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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009294	A. BUILDING: _____ B. WING _____	C 09/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE SKILLED NURSING & REHAB	333 SOUTH WRIGHTSMAN STREET VIRDEN, IL 62690

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S 000	Initial Comments Complaint #1745104/IL96370 Statement of Licensure Violations	S 000		
S9999	Final Observations 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 300.3240a) 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 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	S9999	Attachment A Statement of Licensure Violations	

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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 300.1220 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.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These requirements were not met as evidenced by:

Based on observation, interview, and record review, the facility failed to assess, monitor the

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effectiveness of interventions and implement interventions while providing adequate supervision for 2 of 5 residents (R1, R2), reviewed for falls in a sample of 13. This failure resulted in R2 sustaining an epidural hematoma, multiple facial fractures, and non-displaced fracture of the spine.

Findings Include:

1. The Admission Record documented R2 was admitted on 9/23/2013.

The Minimum Data Set (MDS), dated 6/14/17, documented R2 had a Brief Mental Interview Status(BIMS) score of 15, indicating cognition intact. The MDS documented R2 required extensive assist with all ADLs (Activities of Daily Living), except eating. The MDS documented R2 used a walker and wheelchair for ambulation, and was incontinent of bladder. The MDS documented R2 had the following partial diagnoses: Osteoporosis, Parkinson's disease, Depression, and Generalized Muscle Weakness.

The Care Plan initiated on 3/9/2016 and revised on 3/7/17 documented in part, "Focus: (R2) resistive to care at times due to self transferring and safety issues. Removes her alarm and will fold it so it won't go off or hide it." The Care Plan further documented R2 had repeated attempts to walk unassisted.

The Care Plan, revised on 8/16/17, documented R2 had a fall with injury to her left hand. The Care Plan further documented in part, R2 was at risk for falls and injuries related to Osteoporosis, Parkinson's Pain, Weakness, and having a history of falls. Care Plan documented R2 had the following falls: 1/10/17, 3/6/17, 3/23/17,

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5/21/17, 6/21/17, 6/24/17, 7/7/17, 7/15/17, and 8/16/17. The only interventions listed for the 8/16/2017 fall was to toilet R2 before and after going to beauty shop appointments. The Care Plan did not document the 8/21/17 fall in which R2 suffered a epidural hematoma, multiple facial fractures, and non-displaced fracture of the spine, or list any interventions related to the 8/21/17 fall. On 8/22/2017 updated information on R2's Care Plan documents in part, "(R2) refuses care from certain staff members at times and tells them to get out of her room."

Fall Risk Assessment dated 8/16/17 documented R2 as having a history of falls, having weak gait, and R2 may shuffle her feet. R2's assessment documented R2 was at high risk for falls, scoring 80, with a score of 45 or higher indicating high risk for falls.

An Situation Background Assessment Recommendation (SBAR) dated 8/16/17 at 2:10 PM, documented R2 had an unwitnessed fall while ambulating to the bathroom. The SBAR documeted possible contributing factors as "Other. 1a. Specify Other: Unsteady balance, noncompliant with assistance. 2. Additional Circumstances b. Alarm failure or device removal. f. Call light not activated." Description of occurrence documented in part, "(R2) self transferred to toilet, no call light activated, personal alarm was removed while resident was in beauty shop and not replaced, resident stated she lost her balance." The SBAR indicated R2 suffered a bruise to her left hand from the fall. The SBAR documented as an intervention for R2 to continue to use the alarm and ensure the device was in place as needed. There was no documentation in R2's record the facility reassessed /re-evaluated current interventions for

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S9999	Continued From page 4 effectiveness or implemented new interventions to prevent R2 from falling in the future. An SBAR dated 8/21/2017 at 8:45 PM, documented R2 had an unwitnessed fall from bed while ambulating to the bathroom. The SBAR documented possible contributing factors which included "1. Other. Failure to comply with asking for assistance. 2a. Refused assistance from male caregiver. Assessment. 2. Mental Status a. Alert a. Person, b. Place. 2b. Orientation is: Normal for this resident. 4. Injury d. Laceration or cut e. Bruising f. Discoloration h. External head injury or trauma j. Extremity. Nature of Occurrence: Resident found on floor near bathroom." SBAR further documented in part that R2 called out at 8:40 PM. E8, Registered Nurse/RN, answered the call light. R2 stated there was nothing E8 could do for resident. The SBAR documented "Shortly after words, resident fell hitting her head on the bedside table, while attempting to go to the bathroom by herself. The chair alarm was barely audible outside the bedroom door. (R2) didn't get tangled in blankets or cords. Anti-skid/slip socks were on. The SBAR documented "(R2) refuses help from male caregivers" Additional information on Section Care P of the SBAR documents in part, "1. Episodic Fall Care Plan: The resident will resume usual activities without further incident through next review. The resident uses electronic alarm to wheelchair, bed, recliner. Ensure the device is in place as needed. Tab alarm when in w/c." The SBAR fails to provide documentation for R2's Neurological Assessment for "Complete this Section only for: Unwitnessed Fall or Fall with Head Involvement," or updated interventions for R2. Nurses Progress Note dated 8/21/2017 at 10:16	S9999		

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PM documents in part, "(R2) fell attempting to go to the bathroom by herself. At 2045 (8:45PM), (R2) stated, 'You can't help me at all.' (E8) exited the room and was a few steps away when (E8) heard a loud noise coming from her room sounding like a watermelon being dropped to the floor. (R2) was lying on her left side with her back to her reclining chair and her head on the floor next to the bedside table. Her head was in a pool of blood. Active bleeding was noted coming from both nares. Bleeding controlled and wounds cleansed for assessment. 4 cm (centimeters) laceration noted to left eyebrow, 2 cm puncture wound noted to left zygomatic arch area and a 5 cm hematoma noted to left elbow. Assessment of spine shows no step downs, no pain to palpitation. Pelvis was stable with no pain to rocking or palpation."

R2's Hospital History and Physical dated 8/22/2017 documents in part, "85 year old female (R2) with Parkinson's and frequent falls after another fall. LOC (level of consciousness) unknown." Computed Tomography (CT) Scan of head, face, and spine reveals the following, "CT head - Acute hemorrhage to represent an epidural hematoma. Hemorrhage within the left maxillary sinus. CT face - Nondisplaced fracture of the left inferior orbital wall. 2. Multiple fractures of the left maxillary sinus. 3. Nondisplaced fracture through the anterior inferior wall of the right maxillary sinus. 4. Minimally-displaced fracture of the alveolar process of the left maxilla. CT c spine - Acute nondisplaced fracture through the anterior aspect of the inferior endplate of C3."

On 8/29/17 at 3:30 PM, E8, Registered Nurse (RN), stated he was the nurse on duty when R2 fell. He stated he went to answer R2's call light

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and that R2 refused his help. E8 stated he asked R2 if she wanted to go to the bathroom and he left the room to get a female caregiver, because that is what R2 likes. E8 stated he wasn't "five steps down the hallway, and (R2) fell." He stated there was a pool of blood under R2's head, and he didn't move R2. E8 stated R2's alarm was set to voice only, and "(E8) switched to an actual alarm. Voice could be mistaken for the TV." E8 stated the charting for the SBAR was new to him and he clicked R2 was in bed (prior to fall), but that she was in her recliner when he exited the room that night.

On 9/1/17 at 12:45 PM, E18, CNA, stated she was working on the night R2 fell on 8/21/17. She stated she attached R2's alarm string to her shirt. She stated she was in another room assisting another resident when R2 fell. E18 stated she couldn't hear the voice alert alarm because if the TV is up, alarms are difficult to hear. E18 confirmed R2 had a voice activated alarm on 8/21/17.

On 8/30/17 at 8:34 AM, E9, Certified Nurse's Aide (CNA) stated that alarms are supposed to be checked every shift, but that she only checks the alarms when they don't sound. She stated R2 had a voice alert alarm and that staff doesn't hear the voice alert alarms. E9 stated "We (staff) want alarms that are loud and scream so we go running to answer them."

On 8/29/17 at 10:00 AM, E1, Administrator, stated "All electronic alarms are checked for functionability after care on a daily basis by direct care staff, including making sure you can hear the alarm from down the hall, even the voice alert ones."

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On 8/30/17 at 9:45AM, E10, Corporate Nurse, stated in part she does not consider alarms an intervention, and that the alarms only alert staff that a resident has fallen.

On 8/30/17 at 10:30AM, E4, Care Plan Coordinator, stated there were only two residents that had voice alert alarms in the building, and those residents were R1 and R2.

On 8/31/17 at 2:45PM, E4 stated she did not do a Fall Risk Assessment or reassess R2 after she fell on 8/21/17.

On 8/29/17 at 5:03 PM, an onsite visit was made to another facility where R2 currently resides. She was admitted to this facility after her hospitalization. R2 was sitting up in a high back chair, with her feet elevated, and she had bilateral positioning devices to the side of her body. R2 had a cervical collar around her neck, yellow bruising to her right and left front knees. There was noticeable facial brusing to both the left and right side of R2's face. R2 stated she doesn't remember the fall in detail, but remembers the staff, "wanting me to go to bed," after dinner.

On 8/29/17 at 5:30 PM, Z5, Administrator at new facility where R2 currently resides, stated R2 now required a full mechanical lift in order to transfer and does not make any attempts to rise from the high back chair.

On 8/29/17 at 1:18 PM, Z3, R2's Power of Attorney, stated that R2 fell on 8/16/17 and 8/21/17. She was informed R2 suffered a "brain bleed," with the subsequent fall, and that prior to the 8/21/17 fall, R2 had "always been so sharp," and now her condition is "not the same," and R2 had removed the alarms prior to the 8/16/17 and

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8/21/17 falls.

On 9/1/17 at 3:02PM, Z6, R2's physician, stated the injuries sustained from R2's recent fall could have contributed to the decline in R2's condition, and that he found R2 to be confused upon examination.

2. R1's EHR (Electronic Health Record), undated, documents R1 was admitted to the facility on 3/6/2017.

R1's Care Plan, dated 3/20/17, documents in part, R1 was at risk for falls related to having Hemiplegia/Paresis, Cognitive Impairment, Incontinence, History of Falls, and Poor Safety Awareness. The Care Plan also documented R1 had repeated attempts to walk unassisted, and having fallen while in recliner and/or wheelchair on 3/25/17, 5/15/17, 5/22/17, 5/27/17, 7/5/17, and 8/12/17. The Care Plan documented interventions "1. 5/23/17, non-skid pad to wheelchair and a low bed. 2. 8/15/17, Occupational and Physical Therapy to evaluate and treat, and a "Call Don't Fall" sign to be placed on R1's bathroom door, and to be toileted daily at 4:00PM. 3. 8/25/17, R1 received a chair and bed electronic voice activated (alert) alarm."

R1's MDS, dated 8/24/17, documented R1 having a BIMS of 2, indicating severely impaired cognition, is incontinent of bowel and bladder, and requires extensive assist for all ADLs. The MDS further identifies R1 having in part the following diagnoses: Dementia, Cerebral Vascular Disease, Over Active Bladder, Insulin Dependent Diabetes Mellitus, and Chronic Back Pain.

R1's Fall Risk Assessment, dated 8/30/17, documents R1 having a score of 55, with a score of 45 or higher, indicating high risk for falls.

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R1's SBAR, dated 8/25/17 at 4:10 PM, documents in part, "(R1) Un-Witnessed or Suspected Fall. Pt (patient) on floor on his left side. Recliner noted to be in raised position with wheelchair close to resident. Pt unable to communicate what occurred but stated his head hurts. Unable to tell specifically where or describe pain. Hematoma noted to left side of head and bruising to left upper arm."

R1's Hospital Computed Tomography (CT) scan, dated 8/25/17 at 05:49 AM, documents in part, "There is redemonstration of a small amount of subarachnoid hemorrhage along the right frontal and left parietal regions also, left cerebral subdural hematoma."

On 8/29/17 at 1:15 PM, Z2, R1's family, stated the facility called her on 8/25/17 to state R1 got out of personal recliner chair to self transfer to wheelchair, and was being sent to the hospital because of an injury to R1's head. Z2 also stated since admission, R1 has not been able to understand the use of the call light due to his poor cognition, is dependent on staff for all care, and has always used his electronic controls to his recliner to rise and lower the chair, even prior to the 8/25/17 fall. Z2 further stated R1 has always needed to be busy with his hands. Z2 stated she visits R1 about every other day from about 2:00 PM until after dinner, and has not noted staff to toilet R1 at 4:00 PM on a daily basis.

Based on 15 minutes or less observation intervals on 8/30/17 from 3:30 PM to 4:30 PM, R1 was sitting in his wheelchair with his wife in the main dining room. No attempts from staff to toilet R1 was made during the observation period. At that time, Z2 stated R1 had not been toileted during

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S9999	Continued From page 10 their time in the dining room. The facility staff did not implement the intervention of toileting at 4:00 PM to prevent R1 from falling as noted in R1's Care Plan. On 8/30/17 at 4:45PM, E13, CNA, stated she had not toileted R1 during her shift, as she had just arrived for her shift around 3:00PM. E13 further stated she toilets R1 only when R1 requests to be toileted, and not at a specific time frame. On 8/29/17 at 8:30 AM, E15 (CNA), stated alarms are checked by the Department Heads and that E4 (Care Plan Coordinator) is responsible for maintenance of the alarms. On 8/29/17, at 10:00 AM, E1, Administrator stated that all alarms are checked to ensure they are functioning on a daily bases by direct care staff. E1 stated this included making sure staff can hear the alarms from down the hall, even the voice alert alarms. On 8/30/17, at 9:45 AM, E16 (CNA), stated the personal alarms are checked by E4. E16 stated she also checks the alarms at the beginning of her work shift. On 8/30/17, at 4:15 PM, E13 (CNA), stated the personal alarms are checked by her only during the beginning of her shift. On 8/31/17, at 12:00 PM, E4, Care Plan Coordinator, stated "Every am (morning), all department heads check alarms devices, and during off hours, staff is aware on holidays and weekends, locations of batteries. Day staff is aware if non-functional device come to me." On 8/31/17, at 12:50 PM, E7 and E17 (CNAs)	S9999		

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transferred R1 to the toilet from the wheelchair. E17 removed the chair pad alarm from the wheelchair and placed it in R1's reclining chair. At no time did E17 check the alarm to see if it was functioning. After toileting, E7 and E17 transferred R1 to the reclining chair, E17 and E7 left the room.

The Facility Policy entitled "Alarms, Use of Personal", dated 2008, documented "Purpose: To minimize the risks of falls associated with unsafe transfer attempts. The Policy documented "Assessment Guidelines : Fall Risk Assessment, Appropriateness for the use of the personal alarm." The Procedure section of the policy documented " 1. Assess resident for the appropriateness of using a personal alarm." The Policy documented "5. Verify alarm function prior to placement."

Facility Policy dated 2006, entitled Resident Assessment, documents in part, "Purpose: To develop a comprehensive plan of care for the resident. Care Plan Documentation Guidelines. Problem: Identify the resident's problems and strengths. Goal: List MEASURABLE goal(s) to be accomplished. Approaches: Establish a measurable, time-limited, long-term goal. Establish measurable, time-limited, short-term goals for each problem identified."

Facility Policy dated Aug 2014, entitled Fall Management, documents in part, "Purpose: To evaluate risk factors and provide interventions to minimize risk, injury, and occurrences. Assessment Guidelines: Fall Risk Factors/Fall History, Post-fall Evaluation and Observation. Fall Prevention Procedure: 1. Evaluate risk factors for sustaining falls upon admission, while conducting interdisciplinary (IDT) care plan

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SUNRISE SKILLED NURSING & REHAB	**333 SOUTH WRIGHTSMAN STREET VIRDEN, IL 62690**

(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
S9999	Continued From page 12 reviews. 3. Review, revise, and evaluate care plan effectiveness at minimizing falls and injuries during IDT walking rounds and as needed. Care Plan Documentation Guidelines: Identify fall risk and associated risk factors. Outline fall prevention strategies and approaches." Facility Policy revised on November 2016, entitled Incident Management Policy, documents in part, "Procedures: All incidents will be reviewed and investigated to identify any underlying risk factors, precipitating events, contributory conditions, or environmental issues that may need to be addressed in order to reduce recurrence and contribute to a safer environment. " (A)	S9999		