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	IL6003503	A. BUILDING: _____ B. WING _____	06/24/2015

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BRIA OF GENEVA	1101 EAST STATE STREET GENEVA, IL 60134

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S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS 300.610a) 300.1210b) 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. 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. d) Pursuant to subsection (a), general nursing	S9999	Attachment A Statement of Licensure Violations	

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care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

THESE REGULATIONS WERE NOT MET AS EVIDENCED BY:

Based on observation, interview and record review the facility failed to provide nursing services by not assessing a resident's status R13 for 72 hours after a fall on May 30, 2015. The facility failed to safely transfer one resident at risk for falls.
These failures apply to four of 18 residents (R13, R1, R5 and R15) reviewed for nursing services in the sample of 18.
As a result of this failure, R5 was found on the floor and was hospitalized with a cervical (C2) vertebrae fracture. As a result of these failures, R13 fell from a special bed and sustained a femur fracture.

The findings Include:

1. R13's Face Sheet shows she was admitted on 1/5/2012. R13 has the following diagnoses:

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S9999	Continued From page 2 Closed fracture of lower femur, morbid obesity, osteoarthrosis, necrosis of the head and the neck of the femur and peripheral neuropathy. On 6/16/2015 at 10:59 AM, during the initial tour with E21 (Restorative Nurse), R13 was laying on a bariatric bed, with a left leg cast elevated on a pillow. R13 said, "the bed fell on me" about 4 weeks ago and I got the fracture. R13 said that she did not know why the bed fell on her. 6/17/2015 at 1:29 PM, R13 was again laying in bed with the left leg elevated on a pillow. R13 said her fracture was an accident with her bed. R13 said she had a lot of knee pain post fall and when the nurses moved her leg she expressed the pain after the fall. R13 also said that she has the worst case of neuropathy ever. R13 said it feels like pins are sticking her. R13 could not remember much about the accident other than the pain she experienced. On 6/17/2015 at 4:40 PM, E16 (Nurse) said she was the nurse on duty when R13 fell. E16 (Nurse) said she was made aware of the fall by E30 (Certified Nurse Assistant - CNA). E30 said that R13 fell at about 4 'O clock in the evening, but could not remember the day. E16 said R13 was sent out to the hospital over the next few days with a fracture. E16 said the fracture was not diagnosed until later because R13 is a big lady and always complains of pain. E16 said that R13 had a bruise and swelling for which an ice pack was applied and she received her regular scheduled medication for pain. R13's Medication Administration Record from 5/30/2015 until 6/3/2015 shows R13 received regular tramadol 100 milligrams three times a day for osteoarthrosis pain. The Medication	S9999		

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Administration Record states R13 received Morphine for related shortness of breath, and received one dose on June 1, 2015.

On 6/18/2015 at 3:17 PM, E30 said she was assigned to work with R13 the evening of the fall. After the fall R13 said her leg was hurting, but when we put her back to bed. R13 was not in any pain. The following days the pain increased upon movement.

On 6/18/2015 at 5:34 PM, E15 said that he worked the night shift on 6/3/2015. He did an assessment on R13 and moved her left leg. R13 complained of pain. An x- ray was ordered the previous shift on 6/2/2015. The results came back on his shift and described it as a femur fracture. The doctor was notified and gave orders to send R13 out for evaluation. E15 said that R13 fell on May 30, 2015. E15 said there was pain upon movement and he does not know why it was not discovered sooner, maybe because R13 is obese.

On 6/19/2015 at 10:34 AM, Z4(Physician) said he was notified on 6/2/2015 of R13's fall and ordered an x- ray in which R13 had a femur fracture. Z4 said R13 is obese with a history of pain, osteoarthrosis and neuropathy. All of the diagnosis make it necessary to have range of motion and thorough pain assessments. The fracture would have been diagnosed sooner if that were done.

On 6/19/2015 at 10:56 AM, E3 (Assistant Director of Nurses - ADON) said nurses are supposed to do 72 hour assessments post fall which should include range of motion. E3 said the fracture was minimally displaced and would not cause pain.

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S9999	Continued From page 4 A Nursing Progress Note dated 5/27/2015 states that R13 was placed on hospice. The Nursing Progress Note dated 5/30/2015 states, " At 4:00 PM, R13 was found sitting on the floor next to her bed. Upon thorough investigation, noted bump and bluish purplish skin discoloration to the left medial lower leg. Range of Motion to all extremities within normal limits. Complained of chronic pain. Ice Pack applied to the bump to decrease swelling. Power of Attorney, doctor and Director of nursing made aware." A Nursing Progress Note dated 6/3/3015 states, " X- ray results from 6/2/2015 show an acute complete minimally displaced distal femoral fracture with moderate suprapatellar knee joint effusion to the left knee. Resident continues to be in excruciating pain, the left leg is laterally hyperplexed for comfort and pains if moved. Continues to receive scheduled and as needed pain medication. This shift 250 milligrams tramadol was administered with minimal effectiveness. Z4(Physician) notified by phone of x- ray results. Orders to contact hospice and send resident to the hospital. POA(Power of Attorney) notified and said do what it has to do to rectify the situation." A Nursing Progress Note dated 6/3/3015 states hospice was notified and R13 was transferred to the hospital on 6/3/2015. The Hospital Record dated 6/3/2015 states that R13 was not a candidate for surgery, Left leg immobilization was applied. The X- ray dated 6/2/2015 states, " Left femur, Acute complete minimally displaced distal femoral diametaphyseal fracture. Moderate suprapatellar joint effusion."	S9999		

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The facility's Falls Policy dated 5/2015 states, " 72 Hour Post Incident Notes (3 pages)- review to make sure they are consistent and complete.

The facility's Pain Policy dated 5/2015 states, " Guidelines 3 d. Addressing the underlying causes of the residents pain. 3 d. Monitoring for effectiveness of interventions and 3 d. Modifying approaches as necessary."

2) An unusual occurrence investigation report dated 3/29/15, shows R5 was observed on the floor in his room in front of wheelchair with laceration to his forehead. R5 was sent to the hospital. R5 returned on 3/31 with diagnosis of C2 (cervical vertebrae) fracture wearing a neck brace, 6 stitches to his right eyebrow and abrasion to his forehead.

The investigation shows that R5 was last seen in the TV area with his wife R71 (who is his room mate). R71 was in the room with R5 at the time of the fall but neither resident was able to tell what happened. Both residents have dementia. The BIMS (brief interview for mental status) score for R5 on 4/28/15 MDS (minimum data set) was 4, this score fall into the severely impaired range. This report shows R5 is confused and forgetful, incontinent, has poor trunk control, is noncompliant with safety guidance, has impaired memory, gait imbalance and weakness.

On 6/16/15, 6/17/15, 6/18/15 and 6/19/15 R5 was observed wearing a hard collar spine immobilizer around his neck.

On 6/18/15 at 3:45 PM, E11 CNA recalled when R5 fell on 3/29/15. E11 said she was in another room with E10 (CNA) caring for a resident who needed a 2 person mechanical lift transfer. E11

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went to get a towel when she heard a noise from R5 and R71's room. E11 saw R5 on the floor with blood coming from his head. E11 said that R71 always tries to take care of R5 since they have been married so long. R71 must have pushed R5 back to their room as she likes to do. Before the fall R5 was transferred with a gait belt, he could stand and pivot for transfer. Now he is transferred with a sit to stand lift.

On 6/19/15 at 10:10 AM, E10 said that she was across the hallway in another resident's room when this incident happened. R5 was taken to the TV area after dinner which is near the nurse's station. The station is a more supervised area. E10 and E11 were working together to get residents ready for bed when this happened. They just didn't get to R5 yet when the fall occurred. R5's wife probably took him to their room before the staff could get to him. E10 said that R71 is always trying to take care of her husband.

A significant Change MDS was conducted for R5 on 4/8/15. A clarification nursing note of 6/19/15 documents that this was done related to status post fall with injury including cervical fracture and related hospitalization from 3/29/15 to 3/31/15.

3). On 6/16/15 at 3:30 PM, E20 transferred R1 from his wheel chair to the toilet in his bath room. E20 did not lock the wheel chair breaks. E20 applied a gait belt around R1's waist, but did not use it when lifting and transferring R1 from the wheel chair to the toilet. At this time when E20 stood R1 up from the wheel chair, the chair moved away from R1. E20 not locking wheel chair and not using gait belt has potential for R1 to fall.

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S9999	Continued From page 7 R1's fall log from July 2014 to May 2015 showed he had six fall incidents of staff finding him on the floor. The facility policy and procedure for transferring residents from wheel chair require staff to lock wheel chair, apply gait belt on resident and use it when transferring. E20 (Certified Nurse Aide - CNA) on 6/16/15 at 3:45 PM stated he should have locked the wheel chair, which he realized after he transferred R1 from wheel chair to toilet. (B) 300.610a) 300.1210b) 300.1210c) 300.1210d)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	S9999		

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S9999	Continued From page 8 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' 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: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) THESE REGULATIONS WERE NOT MET AS EVIDENCED BY:	S9999		

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Based on observation, interview and record review the facility failed to monitor the skin of residents who are at risk for skin breakdown. The facility failed to offload residents' heels to prevent skin breakdown. The facility failed to have a clean field to administer pressure ulcer wound care and failed to administer pain medication during dressing changes.

These failures contributed to R4 developing a 2.90 x 4.10cm pressure sore to the left heel that was first identified as unstageable eschar and performing a dressing change that was painful to the resident.

This applies to 2 of 3 residents (R4, R3) reviewed for pressure sores in the sample of 18.

The findings include:

1). On 6/19/15 at 11:30am, R4 was observed to be sitting in her room in a wheelchair. E3 (assistant director of nursing) was present along with E9 (registered nurse) and informed R4 a dressing change to the left heel wound would be performed. R4 was pleasant and oriented, stating "that would be fine. How did I get that anyway?" E3 responded, "It's from pressure."

Facility's Wound Summary report dated 6/17/15 shows R4 was identified in the facility with an unstageable necrotic left heel pressure wound, 2.90 x 4.10cm on 4/17/15. Nurse's note dated 4/12/15 at 5:41pm documents R4 has "pain in left heel, administered scheduled tramadol." Another nurse's note dated 4/15/15 5:49pm "had occasional complaints of pain to left heel, scheduled medications to relieve this pain."

E2 stated on 6/18/15 at 5:00pm that there was no

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documentation showing the nurse had assessed R4's complaints of left heel pain on 4/12/15 or 4/15/15. E2 also stated there was no documentation showing staff were off loading R4's heels upon return from the hospital 3/27/15 following surgical left hip repair, until the wound was identified on 4/17/15. That is when the care plan was revised to include this intervention.

Medical summary prepared by E2 (director of nursing) dated 6/18/15 states R4 is 94 and was admitted to facility on 12/10/15. R4 sustained a fall in facility on 3/24/15 and was readmitted following surgical repair to left hip on 3/27/15. This report also shows "... She has decreased mobility. The ORIF (hip surgery) undoubtedly affected blood flow to her left lower extremity. As early as 2013, she had a diagnosis of neuropathy which compounds the issue on mobility, sensory function of her extremities, especially her affected lower extremity." The facility had information of R4's significant risk factors for developing pressure wounds upon her readmission on 3/27/15 following left hip repair.

On 6/18/15 at 10:50am, E9 (nurse) stated that unless otherwise ordered, skin checks are performed weekly by the aides during showers and entered in the resident's electronic record. E9 looked through R4's electronic record and found one for 4/4/15 and the next one dated 4/18/15, 1 day after the left heel pressure ulcer was identified. E9 looked twice and stated there were no skin checks in between.

On 6/17/15 at 5:00PM E2 provided the skin integrity care plan in place at the time of R4's readmission from the hip surgery on 3/27/15. The interventions listed do not address the specific risk factors as presented by E2 upon R4's

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readmission to the facility on 3/27/15. The intervention to "Off load heels at all times" is dated 4/17/15, the day the facility identified the wound.

On 6/19/15 at 11:30am E3 (assistant director of nursing) gathered house stock supplies of saline, Betadine and a stack of 4 x 4 gauze pads. E3 did not wash hands prior to handling these items which were taken from the treatment cart into R4's room. E3 instructed E9 to obtain something to set the items on. E9 left the room and wheeled in a bedside table. The items were set on the table without a clean field. E3 removed R4's foam bootie and sock while in the wheelchair, E9 then elevated R4's left leg above the hip to provide access to the heel for treatment. R4 stated to not lift it any higher as it was uncomfortable. E3 stated she (E3) was aware R4 had a surgical repair to the left hip following a fall in facility on 3/24/15.

The appearance of the wound was black eschar. E3 measured the wound at 1.8 x 2.3cm. After spraying the area with normal saline, E3 used a gauze pad to dry by cupping her hand and placing the heel in it. R4 grimaced and stated it hurt. Then E3 swabbed the area with Betadine. When finished, E3 said R4 should put a clean sock. After requesting staff to find one, E3 again placed R4's heel in the palm of her hand while waiting. R4 called out that it was painful, questioning how she got the wound in the first place and when would it not hurt anymore. E3 then instructed E9 to administer pain medication to R4. E3 stated she had not medicated R4 for pain prior to the wound treatment.

2). R3's Wound Care Notes dated 6/10/2015 show she has a stage 4 left heel pressure sore.

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S9999	Continued From page 12 R3 was admitted on 6/9/2014. On 6/16/2015 at 3:00 PM, R3 was laying on a low bed with both heels flat on the bed. No offloading was done for both feet. E27(Certified Nursing Assistant, CNA) said R3 has a left heel wound " I think her feet should be on pillows." E27(CNA) did not offload R3's feet. On 6/17/2015 at 9:14 AM, E32(CNA) and E35(CNA)transferred R3 from the chair to the bed. No offloading of her heels was done when they transferred R3 to the bed. On 6/17/2015 at 9:20 AM, E14(Wound Care Nurse) entered R3's room and said R3's heels should be offloaded on a pillow. E14 then did the treatment to R3's stage 4 left heel wound. The wound was small. Wound Care Notes dated 610/2015 describe the wound as .50 cm in length by .40 cm in width. On 6/17/2015 at 9:30 AM, E14 said R3's heels should be offloaded to promote healing. On 6/17/2015 at 11:59 AM, Z3(Wound Physician) said R3's heels should be offloaded while in bed to promote healing. Z3(Wound Physician) said R3 acquired the pressure sore when R3 went out to the hospital. R3's Care Plan for /skin breakdown dated 2/4/2015 states, " encourage and assist resident to offload heels on pillows when in bed." The Facility's Pressure Ulcer Treatment Guidelines Procedure (undated) states, " Treatment Guidelines for Stage 111-IV Pressure Ulcers Utilize pressure relief devices for the bed and chair." (B)	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003503	A. BUILDING: _____ B. WING _____	06/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF GENEVA	1101 EAST STATE STREET GENEVA, IL 60134

(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