STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009864	A. BUILDING: _____ B. WING _____	12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY VILLAGE	1200 EAST GRANT STREET MACOMB, IL 61455

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S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300/1220b)3 300.3240a) 300.3240d) 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 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	S9999		

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the active participation of the resident and the resident's guardian or representative, as applicable
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.

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. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.
d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act)

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S9999	Continued From page 2 These requirements are not met as evidenced by: 1. Based on interview, observation and record review the facility failed to implement new fall interventions after each fall and failed to follow a fall prevention care plan for one of seven residents (R1) reviewed for falls in the sample of fifteen resulting in R1 falling and sustaining a hairline fracture of R1's nose, and requiring sutures to R1's forehead. The facility failed to investigate, analyze and educate staff for two incidents involving resident injury for R18 and R19 in the supplemental sample Findings include: R1's Incident Report dated 1/17/14 documents R1 fell at the facility while using an enclosed walker on 1/17/14. This same report documents no new intervention was implemented and instructed facility staff, "Continue to monitor." R1's Incident Report dated 1/26/14 documents R1 fell at the facility while using an enclosed walker on 1/26/14. This same report documents the intervention, "Staff reminded to keep (R1) in direct supervision at all times," was implemented. R1's Incident Report dated 3/13/14 documents R1 fell while using an enclosed walker at the facility on 3/13/14. This same report documents no new intervention was implemented and the intervention, "Remind staff (R1) needs constant supervision while in (enclosed walker)," was continued. R1's Care Plan dated 4/14/14 documents the following interventions: "Continue to monitor...remind staff that (R1) needs supervision	S9999		

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at all times while in the (enclosed walker)...remind staff to keep (R1) in direct supervision at all times when (R1) is in (enclosed walker).

R1's Incident Report dated 5/6/14 documents R1 fell at the facility on 5/6/14. This same report documents, "Heard cluttering sound down hallway. (R1) had tipped over (enclosed walker). Lying on side. Has a half inch size gash on right side of forehead. Has a quarter inch horseshoe shaped gash on nose. Forehead and nose both bleeding...took resident to (local emergency department) to be evaluated."

R1's Emergency Room record dated 5/6/14 documents R1 had a three centimeter laceration to R1's forehead, and R1 received four sutures to repair the laceration. This same record documents R1 received a Computerized Tomography scan of the head, diagnosing a bilateral nasal fracture.

On 12/04/14 at 10:05 a.m., E2, Director of Nursing, verified that R1's fall with injury on 5/6/14 was unwitnessed.

On 12/4/14 at 11:00 a.m., E1, Administrator, stated that E1 expects a new intervention to be implemented after a resident falls to prevent further falls. E1 also verified no new interventions were implemented after R1's falls on 1/17/14 and 3/13/14. E1 then stated that E1 expects facility staff to follow R1's care plan, and verified the interventions on R1's fall prevention care plan dated 4/14/14 were not followed on 5/06/14.

R19's incident report dated 12/15/13 documents unidentified CNA (Certified Nursing Assistant) asked "the nurse to check (R19) because another CNA, E12 "just made incident to (R19)

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while being positioned." When the unidentified nurse went to check R19, E12 explained that R19 hit R19's head with R19's right siderail when E12 was performing morning cares." The same form documents under section titled Description of action taken: "...checked the head area. noted right forehead is red and hematoma, also observed facial grimaces of pain while doing assessment." The same form documents under signatures: E1 Administrator notified 3/17/14 and E2 DON (Director of Nursing) notified 12/17/13.

E12's CNA personnel file reviewed and did not contain education following the incident on 12/15/13.

R18's incident form dated 1/22/14 documents R18 complained of discomfort and tells nurse R18's face "is hit by the lifting machine while...helped R18 transfer from the wheelchair to the recliner." The same form documents under Description of Action Taken: "noted redness on R18's left face. Applied ice pack on R18's left face." The same form documents the incident was witnessed by E9 (SSD/Social Service Director).

On 12/3/14 at 2:15 p.m. E9 (SSD) stated during the incident on 1/22/14 the lifting machine did not hit R18. E9 verified E9 did not fill out a witness statement.

On 12/3/14 E1 Administrator provided E11's CNA (Certified Nursing Assistant) personnel file which did not contain education following the incident on 1/22/14. E1 identified E11 as the CNA involved in the incident dated 1/22/14.

On 12/3/14 at 2:15 p.m. E1 stated "I did not see concern for the incidents on 12/15/13 and

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S9999	Continued From page 5 1/22/14. E1 stated "I know the staff and in life, things happen." E1 verified additional inservices were not held after the incidents on 12/15/13 and 1/22/14. (B)	S9999		