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S9999	Final Observations Statement of Licensure Violations: 300.610 300.1210b) 300.1210c) 300.1210d)6 300.1220b)3) 300.1230b)d)e)f)h)i)j)1),5),k)1)2)3)4)5) 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 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents'	S9999	Attachment A Statement of Licensure Violations	

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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 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.
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.

Section 300.1230 Direct Care Staffing

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b) The number of staff who provide direct care who are needed at any time in the facility shall be based on the needs of the residents, and shall be determined by figuring the number of hours of direct care each resident needs on each shift of the day.

d) Each facility shall provide minimum direct care staff by:

1) Determining the amount of direct care staffing needed to meet the needs of its residents; and

2) Meeting the minimum direct care staffing ratios set forth in this Section.

e) The direct care staffing requirements in this Section apply to the number of persons actually on duty and not to the number of persons scheduled to be on duty.

f) For the purpose of computing staff to resident ratios, direct care staff shall include the following, as long as the person is assigned to duties consistent with the identified job title and documented in employee time schedules as required by Section 300.650(i):

1) registered nurses;

2) licensed practical nurses;

3) certified nurse assistants;

4) psychiatric services rehabilitation aides (see Section 300.4090);

5) rehabilitation and therapy aides;

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S9999	Continued From page 3 6) psychiatric services rehabilitation coordinators (see Section 300.4090); 7) assistant directors of nursing; 8) 50% of the Director of Nurses' time; 9) 30% of the Social Services Directors' time (Section 3-202.05 of the Act); and h) Care Determinations When differences of opinion occur between facility staff and Department surveyors regarding the care an individual resident may require, the surveyor shall determine whether the resident is receiving appropriate care. If the resident is receiving appropriate care, the surveyor will accept the facility's determination of the number of direct care hours the facility shall provide. i) The facility shall schedule nursing personnel so that the nursing needs of all residents are met. j) Skilled Nursing and Intermediate Care 1) Effective July 1, 2010, for each resident needing skilled care, a minimum staffing ratio of 2.5 hours of nursing and personal care each day must be provided; for each resident needing intermediate care, 1.7 hours of nursing and personal care each day must be provided. 5) Effective January 1, 2014, the minimum staffing ratios shall be increased to 3.8 hours of nursing and personal care each day for a resident needing skilled care and 2.5 hours of nursing and	S9999		

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personal care each day for a resident needing intermediate care. (Section 3-202.05(d) of the Act)

k) Effective September 12, 2012, a minimum of 25% of nursing and personal care time shall be provided by licensed nurses, with at least 10% of nursing and personal care time provided by registered nurses. Registered nurses and licensed practical nurses employed by a facility in excess of these requirements may be used to satisfy the remaining 75% of the nursing and personal care time requirements. (Section 3-202.05(e) of the Act)

l) To determine the numbers of direct care personnel needed to staff any facility, the following procedures shall be used:

1) The facility shall determine the number of residents needing skilled or intermediate care.

2) The number of residents in each category shall be multiplied by the overall hours of direct care needed each day for each category.

3) Adding the hours of direct care needed for the residents in each category will give the total hours of direct care needed by all residents in the facility.

4) Multiplying the total minimum hours of direct care needed by 25% will give the minimum amount of licensed nurse time that shall be provided during a 24-hour period. Multiplying the total minimum hours of direct care needed by 10% will give the minimum amount of registered nurse time that shall be provided during a 24-hour period.

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5) Additional Direct Care Hours Equal to at Least 75% of the Minimum Required

The remaining 75% of the minimum required direct care hours may be fulfilled by other staff identified in subsection (f) as long as it can be documented that they provide direct care and as long as nursing care is provided in accordance with the Nurse Practice 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

These Requirements are not met as evidenced by:
Based on interview, observation, and record review the facility failed to assess and treat pain for one of three residents (R2) reviewed for pain in the sample of three. As a result of these failures, R2 had uncontrolled pain related to sustaining a right elbow fracture and head/facial lacerations.Facility failed to provide treatment and services to prevent a significant decline in the ability to perform ADL's (Activities of Daily Living) for one of three residents (R2) reviewed for falls in the sample of three. This failure resulted in R2 declining from being independent to requiring extensive assistance with transfers, with walking in the room/corridor, and with locomotion on the unit. R2 also declined from requiring supervision to needing extensive assistance with bed mobility.Facility failed to provide adequate supervision to prevent falls, failed to evaluate and analyze cause of falls, failed to implement fall related interventions, and failed to monitor effectiveness and modify fall related interventions

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for one of three residents (R2) reviewed for falls in the sample of three and the facility failed to provide sufficient staff to meet the resident's needs per the plan of care and facility policy, and to provide supervision of the resident to prevent injuries for one resident (R2) of three residents reviewed for falls in a sample of three. R2 had multiple falls resulting in injury due to a lack of supervision related to facility staffing. These failures resulted in R2 falling and sustaining head/facial lacerations on three separate occasions and a fracture of the left elbow. Facility failed the to monitor the use of antipsychotic medications, and provide medical justification and clinical indication for the use of duplicate antipsychotic medications for one of one residents (R2) reviewed for antipsychotic medications in a sample of three. This failure resulted in R2 having multiple falls with head/facial lacerations on three separate occasions and a fracture of the left elbow.

Findings include:

R2's Physician's Order Sheet (POS) dated 2/01/15, documents that R2 has a diagnosis of Alzheimer's Dementia. R2's Minimum Data Set (MDS) dated 12/13/14 documents R2's cognitive status as severely impaired.

R2 ' s x-ray report dated 2/2/15 documents a left elbow fracture. R2 ' s Physician's Order Sheet (POS) dated 02/2015 did not contain an order for a pain relieving medication until 2/18/15. An order dated 2/18/15 documents an order for Tylenol 650 milligrams (mg) every four hours, as needed for pain. R2's nursing notes dated

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S9999	Continued From page 7 02/18/15 at 12:10 A.M, document R2 having a laceration in the right eyebrow with five to six sutures, laceration to right upper nose with two sutures, laceration under right eye with three sutures, right eye swollen and dark purple, nose swollen, dried blood noted in bilateral nares and in mouth, and abrasion under chin as a result of a fall occurring on 2/17/15 at 8:45 P.M. On 2/19/15 at 10:30 A.M., E4 Certified Nurse ' s Assistant (C.N.A.) and E12 C.N.A. transferred R2 from wheelchair to the bed. R2 had facial grimacing during transfer. E4 asked R2, " Does your eye hurt? " R2 replied, " It hurts, it is bothering me. " E4 and E12 then exited room. On 2/19/15 at 10:50 A.M., E10 Licensed Practical Nurse (L.P.N.) stated, " I have not given (R2) anything for pain. No one has reported to (E10) that (R2) has complained of pain. I did not know that (R2) received a new order for Tylenol. I would expect (R2) to have pain due to (R2)' s injuries. If I was told (R2) was in pain I would have given (R2) something for pain. " On 2/19/15 at 11:15 A.M., E4 confirmed that E4 did not report R2 ' s complaint of pain to R2 ' s nurse. On 2/19/15 at 11:15 A.M., E12 confirmed that E12 did not report R2 ' s complaint of pain to R2 ' s nurse. R2 ' s Pain Care Plan last updated 9/18/14 does not include any interventions to inform staff on providing care and monitoring for pain after R2's lacerations and fracture, or transferring R2 after receiving a left elbow fracture. On 2/18/15 at 2:30 P.M., Z1 (R2 ' s spouse)	S9999		

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stated, " (R2) does complain of pain. (R2) has pain after every fall and it takes about three days for (R2) to feel better. "

On 02/19/15 at 2:00 P.M., E15, Care Plan Coordinator, stated, "Nothing triggered me to change the pain care plan or do a new Pain Assessment when (R2) got the fracture or lacerations to the head. (R2)'s pain care plan was not updated with anything new. The last time a new intervention was added to (R2)'s pain care plan was on 9/18/14. I am the one who got (R2) the new order for (R2) as needed pain medication. I saw (R2) and knew (R2) had to be in pain and I couldn't believe (R2) didn't have a prn order by now."

On 2/18/15 at 11:00 A.M., E1 stated that R2 has not been to see an orthopedist. E1 stated that the appointment was made for March because the transportation aide did not know that R2 had a left elbow fracture. E1 stated, "The ortho (orthopedic) appointment does seem scheduled far out and an appointment should have been made as soon as possible."

On 2/23/15 at 1:30 P.M., Z5 (R2 ' s physician) stated, " I would have expected an orthopedist follow up as soon as possible since (R2) had a left elbow fracture. The appointment should have been made the next day. They (Orthopedist Office) usually have appointments for acute issues. R2's nurse could have called the office and my nurse would have got (R2) an appointment sooner. An appointment in March is not soon enough. "

On 2/18/15 at 3:15 P.M., E1 states, " We had a system failure with (R2). I spoke with corporate staff and they agree we have had a system

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failure. "

The Pain Prevention and Treatment policy dated 01/2010 documents, " The MDS Coordinator will complete the MDS/Significant Change Pain Assessment Form at least quarterly and with any significant change in resident condition. Information collected on the MDS Significant Change Pain Assessment Form will be used to formulate and implement a resident Pain Treatment Plan documented in the resident's care plan.

On 2-17-15 at 2:15 p.m., E18 (CNA/Certified Nursing Assistant) wheeled R2, in a wheelchair, from the dining room to (R2's) room.

R2's MDS (Minimum Data Set) ADL assistance section dated 9-13-14, indicates R2 required supervision with bed mobility and eating, was independent with transfers, walking in the room/corridor, and locomotion on the unit. R2 also required limited assistance with toilet use.

R2's MDS ADL assistance section dated 12-13-14, documents R2's ADL's declined from the prior assessment on 9-13-14, to requiring extensive assistance with bed mobility, transfers, walking in the room/corridor, and locomotion on the unit. R2 also required extensive assistance with toilet use.

R2's Restorative Walk to Dine Program dated 2-1-15 through 2-17-15, is incomplete (not initialed as being done by staff) on 2-1-15, 2-3-15, 2-8-15 through 2-13-15, 2-15-15, and 2-17-15.

R2's current Fall Plan of Care, documents a fall

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intervention dated 1-25-15 to obtain a PT (Physical Therapy) and OT (Occupational Therapy) evaluation.

On 2-17-15 at 11:30 a.m., E1 (Administrator) verified with the therapy department that R2's therapy evaluation intervention from 1-25-15 had never been obtained, therefore, R2 did not receive PT or OT services.

On 2-17-15 at 2:15 p.m., E18 stated, "I wheeled (R2) in a wheelchair to the dining room and back, before and after lunch today. We (the staff) do not have time to walk R2 to the dining room because we (the staff) are short staffed."

On 2-17-15 at 12:45 p.m., E12 (CNA) stated, "(E18) wheeled (R2) to the dining room and back today. We do not have time to walk (R2)."

On 2-18-15 at 2:25 p.m., E11 (CNA) stated, "Most CNA's prefer to take (R2) to meals in the wheelchair and not walk (R2). It is easier."

On 2-19-15 at 2:00 p.m., E15 (Care Plan/MDS Coordinator) stated, "(R2) has not had any significant change MDS's or assessments done since being admitted here. (R2's) MDS's from 9-13-14 to 12-13-14 indicated (R2's) ADL's decreased with bed mobility, transfers, locomotion, dressing, eating, toilet use, and hygiene. (R2) and (R2's) family desired (R2) to maintain independence. I (E15) did not do a significant change assessment, or update (R2's) care plan when (R2's) ADL's declined from 9-13-14 through 12-13-14. A restorative program was started after a fall on 11-25-14, instructing

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staff to walk (R2) to the dining room and back. I have not re-assessed that program to determine if the program was effective. I did not know I had to re-assess the restorative programs. If the restoratives are not initialed by the staff, then it is presumed they didn't do them. I think (R2) needed to see a neurologist. I called and spoke to a neurologist regarding (R2), but the neurologist never got back to me. I think (R2's) medications are what caused the decline."

On 2-18-15 at 3:15 p.m., E1 stated, "We had a system failure with (R2). I spoke with corporate and they (corporate staff) agree we (facility staff) have had a system failure."

On 2-18-15 at 2:00 p.m., Z1 (R2's Spouse) stated, "(R2) has declined because the staff never walk (R2). I am here every other day, and I never see the staff walk (R2)."

An undated Comprehensive Assessment\Care Planning policy, documents a MDS and care plan shall be re-evaluated within 14 days of determination that a significant change in a resident's status impacts more than one area of the resident's health status and is consistently noted in two or more areas of decline.

A Restorative Nursing Program dated 9/2008, documents after a restorative program has been initiated, the program should be evaluated to determine if the goal has been achieved by measuring and comparing objectives.

R2's Physician's Order Sheet (POS) date 2/01/15, documents that R2 has a diagnosis of Alzheimer's Dementia. R2's Minimum Data Set

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(MDS) dated 12/13/14 documents R2's cognitive status as severely impaired. The MDS documents that R2 requires a two person extensive assistance with bed mobility, transfers, walking, and toilet use. The MDS documents R2 is not steady and is only able to stabilize with staff assistance. The MDS documents that R2 uses a walker and wheelchair for mobility.

R2's POS dated 2/01/15, documents an order dated 2/03/15 as "Nurse to verify placement and function of alarm every shift." R2's fall care plan documents an intervention dated 12/20/14 to add half side rails for mobility. R2's fall care plan documents an intervention dated 11/28/15 to provide a motion sensor alarm and to continue with 15 minute checks.

On 2/17/15 at 11:05 A.M., R2's Medication Administration Record (MAR) documents the nurse is to verify placement and function of the alarm every shift was not initialed on 2/11/15 for second shift and 2/08/15, 2/12/15, 2/14/15, and 2/17/15 for the third shift.

On 2/17/15 at 11:05 A.M., R2 was lying in bed. No side rails were present on R2's bed. A motion alarm was on top of a bedside table angled toward R2's bed. Alarm did not sound when activated. At 11:10 A.M., E17 Licensed Practical Nurse (L.P.N.) called E25 (Maintenance Assistance) concerning the motion alarm not working. At 11:25 A.M., E25 took the alarm from the bedside table and exited room.

On 2/17/15 at 11:05 A.M., E17 confirmed that R2's motion alarm was not working. E17 confirmed that there are no initials documented to verify placement and function of alarm on 2/11/15 for second shift and 2/08/15, 2/12/15, 2/14/15,

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and 2/17/15 for third shift. On 2/17/15 at 11:30 A.M. E17 confirmed that R2's bed did not have side rails. On 2/17/15 at 1:00 P.M., E17 stated that at 12:15 P.M. the motion alarm was working and placed back in room. E17 stated that from 11:05 A.M. to 12:15 P.M. no alarm was present in R2's room and that no one implemented a new fall intervention during that time.

On 2/18/15 at 9:00 A.M., R2 was sitting across from the nursing station in a wheel chair facing a television. R2 had a hematoma and a large laceration with bruising above R2's right eye socket.

Nurse's Notes dated 2/17/15 at 8:45 P.M. document that R2 was found on floor beside the bed. Nurse's Notes dated 2/17/15 at 9:00 P.M., document R2 was sent to the emergency room. Nurse's Notes dated 02/18/15 at 12:10 A.M., document that R2 returned to facility. Nurse's Notes at that time document R2 having a laceration in right eyebrow with five to six sutures, laceration to right upper nose with two sutures, laceration under right eye with three sutures, right eye swollen and dark purple, nose swollen, dried blood noted in bilateral nares and in mouth, and an abrasion under chin.

On 2/18/15 at 9:30 A.M., E21 Certified Nurse's Assistant (C.N.A.) stated that E21 was on break at the time of R2's 2/17/15 fall. R2 stated, "Myself and (E20/C.N.A.) were assigned to (R2). I think (E20) filled out (R2's) 15 minute checks. (R2)'s alarms go off all the time. I do not think they keep (R2) from falling. One on one is a better way to go with (R2). A one on one is the only way to keep (R2) from falling. There is not enough staff to care for (R2). (R2) was antsy before I went to break so I took the bed remote away from (R2),

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because (R2) was moving the bed up and down."

On 2/18/15 at 9:35 A.M., E20 (C.N.A.) stated, "I was on the 300 wing hallway helping another resident at the time of (R2's) 2/17/15 fall. E(R2)'s alarm frequently goes off. (R2) rips bed alarms apart. I thought (R2) did well in (R2)'s recliner. I think if someone was a one on one it would probably work good. No one has asked me about new interventions for (R2)."

On 2/18/15 at 10:15 A.M., E15 Care Plan Coordinator stated, "I do not know the root cause of (R2's) 2/17/15 fall. I think the C.N.A.'s found (R2) on the floor. I am unsure who exactly found (R2) on the floor. (R2) prefers to sleep in the recliner. We do not have a recliner for (R2) to use. I didn't think about using the recliner in the TV room. The Interdisciplinary Team (IDT) decided on a perimeter mattress. The mattress was put on (R2)'s bed at 8:00 A.M. There were no new interventions added to (R2)'s care plan until this morning at 8:00 A.M., approximately 8 hours after (R2) returned from the hospital to the facility."

On 2/18/15 at 10:30 A.M., E25 confirmed that E25 put a perimeter mattress on R2's bed at 8:00 A.M.

On 2/18/15 at 10:45 A.M., E16 Registered Nurse (R.N.) stated, "On 2/18/15, (R2) came back to the facility around 12:10 A.M. per ambulance transport. (R2) stayed in (R2's) room all night. I talked to (E15) about (R2) transferring back to facility. (E15) told me it was ok for (R2) to come back by ambulance. We continued with (R2)'s sensor alarm and fifteen minutes checks. (R2) wasn't kept in constant sight. (R2) is quick and gives no warning when (R2) gets up. The most

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effective intervention would be a one on one. (E15) did not instruct me to do anything different for (R2)."

On 2/18/15 at 2:25 P.M., E11 C.N.A. stated, "I was called to (R2's) room on 2/17/15 after (R2's) fall. I sat with (R2) and there was blood coming from (R2)'s eye. (R2) hit (R2)'s head on the corner of the night stand. No one has called me to investigate (R2)'s fall. (R2) falls frequently. (R2) did not fall as bad when (R2) had (R2)'s recliner. (R2) has an alarm. It did not go off when (R2) got up and fell. One of the C.N.A.s mentioned that the alarm had been moved because it kept going off. I am not sure who moved it. If there were more C.N.A.s it would help. We need three C.N.A.s down that hall because they are all two assist. No one can get their 15 minute checks done. There was no C.N.A.s on the hall when (R2) fell. (R2) hit (R2)'s head so hard the nurse heard it from the nurse 's station."

On 2/18/15 at 2:25 P.M., E19 R.N. stated, "I found (R2) on the floor on 2/17/15 at 8:45 P.M. I found (R2) in the prone position and that (R2) appeared to have hit (R2's) face on the bedside table. At the time of (R2's) fall (E19) was sitting at nurse's station and heard (R2) fall. No one was on hallway at the time of the fall. One C.N.A. was on break and the other C.N.A. was helping a resident on another hall. I really hope for one on one assist for (R2). I think it would prevent (R2) from falling."

R2's Resident Monitoring - 15 minute sheet dated 2/17/15, is incomplete from 1:30 P.M. to 12:00 A.M.

On 2/18/15 at 9:15 A.M., E24 C.N.A. verified (E24) has not completed 15 minute checks for

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S9999	Continued From page 16 R2. On 2/18/15 at 9:15 A.M., E26 (CNA) stated, "I have not filled out 15 minute checks for (R2) today. I came on at 6:00 A.M. I usually fill out 15 minute checks on my breaks because I don't have time until my break. I am not sure of any new interventions for (R2). I haven't worked in a couple of days. I think (R2) needs a one on one because (R2) breaks (R2)'s alarms. No one has asked me what would work to prevent (R2) from falling." On 2/18/15 at 11:00 A.M., E1 Administrator stated, "After a resident falls, a quality assurance form is completed. The form is an internal form and I can answer questions regarding information contained on the form, but I can not provide a completed form for review. (R2) has had eighteen falls from 10/03/14 to 2/17/15. After a fall the IDT (Interdisciplinary Team) reviews it the next day during morning meeting to add new fall prevention interventions. On 12/20/14 at 6:00 A.M., (R2) was found lying next to the recliner. The IDT added the intervention of half side rails for mobility. The family refused the intervention so the side rails were not implemented. The IDT team did not re-evaluate or provide a new intervention when the family refused the side rails. On 1/25/15 at 3:40 P.M., (R2) fell attempting to self ambulate. The IDT added the intervention of therapy to evaluate and treat. (R2) was not evaluated by therapy and did not receive services. (R2's) falls on 12/31/14, 01/09/15, and 01/25/15 were caused from (R2) tripping over or being tangled up in a blanket. The IDT team has not discussed the blanket but I think we should have. On 2/2/15 at 4:40 P.M., (R2) was found on floor next to recliner. At that time (R2) alarm did not sound. New interventions to check the battery	S9999		

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on the motion alarm and replace the battery if needed every shift was added to the care plan, and a new order for (R2) to see an orthopedist was added due to a left elbow fracture. (R2) has not been to the orthopedist. On 2/17/15 at 8:45 P.M., (R2) fell. The root, cause, and analysis of the fall has not been determined yet. They have five days to figure that out and complete the investigation. The IDT decided to put a perimeter mattress on (R2's) bed because it is the least restrictive intervention they could come up with. I am unsure who found (R2) on the floor. (R2) fell from bed and I am unsure if the motion alarm was sounding or not sounding. A one on one could have prevented the falls. We have not tried a one on one because it is the last resort because of staffing and cost effectiveness. We are not equipped to do a one on one. I am aware that (R2) breaks alarms and that the alarms probably annoy (R2). I would expect the staff to replace the alarm right away if the alarm is not working or the batteries need replaced. It is my expectation that if a C.N.A. takes a break the other C.N.A. stay on the hallway. Fifteen minute checks should be filled out after the check is done. The C.N.A.s should communicate with each other. The C.N.A.s should not be waiting to complete their fifteen minute checks until break or the end of their shift. Blanks on the fifteen minute check sheets and on the Medication Administration Record would indicate that they did not do it. The Director of Nursing should be monitoring that. (R2) started falling more after (R2) was sent to the hospital in October. After they adjusted (R2)'s psychotropic medications (R2) began falling more. You know how it is they medicate them and send them back all doped up and they start falling. I think the psychotropic medications have caused (R2) to fall more."

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On 2-17-15 at 3:15 p.m., E1 (Administrator) stated, "We had a system failure with (R2). I spoke with corporate and they agree we have had a system failure."

On 2/18/15 at 2:00 P.M., R2's spouse stated, "I visit every other day. (R2) did not have falls prior to being here. We feel like the staff are not here on time. When (R2)'s light is on they do not respond for at least twenty minutes. This has went on for at least six months on all shifts. I think they are short staffed. During the meal time the staff are in the dining room and no one is left on the hall to toilet (R2). When I am here visiting it takes them at least three hours before they toilet (R2). (R2) never falls when I am here because I help (R2) to the bathroom. The staff just walk on by when the call light is on. When I go to get staff to help take (R2) to the bathroom the staff tell me (R2) is not the only one we take care of here. I have never heard (R2)'s alarm work before today. (R2) has declined because the staff do not walk (R2). I feel like (R2) has fell more since (R2) has returned from the hospital in October."

On 2/19/15 at 10:30 A.M., E4 C.N.A. and E12 C.N.A. transferred R2 from the wheelchair into the bed. The motion sensor alarm was on bedside table pointing away from the bed. E4 and E12 left R2's room.
On 2/19/15 at 10:40 A.M., E4 confirmed R2's motion alarm was pointed away from the bed. E4 confirmed the motion alarm should point towards the bed. E4 confirmed that it would not sound if R2 got out of bed. E4 confirms E4 did not check it prior to leaving the room.

The 12/2009 Fall Prevention Policy documents, "Report all falls during the morning Quality

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Assurance meetings Monday through Friday. All falls will be discussed and comments will be written on the Fall Tracking Form and any new interventions will be written on the care plan."

On 2-18-15 at 9:00 a.m., R1 was propelling self in a wheelchair, down the hallway. R1 did not have an alarm attached to the wheelchair or to self.

R1's current fall care plan includes interventions to provide R1 with a television remote and apply a body alarm to R1 while in the wheelchair.

On 2-18-15 at 8:50 a.m., E4 (CNA) verified R1 did not have an alarm on. On 2-18-15 at 10:00 a.m., E1 (Administrator) stated, "The nurse misunderstood this morning. (R1) should have had an alarm on."

On 2-17-15 at 2:25 p.m., E2 (Care Plan Coordinator) stated, "(R1's) current fall interventions include educating (R1) to seek assistance, provide (R1) with a television remote, and attach a body alarm to (R1's) self and wheelchair."

On 2-17-15 at 2:00 p.m., E6 (Certified Nursing Assistant/CNA) stated, "(R1) does not have a television remote. (R1) never has. We do not have spare remotes to give out. (R1) watches television every night."

On 2-17-15 at 2:45 p.m., E1 verified E1 had told staff to get R1 a remote, but the staff did not. E1 verified R1 should have had a remote since sustaining a fall on 1-30-15, but had not received it yet.

On 2-18-15 at 9:00 a.m., R2 was sitting in a wheelchair at the nurse's station. R2 had

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S9999	Continued From page 20 extensive bruising to the right side of the face, a large hematoma above the right eye, and a laceration above the right eye. R2's Physician Order Sheet dated 2-1-15 through 2-28-15, documents R2 has a diagnosis of Alzheimer's Dementia and receives the following medications: 1. Saphris (Antipsychotic) 5 mg (milligram) once daily for the diagnosis of Dementia with aggression. 2. Zyprexa (Antipsychotic) 7.5 mg at bedtime daily for Dementia with aggression initiated 11-3-15. Depakote 125 mg three times daily for Dementia. R2's Nurse's Notes from 10-3-15 through 2-17-15, include documentation of R2 having 18 falls, resulting in head/facial lacerations on 10-8-14, 10-25-14, and 2-17-15, and a left elbow fracture on 2-2-15. R2's Behavior Monitoring Records from February 2014 through June 2104, and December, 2014 through February 19th, 2015, do not include any documented behaviors. R2's Behavior Monitoring for August, 2014, includes one documented behavior. On 2-19-15 at 11:30 a.m., E13 (Social Service Director) stated, "(R2) has had no documented behaviors from December, 2014 through February, 2015." On 2-23-15 at 9:05 a.m., E13 stated, "We do not have any behavior tracking for (R2) for September through November, 2014."	S9999		

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On 2-23-15 at 8:45 a.m., E3 (Director of Nursing) stated, "(R2) is currently on Saphris 5mg daily, Depakote 125 mg three times daily, and Zyprexa 7.5mg daily. (R2) receives all three of these medications for dementia. We do not have any documentation to support the use of duplicate antipsychotic medications for the diagnosis of dementia. The use of antipsychotics for dementia is not an appropriate diagnosis. I am not sure when the Zyprexa was started. I do not have any tracking of when the antipsychotics have been increased. I do the antipsychotic progress notes for this resident. The last time a progress note was completed was in October, 2014. The progress note was due in January, 2015, but was not completed. The use of dual antipsychotics for (R2) is not documented in (R2's) care plan, either. (Z6/R2's Psychiatrist) has been uncooperative with providing documentation to us regarding (R2's) antipsychotics."

On 2-18-15 at 11:00 a.m., E1 (Administrator) stated, "Since September or October, when they (Physicians) adjusted (R2's) psychotropic medications, (R2) began falling more. You know how it is. They medicate them, send them back to us doped up, and then they (the residents) start falling. Since September or October, (R2) has started falling all of the time and I think the psychotropic medications have caused (R2) to fall more."

On 2-23-15 at 10:30 a.m., Z4 (R2's Consulting Pharmacist) stated, "I would not recommend dual antipsychotics in the elderly. I would recommend gradually getting (R2) off of one of the

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antipsychotics and talk to the Director of Nursing about getting an appropriate diagnosis for the use of the antipsychotics. The diagnosis of dementia does not justify the use of antipsychotics. (R2's) antipsychotics would contribute to (R2) having falls. I would have recommended a medication review to have been done in the past, since (R2) has had so many falls. I will have to talk to the Director of Nursing about getting me a fall list each month, so I can review the residents who are at increased risk of falls."

On 2-23-15 at 1:20 p.m., Z5 (R2's Primary Physician) stated, "(R2's) antipsychotic use is managed by behavioral health management. I do not prescribe Saphris for anything, except hospice residents. (R2's) antipsychotics would contribute to (R2) falling. (R2) has behaviors of constantly trying to stand up."

On 2-18-15 at 2:00 p.m., Z1 (R2's Spouse) stated, "(R2) was never on antipsychotics when (R2) lived at home. (R2) has not acted right for quite some time. Since (R2) came back from the hospital in October, (R2) has had a lot more falls."

The Psychotropic Medication Policy dated 12-30-13, documents the following: Residents shall not be given unnecessary drugs including duplicative therapy.

The Geriatric Dosage Handbook Reference 12th edition states, "Patients with dementia-related behavioral disorders treated with antipsychotics are at an increased risk of death. Olanzapine (Zyprexa) is not approved for this indication.

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R2's Nurse's Notes from 10-3-15 through 2-17-15, include documentation of R2 having 18 falls, resulting in head/facial lacerations on 10-8-14, 10-25-14, and 2-17-15, and a left elbow fracture on 2-2-15.

R2's Nurse's Notes dated 2-17-15 at 8:45 p.m. through 2-18-15 at 12:10 a.m., document R2 was found on the floor beside the bed, resulting in R2 sustaining multiple facial/head lacerations, and requiring sutures.

On 2-17-15 at 11:40 a.m., E12 (CNA) stated, "We have been short staffed lately.

On 2-18-15 at 9:30 a.m., E21 (Certified Nursing Assistant/CNA) stated "I was on break at the time of the fall on 2-17-15. Myself and E20 (CNA) were assigned to care for (R2). A one on one staff is the only way to keep (R2) from falling. We (the staff) do not have enough staff on the weekends. We are suppose to have two per hallway, but we have only been having one per hallway. We do not have enough staff to care for R2 and all of the other residents.""

On 2-18-15 at 9:30 a.m., E20 (CNA) stated, "I was on a different hallway, helping another resident at the time of (R2's) fall on 2-17-15. I think if someone was a one on one with (R2) it would probably work good."

On 2-18-15 at 2:25 p.m., E11 (CNA) stated, "There were no CNA's on the hallway when (R2) fell on 2-17-15. (R2) hit (R2's) head so hard that the nurse (E19) heard it at the nurses' station. We do not have enough to staff to take care of the residents on the hallway (R2) is on. Most of the

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(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
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residents on that hallway require two assist. Sometimes we cannot get our 15 minute resident monitor checks done."

On 2-18-15 at 2:25 p.m., E19 (Registered Nurse) stated, "No one was on the hallway at the time of (R2's) fall. One CNA was on break, and the other CNA was taking care of another resident on another hallway. I really hope for a one on one assist for (R2). I think it would help keep (R2) from falling."

On 2-18-15 at 11:00 a.m., E1 confirmed R2 has had 18 falls from 10-3-14 to 2-17-15. E1 stated, "One on one staff could have prevented (R2's) falls. We (the staff) have not tried a one on one because it is the last resort due to staffing and cost effectiveness. We (the staff)are not equipped to do a one on one."

On 2-18-15 at 2:00 p.m., Z1 (R2's spouse) stated, "I visit every other day. (R2) did not have falls prior to living here. I feel like the staff are not here on time. When (R2's) call light is on they do not respond for at least twenty minutes. This has went on for at least six months on all shifts. I think they are short staffed. During mealtime, all staff are in the dining room, and no one is left on the hallway to toilet (R2)."

B

300.1230
Section 300.1230 Direct Care Staffing

b) The number of staff who provide direct care who are needed at any time in the facility shall be based on the needs of the residents, and shall be determined by figuring the number of hours of direct care each resident needs on each

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	IL6007330	A. BUILDING: _____ B. WING _____	C 02/23/2015

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S9999	Continued From page 25 shift of the day. d) Each facility shall provide minimum direct care staff by: 1) Determining the amount of direct care staffing needed to meet the needs of its residents; and 2) Meeting the minimum direct care staffing ratios set forth in this Section. e) The direct care staffing requirements in this Section apply to the number of persons actually on duty and not to the number of persons scheduled to be on duty. f) For the purpose of computing staff to resident ratios, direct care staff shall include the following, as long as the person is assigned to duties consistent with the identified job title and documented in employee time schedules as required by Section 300.650(i): 1) registered nurses; 2) licensed practical nurses; 3) certified nurse assistants; 4) psychiatric services rehabilitation aides (see Section 300.4090); 5) rehabilitation and therapy aides; 6) psychiatric services rehabilitation coordinators (see Section 300.4090); 7) assistant directors of nursing;	S9999		

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S9999	Continued From page 26 8) 50% of the Director of Nurses' time; 9) 30% of the Social Services Directors' time (Section 3-202.05 of the Act); and h) Care Determinations When differences of opinion occur between facility staff and Department surveyors regarding the care an individual resident may require, the surveyor shall determine whether the resident is receiving appropriate care. If the resident is receiving appropriate care, the surveyor will accept the facility's determination of the number of direct care hours the facility shall provide. i) The facility shall schedule nursing personnel so that the nursing needs of all residents are met. j) Skilled Nursing and Intermediate Care 1) Effective July 1, 2010, for each resident needing skilled care, a minimum staffing ratio of 2.5 hours of nursing and personal care each day must be provided; for each resident needing intermediate care, 1.7 hours of nursing and personal care each day must be provided. 5) Effective January 1, 2014, the minimum staffing ratios shall be increased to 3.8 hours of nursing and personal care each day for a resident needing skilled care and 2.5 hours of nursing and personal care each day for a resident needing intermediate care. (Section 3-202.05(d) of the Act) k) Effective September 12, 2012, a minimum of 25% of nursing and personal care	S9999		

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time shall be provided by licensed nurses, with at least 10% of nursing and personal care time provided by registered nurses. Registered nurses and licensed practical nurses employed by a facility in excess of these requirements may be used to satisfy the remaining 75% of the nursing and personal care time requirements. (Section 3-202.05(e) of the Act)

l) To determine the numbers of direct care personnel needed to staff any facility, the following procedures shall be used:

1) The facility shall determine the number of residents needing skilled or intermediate care.

2) The number of residents in each category shall be multiplied by the overall hours of direct care needed each day for each category.

3) Adding the hours of direct care needed for the residents in each category will give the total hours of direct care needed by all residents in the facility.

4) Multiplying the total minimum hours of direct care needed by 25% will give the minimum amount of licensed nurse time that shall be provided during a 24-hour period. Multiplying the total minimum hours of direct care needed by 10% will give the minimum amount of registered nurse time that shall be provided during a 24-hour period.

5) Additional Direct Care Hours Equal to at Least 75% of the Minimum Required

The remaining 75% of the minimum required direct care hours may be fulfilled by other staff identified in subsection (f) as long as it can be

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S9999	Continued From page 28 documented that they provide direct care and as long as nursing care is provided in accordance with the Nurse Practice Act. THIS REQUIREMENT IS NOT MET AS EVIDENCED BY: Based on interview and record review the facility failed to staff the minimum direct care hours for two weekend days in February 2015. This failure had the potential to affect all 127 residents in the facility. Findings include: On 2-18-15 at 9:00 a.m., E1 (Administrator) provided the February 2015 work schedules, February 2015 Census Detail reports, February 2015 Extended Management calendar, and February 2015 Labor Analysis Reports for direct care staffing totals. According to the facility's February 2015 Census Detail Report dated 2-7-15 and 2-14-15, the facility is required to have a minimum of 356 hours of direct care staff on 2-7-15, and a minimum of 342 hours of direct care staff on 2-14-15. According to the facility's Labor Analysis Report and facility's Extended Management calendar, the facility only had 338.70 hours of direct care staff on 2-7-15, and 327.11 hours of direct care staff on 2-14-15. On 2-19-15 at 9:50 a.m., E1 (Administrator) stated, "The February 2015 Census Detail reports, February 2015 Extended Management calendar, and February 2015 Labor Analysis	S9999		

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Reports include all of the direct care staff scheduled. My scheduler has quit on me (E1), so that is why staffing the facility has been a problem."

On 2-17-15 at 11:40 a.m., E12 (Certified Nursing Assistant/CNA) stated, "We have been short staffed on C 300 hallway lately.

On 2-18-15 at 9:30 a.m., E21 (CNA) stated, "We (the staff) do not have enough staff on the weekends. We (the staff) are suppose to have two per hallway, but we (the staff) have only been having one per hallway. We (the staff) do not have enough staff to care for R2 and all of the other residents."

On 2-18-15 at 2:25 p.m., E11 (CNA) stated, "We (the staff) do not have enough to staff to take care of the residents on C 400 hallway. Most of the residents on that hallway require two assist. Sometimes we (the staff) cannot get our 15 minute resident monitor checks done."

The undated Minimum Daily Staffing Calculations policy, documents the facility requires 3.8 hours multiplied by the number of skilled residents, and 2.5 hours multiplied by the number of intermediate residents to obtain the total number of direct care staff hours needed to provide care.

The Facility Data Sheet dated 2-17-15 and signed by E1, documents that at the time of survey 127 residents resided in the facility.

B