STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014377	A. BUILDING _____ B. WING _____	C 09/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN BARR LINCOLNSHIRE	150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069

(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
S 000	Initial Comments Facility Reported Investigation of August 26, 2018/ IL105487	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. 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	S9999		

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S9999	Continued From page 2 neglect a resident. These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to safely turn a resident in bed. This failure resulted in resident rolling out of bed and sustaining a laceration requiring six staples to left lower extremity. This applies to 1 of 3 residents (R1) reviewed for falls in the sample of 5. The findings include: R1's Physician Order Sheet (POS) dated September 2018, shows R1 has diagnoses of Acute Embolism of Lower Extremity and Atrial Fibrillation. R1's Minimum Data Set Assessment dated August 19, 2018 shows R1 needs extensive assist of 2 or more staff for bed mobility. R1's facility incident report dated August 26, 2018 shows "[R1] was assisted to turn, Certified Nursing Assistant-(CNA) wasn't able to hold her weight which caused her to slip out of bed. Laceration to the left lower extremity...resident sent to the hospital." R1's progress notes dated August 26, 2018 at 9:50 PM shows" per CNA, he was providing care to resident, while resident was turn on her side, resident slid out of the bed. Per resident, she hit her knee, sustained lacerations. Pressure dressing applied to laceration to control bleeding. Resident was sent out to Emergency Room for evaluation."	S9999		

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S9999	Continued From page 3	S9999		

R1's Emergency visit summary dated August 26, 2018 shows "[R1] was evaluated after a fall, 6 staples applied to laceration to left knee. R1's home care instruction shows, for [R1] sutures and staples, to keep clean and dry."

On September 5, 2018 at 9:18 AM, R1 was lying in bed. R1 said more than a week ago, she fell out of bed and had to be sent to the emergency room. R1 said the CNA came to her room to change her after having a bowel movement. R1 said she told the CNA that he needed another staff to help him turn R1. R1 said the CNA told her he was able to assist her by himself. R1 stated, "He pushed me to turn towards the window, my left leg moved forward and caused me to roll out of bed." R1 said if there were 2 staff, one on each of side of her, she would have not fallen. R1 stated "I tried to tell him that he needed another staff but he didn't listen." R1 said she was sent to the hospital and had staples to her left knee.

On September 5, 2018 at 10:30 AM, V3 (CNA) said he was assigned to R1 on August 26, 2018 at the time of the incident. V3 said he went to R1's room to answer R1's call light. R1 had a bowel movement. V3 said he asked R1 to turn to her right side to clean her up. V3 said as he rolled R1 towards the window, he asked R1 to lift her left leg so V3 can clean between R1's legs but R1 rolled out of bed. V3 said he tried to hold on to R1 but was not able to due to R1's weight. V3 said the weight of R1's unsupported left leg caused R1's entire body to roll out of the bed. R1's left knee hit the night stand as she was falling and immediately begun bleeding. V3 said he informed the nurse that R1 was on the floor bleeding. R1 was sent to the hospital. V3 said

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S9999	Continued From page 4	S9999		

he knew R1 was a 2 person assist when turning in bed, but the other staff were busy. V3 said he thought he was able to do it himself.

On September 5, 2018 at 1:45 PM, V4 (Registered Nurse-RN) said she was the nurse working on the day R1 fell. V4 said she was informed by V3 that R1 slid off the bed and ended on the floor. V4 said R1 sustained a laceration to her left knee. V4 said R1 was sent to the local hospital.

On September 5, 2018 at 10:00 AM, V5 (RN) said R1 needs an assist of 2 staff when rolling R1 side to side in bed.

On September 5, 2018 at 11:32 AM, V2 (Director Of Nursing) said R1 is a 2 person assist when being provided care in bed. V2 stated "R1 definitely needs 2 assist to be safely turned side to side in bed."

R1's care plan dated June 19, 2018 shows R1 is at high risk for falls related to impaired mobility. R1's care plan interventions include: bed mobility- requires 2 staff assist to reposition and turn in bed. Assist safely in bed to prevent sliding out of bed.

The facility policy entitled Fall Occurrence shows, It is the policy of the facility to ensure residents are assessed and interventions are put in place to prevent them from falling.

(B)