STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016729	A. BUILDING: _____ B. WING _____	C 12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY GARDENS NSG & REHAB	212 AIRPORT ROAD NORTH AURORA, IL 60542

(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	Final Observations Statement of Licensure Violation: 300.610a) 300.610c)4 300.1210a) 300.1210b)3 300.1210d)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. c) The written policies shall include, at a minimum the following provisions: 4) A policy to identify, assess, and develop strategies to control risk of injury to residents Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. 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: 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. These requirements are not met as evidenced by: Based on interview and record review the facility failed to supervise residents at high risk for falls, identify individulaized risks related to falls and implement interventions to reduce the risk and prevent avoidable injuries.	S9999		

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S9999	Continued From page 2 This applies to 2 (R1 and R2) of 3 residents reviewed for accidents, supervision and injuries. This failure resulted in R1 sustaining two falls with significant injuries requiring hospitalization, sutures to the scalp and surgical repair of the left hip. The findings include: R1 was admitted to the facility on 8/31/15 with a left humeral fracture from a fall. R1 also has a medical history of history of falling, pain, type 2 diabetes, hypertension,dementia without behavioral disturbance. R1's initial care plan dated 8/31/15 documents problems of ADL(activities of daily living) deficit related to the fractured arm. Fall risk was initiated on 9/4/15. The interventions were not individualized to R1's needs and the there were no identified risk factors. The interventions included, to put the call light in reach and observe the ability to use. R1 has dementia with a BIMS(brief interview for mental status) score of 3 of 15 showing her to be significantly cognitively impaired. The care plan also documents to review past information of falls and to determine root cause if possible. This is not evident in the interventions in the care plan. R1 was on antipsychotic medication, had dementia, and a UTI(urinary tract infection) and episodes of hypoglycemia. None of these were identified in R1's care plan for risk factors for falls. R1 sustained two falls in September 2015: 9/7/15 and 9/24/15. No injuries with these falls. On 9/7/15 chair and bed alarms were initiated as well as floor mats. No new interventions were added on 9/24/15. R1 sustained two falls with injury in	S9999		

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S9999	Continued From page 3 October 2015. On 10/3/15 a CNA (Certified Nursing Assistant) took R1 to the bathroom, closed the door and told R1 to pull call light when done and left the room. CNA later returned and found R1 next to the bed on the floor bleeding from her head. R1 was transferred to the local hospital and received sutures to her head wound. On 11/25/15 at 1:15 PM, E2(DON, Director of Nursing) stated the CNA was new to the facility and should have been with her orientation partner at the time. E2 stated it was not appropriate action to leave R1 in the bathroom alone. On 10/13/15 R1 was documented to be in the dining room finishing breakfast while the staff nurse was passing medications and heard R1's chair alarm go off and R1 was on the floor. R1 sustained a fractured left femur and was sent to the local hospital for surgical repair and returned 10/17/15 to the facility. The only care plan update done at that time was staff inserviced to not leave resident alone in the bathroom. There were no new additional interventions added to R1's plan of care. On 11/3/15 Z1 (Physician) documented in the physician notes that R1 had multiple falls, hit her head and since that time has mentally declined. R1 was noted to be on an antipsychotic medication, Risperdal, started 9/21/15 at 0.75 mg at bedtime for dementia. On 10/9/15 the medication was decreased to 0.5 mg at 6:00 PM. R1's targeted behaviors for October 2015 were documented as depressed and restless. The facility also documents monitoring for side effects	S9999		

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S9999	Continued From page 4	S9999		

related to antipsychotics such as tremors and tardive dyskinesia (uncontrolled movements of lips and tongue) all month and is documented as none.

The nursing notes dated 10/29/15 at 10:37 AM, documents R1 had drowsiness with slurred speech. At 10:38 AM, the nursing notes document R1 had intermittent tremors and protruding tongue. There is no documentation to show the physician was notified. There are multiple nursing notes from different nurses stating R1 was sleepy, lethargic or drowsy yet the risperdal was only held for 4 days in the month of October until R1's POA(Power of Attorney) requested it be discontinued due to increased confusion.

On 10/9/15 the nursing notes triggered an automatic medication warning for Tramadol (pain medication), Risperdal (antipsychotic) and Donepezil (Alzheimer's-dementia medication) stating they may precipitate unexpected central nervous system toxicity including, tremors, gait instability and protruding tongue.

R1's care plan under behavior problem and anxiety documents observe , document and report any adverse reactions such as unsteady gait, tardive dyskinesia(involuntary movements of lips or tongue), frequent falls, loss of appetite, weight loss or behavior symptoms not usual to the resident. These symptoms were documented but not reported.

The undated facility fall policy documents the staff and physician will identify pertinent interventions to try and prevent subsequent falls and to address risks of serious consequences of falling. If underlying causes cannot be identified, staff will

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S9999	Continued From page 5	S9999		

try various interventions, based on the assessment and the nature of the fall until falling stops or reduces. This was not evident in the care plan for R1 or R2.

2. R2 has a medical history of pneumonia, delirium and dehydration. R2 has a BIMS of 0/15 showing R2 is not cognitively intact. R2's MDS(Minimum Data Set) dated 9/17/15 shows R2 to need extensive assist from one person when ambulating and one person assist with transfers.

R2 sustained two falls while in the facility one on 9/21/15 and one on 10/13/15. Both without significant injury.

R2's care plan related to falls initiated on 4/13/15 and a target date of 12/27/15, documents multiple falls in April 2015 and one of the falls in October, 10/13/15. The interventions are not individualized to R2's needs as well as individualized risk factors for R2. All the intervention listed are dated 4/13/15 and one for 7/10/15 and 8/24/15. No new interventions were identified for the October 2015 falls and the plan of care was not updated.

R2's care plan documents one of the interventions to be a bed and wheel chair alarm. The nursing notes dated 10/13/15 12:53 PM, documents R2 was heard yelling" help" from her room. Found on floor with her wheel chair on top of her. The chair pad alarm was on her chair and on but did not sound an alarm.
11/10/15 03:47 AM, R2 ambulated to nurses station crying and had a bowel movement all over her and the room, bed alarm did not sound.
11/18/15 at 7;21 PM, R2 noted to be self transferring to the bed x 1 and ambulating

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S9999	Continued From page 6	S9999		

unassisted in the hall x 1 both times alarms were not activated.

On 12/3/15 at 11:00 AM, E2 stated she was not aware of R2's alarms not working. E2 (DON) stated she does 24 hour checks on nursing notes but does not recall those multiple situations of alarms not working or not being activated.

R2's care plan intervention under falls also documents to not leave R2 alone in her room in the wheelchair. dated 7/10/15. On 11/25/15 at 2:00 PM R2 was in her room in the wheelchair watching television. E3 (CNA) then came in and asked if she wanted to lay down. The call light was attached to the wheel chair although E3 stated she was mentally unable to use it.

On 11/25/15 at 2:15 PM E3 stated they try to toilet R2 after meals and keep her busy with activities to prevent falls. E3 stated it was all of the CNA's and staff nurses responsibility to check and ensure the wheel chair and bed alarms are working. There is no specific protocol or policy to check the alarms.

(A)

IMPOSED PLAN OF CORRECTION
ASBURY GARDENS NURSING AND REHABILITATION CENTER
DATE OF SURVEY: 12/3/15
TYPE OF SURVEY: Complaint #1576483/IL81766

300.610a)
300.610c)4
300.1210a)
300.1210b)3
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.
c) The written policies shall include, at a minimum the following provisions:
4) A policy to identify, assess, and develop strategies to control risk of injury to residents.

Section 300.1210 General Requirements for Nursing and Personal Care

a) *Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.* (Section 3-202.2a of the Act)

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.

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:

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*

This will be accomplished by:

I. A Committee consisting of, at a minimum, the Medical Director, Administrator, and Director of Nursing (DON) will review and revise the policies and procedures regarding accident hazards/assistance devices/adequate nursing supervision/measurable timelines and goals to the residents' plan of care. Additionally, monitoring of side effects to antipsychotic medications. This review will ensure that the facility's policies and procedures address, at a minimum, the following:

A. Recognition of situations that could lead to resident injury and/or death.
B. Appropriate reporting procedures for staff.
C. Appropriate and thorough investigations and follow-ups of accident hazards, inadequate assistance devices and supervision.
D. The facility's responsibilities to prevent further potential accidents.
E. Measurable timelines that are individualized to residents' plan of care.
F. Monitoring of potential side effects to antipsychotic medications.
G. The facility taking appropriate corrective action when an alleged violation is verified.

II. The facility will conduct MANDATORY in-services for all staff within 30 days that addresses, at a minimum, the following:

A. Any new or revised policies and procedures, including actions needed to follow them that are developed as a result of this Plan of Correction.
B. All staff will be informed of their specific responsibilities and accountability for the care provided to residents.
C. Documentation of these In-Services will include the names of those attending, topics covered, location, day, and time. This documentation will be maintained in the Administrator's office.

III. The following actions will be taken to prevent re-occurrence.

A. The above In-Service Education will be reviewed with all staff on a regular basis.
B. Supervisory staff will ensure that the State Regulations regarding environmental hazards (reporting and follow-up) are followed.
C. Supervisory staff will ensure that staffs are informed of the level of care required for each resident to whom they are assigned.
D. Supervisory staff will ensure there is a sufficient quantity of resident care equipment of satisfactory design and in good condition to carry out established resident care procedures.

IV. A Committee consisting of, at a minimum, the Medical Director, Administrator, and Director of Nursing (DON) will review and revise the policies and procedures regarding abuse, and neglect. This review will ensure that the facility's policies and procedures address, at a minimum, the following:

A. Monitor items 1 through 3 to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Ten (10) days from receipt of the Imposed Plan of Correction.