if there are changes, to call Z1 back and then give Narcan."

R1's Medication Review Report dated July 13, 2107 shows, an order to check vital signs every two hours was entered on June 27, 2017. No orders were entered on June 26, 2017.

R1's Medication Administration report shows vital signs every two hours for 24 hours was entered on June 27, 2017 at 2:00 PM by E3 ADON (Assistant Director of Nursing). There were no orders for vital signs entered on June 26, 2017.

On July 5, 2107, E5 LPN documented in R1's progress notes that R1's vital signs were taken on June 26, 2017 at 8:48 PM, 9:45 PM, and 10:52 PM. (According to R1's progress notes, the medication error occurred at approximately 7:45 PM).

On July 6, 2017, E10 RN (Registered Nurse) documented in R1's progress notes that on June 27, 2017 at 12:25 AM, "R1 appears to be sleeping normally. Respirations are 20." (No other vital signs are included in the note). At 3:17 AM, E10 RN documented R1's vital signs. Another progress note was entered by E10 RN on June 27, 2017 that R1's vital signs were taken at 5:38

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AM. (E10 RN took a full set of vital signs at 3:17 AM and 5:38 AM). R1's vital signs were not taken or documented on from 10:52 PM on June 26, 2017 to 3:17 AM on June 27, 2017. On July 10, 2017, E10 RN stated, "E5 LPN did not tell me how often to monitor R1. I think I took her vital signs twice."

On July 12, 2017 at 12:55 PM, E2 DON (Director of Nurses) stated, "I expect the nurses to enter new orders into the computer and to follow the orders."

The facility's undated policy on Physician Orders show the nursing staff member who took the order, or the one assigned to the resident is responsible to transcribe the order ...orders must be promptly entered into the computer.
The facility's Change in Condition Physician Notification Policy dated April 2014, shows medical care emergency problems are communicated to the family immediately (generally within two hours or sooner ...Responsible Party is to be notified of change in condition.

The facility's policy on Change in Condition Physician Notification dated April 2014, shows all significant changes in resident status are thoroughly assessed ...

(B)

300.610a)
300.1210b)

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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 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

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

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 followed as evidenced by:

Based on observation, interview, and record review the facility failed to transfer a resident who needs extensive assist, and history of falls, in a safe manor by not using a gait belt and 2 persons. This failure contributed to R7 experiencing a fall following a spontaneous fracture, and sustaining three additional fractures. R7 fractured both arms and both legs.

This applies to 1 of 3 residents (R7) reviewed for falls.

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The findings include:

R7's most recent Face Sheet shows R7 has diagnoses of chronic obstructive pulmonary disease with acute exacerbation, muscle weakness, repeated falls, other lack of coordination, difficulty in walking, morbid obesity, hypertension, heart failure, pressure ulcers, type 1 diabetes, cellulitis, and unspecified fractures to the right and left femurs.

R7's Minimum Data Set (MDS) dated June 20, 2017 shows R7 is cognitively intact, requires extensive assistance of 2 for transfers, and is not steady moving on and off the toilet (only able to stabilize with staff assist). R7 is independent with locomotion once in wheelchair and requires only setup help for eating.

R7's Incident Report for July 4, 2017 shows R7 sustained a fall resulting in injury. R7 "was in the bathroom, with an aide, transferring from the toilet to the wheelchair with assist of a walker when resident's leg popped and buckled at the knee. Resident was lowered to the floor per Certified Nursing Assistants (CNA). Laceration approximately 3 inches received to upper shin just below knee and right lower extremity exhibiting a visible outward rotation, not in alignment with knee. Resident able to move upper right extremity though pain expressed along with guarding. Resident alert and oriented throughout and Nurse Practitioner notified. 911 were contacted ...Resident was transported to hospital emergency per ambulance."

On July 11, 2017 at 4:00 PM, R7 was at the local hospital, laying flat on his back in bed, both arms and legs propped up on pillows. R7's arms were wrapped in bandages with only his fingers visible.

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R7 was pale and edematous. R7 was alert and stated where he was, the date, and the last holiday. R7 stated he was transferring from the toilet to the wheelchair when his legs gave out and he fell down on both knees. "There was just one girl helping me and I told her my legs weren't working and then down I came. There was no belt around by waist, they don't usually use one. I don't recall hitting anything on my way down I was just weak that day. I broke both of my arms and legs."

On July 11, 2017 at 4:15 PM, Z7 Registered Nurse (RN) at the hospital stated R7" has an open fracture to his tibula/fibula of the right leg, a closed fracture to his tibula/fibula of the left leg, and fractures to the humerus of both arms. All 4 of R7's extremities are splinted." R7 is a high risk for surgery and there are no plans for surgery.

On July 12, 2017 at 2:00 PM, Z8 RN at the hospital stated "R7 can't do anything, not even feed himself. He can only move his fingers and he is splinted everywhere else."

R7's Hospital Emergency Room History and Physical dated July 4, 2017 at 11:11 AM, shows "R7 had a spontaneous open fracture of his right proximal tibia and fibula. He then fell breaking his other 3 extremities. Principal Problem: open fracture of proximal end of right tibia and fibula (lower leg) Active Problems: Closed fracture of proximal end of tibia and fibula(lower leg) , Closed supracondylar fracture of left humerus(upper arm by elbow), and Closed supracondylar fracture of right humerus (upper arm by elbow)."

R7's Hospital Orthopedic Surgery Consultation Note dated July 4, 2017 at 3:49 PM shows "R7 right proximal tib-fib resulted in a laceration to the

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right leg anteriorly over the fracture site. The right proximal tib-fib fracture site is exposed to the external environment."

On July 18, 2017 at 12:12 PM, Z11 Orthopedic Physician stated R7 had a spontaneous fracture to the right leg, fell and then broke other 3 extremities. R7's weight from falling from a standing height would have been enough for the other three fractures. R7's arm fractures were the same type of break and in the same location on both arms. The combination of velocity of the fall and the torque from R7's arms going over his head could break the humerus bones. "Based on simple physics if R7 was lowered to the ground slowly there would have been less injury. My guess is that R7 needs 2 people to transfer."

R7's Nurses Note dated July 3, 2017 at 1:33 PM shows "resident requests to remain in bed today, confusion noted. Unable to answer questions appropriately. Current loss of appetite noted. Orders received for STAT CBC."
R7's Nurses Note dated July 3, 2017 at 8:21 PM shows R7 "res had been in bed throughout shift ...res is lethargic and has episodes of confusion. Res usually wakes up, responds to name when called upon, talks to writers and will go back to sleep. O2 sat is 90% at 4 liters oxygen ...Res bilateral lower extremities warm to touch and red. Nurse Practitioner notified and orders received for an antibiotic."

R7's Nurses Note dated July 4, 2017 at 7:00 AM, shows R7 "alert and responsive to verbal/tactile stimuli ...antibiotic therapy in progress for cellulitis to bilateral lower extremities (reddened, warm to touch and slightly swollen)."

R7's Nurses Noted dated July 4, 2017 at 11:20

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AM (after R7's fall) shows "resident in bathroom with aide transferring from toilet to wheelchair with assist of walker when resident's leg popped and buckled at the knee, resident lowered to floor per CNA. Laceration approximately 3 inches across received to upper shin just below the knee, bleeding profusely ...Area stabilized due to right lower extremity exhibiting a visible outward rotation, not in alignment with knee. Resident able to move upper extremity although pain expressed along with resident guarding ...Resident alert and oriented throughout ordeal. Resident noted to be lethargic this am heavy smoker although resident could only take 3 puffs this am. Oxygen delivered per nasal cannula at 4 liters, oxygen saturation 88%. Face flushed, skin clammy, lips slightly blue in color ...Resident transported to emergency via ambulance."
On July 12, 2017 at 12:30 PM, E15 Licensed Practical Nurse (LPN) stated she was taking care of R7 the day of the incident. E15 stated "R7 was not his normal self that day, he was off a little and a little weak." R7 was alert and oriented but his face was flushed and his oxygen saturation was 89-90% on 4 liters oxygen via nasal cannula. E15 stated "I told him I hope I don't have to send you out this morning." R7 is a heavy smoker and had only smoked half a cigarette and came back in and requested his nebulizer treatment which was very uncommon. E15 stated "I normally have to talk him into taking his treatment. R7 needed to go to the bathroom and I assisted him to the toilet and went on lunch. R7 usually sits in the bathroom a good 30 minutes. When I came back from lunch, I went to the room and R7 was already on the floor and 911 had been called. R7 was able to tell me everything that happened he was alert and oriented. R7 was guarding his right arm and his right leg didn't look right it was bowed out to the right." E15 stated she helped

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paramedics load R7 up.

On July 12, 2017 at 9:40 AM, E14 CNA stated she answered R7's bathroom call light and R7 stated he was ready. E14 stated R7 stood up from the toilet, while holding his walker. E14 wiped R7 and fastened the incontinence brief on the right and reached over to fasten the left side of the brief when R7 stated "I can't do it." E14 stated she felt he was going down and told him "to go down R7 go down." While R7 was going down he held onto the walker the entire time. R7 landed on his knees and stated "I think I broke my leg" and was holding one arm.

On July 13, 2017 at 1:35 PM, E15 stated prior to R7's fall, "R7 was acting strange that day." R7 went outside to smoke (without his oxygen) and came back in and requested his oxygen and breathing treatment. R7 only had half of his breathing treatment and then wanted to go to the bathroom. R7 did not have oxygen on in the bathroom. "R7 must not have been feeling the greatest to ask for oxygen and his breathing treatment."

On July 12, 2017 at 3:20 PM, E17 RN stated R7 transfers with a walker, a gait belt, and 1 or 2 staff to assist depending on if he is compliant with his oxygen. If R7 is noncompliant with his oxygen it makes him weak and lethargic and then 2 staff members are needed for transfers.

On July 12, 2017 at 12:40 PM, E12 Restorative Nurse stated she was paged to R7's room when R7 fell. E3 saw R7 on his knees still holding onto walker with blood on the floor. E3 left R7's room to go call the doctor and 911 and did not see if R7 had a gait belt on. "R7 has weakness in his legs and requires a gait belt, a walker, and one person

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assist for transfers, but if R7 is having an off day that staff should go to the next step of 2 person assist or a mechanical lift. E12 stated she does the transfer and fall risk section of care plans and prints the Kardex MDS book for the CNAs. The Kardex book is updated and is the most current." When this surveyor inquired about R7's Look Back Charting and Transfer & Bed Mobility Assessment (completed by her) showing R7 requires extensive assistance of 2 for transfers E12 was not sure of the discrepancy and stated "R7 fluctuates."

On July 12, 2017 at 12:50 PM, E2 Director of Nursing stated staff is expected to follow the residents care plan. E2 stated she did not know how R7 transferred and could not explain why current charting shows R7 transfers with extensive assist of 2 and the staff were using one person for transfers.

On July 12, 2017 at 1:00 PM, E3 Assistant Director of Nursing (ADON) stated R7 transfers with 1 assist and a gait belt. E3 stated a change in condition could change a residents needs for assistance and could explain why the recent charting shows R7 needs 2 assist.

On July 12, 2017 at 11:55 AM, Z5 Occupational Therapist stated R7's last Physical Therapy and Occupational Therapy assessments were done (June 20, 2017) 2 weeks before his fall on July 4, 2017, when his therapy ended. At 12:12 PM, Z5 stated R7's therapy report dated June 20, 2017 shows R7 requires moderate assistance (26-75%) to transfer to the toilet because "on a good day R7 needs less help but if R7 is lethargic he needs more help thus the range."

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R7's Minimum Data Set (MDS) dated July 3, 2017 (which is incomplete-still in progress) shows R7 requires extensive assist of 2 staff for toileting and is not steady moving on and off the toilet.

R7's Look Back Charting Forms for July 2-3, 2017 show R7 was alert and oriented, transfers with extensive assist of 2, has shortness of breath with exertion and at rest, is a fall risk, and was on acute monitoring for infection.

R7's Transfer & Bed Mobility/Limited Lift Review Form dated June 27, 2017 completed by E12, shows R7 is an extensive assist of 2 persons for transfer, has poor ability to stand and maintain balance, is not steady moving on and off toilet, and has a recommendation "resident will be designated for a Sit to Stand Transfer Device with a Standard Sling as the resident requires Extensive Assist for transfer abilities with staff assistance at over 26% weight bearing assistance for transfers."

R7's MDS Kardex Report in the CNA book at the Nurses station dated June 13, 2017 shows R7 requires extensive assistance of 2 person physical assist for transfers and is not steady moving on and off the toilet.

R7's Fall Risk Review dated June 27, 2017 shows R7 is a high fall risk due to history of falls (bilateral femur fractures in October 2016), R7 exhibits loss of balance while standing, and has diagnoses of fatigue/weakness.

R7's Care Plan (not updated since April 29, 2016) shows R7 is at risk for falls, has general weakness, moderate to severe range of motion loss to all extremities, bilateral femur fractures, and requires extensive assistance with most

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activities of daily living. R7's interventions shows "gait belt for all transfers" and "if resident appears to have declined staff will get more assistance and/or use mechanical lift for transfer."

The facility's Lifting/Transfer Policy dated February 2017 shows the purpose "To promote comfort ... .and decrease the possibility of injury to the resident and/or nursing personnel."

The facility's Gait Belt Policy dated February 2017 shows the purpose of gait belts "To provide support and safety during ambulation, lifting, or transferring residents."

(A)