STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000228	A. BUILDING: _____ B. WING _____	C 06/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF ARLINGTON HEIGHTS	715 WEST CENTRAL ROAD ARLINGTON HTS, IL 60005

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S9999	Final Observations Statment of Licensure Violations: 300.1210a) 300.1210b) 300.1210c) 300.1210d)6 300.1220b)3 300.3240a) 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 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.	S9999		

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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 neglect a resident

Based upon observation, interview and record review, the facility failed to implement fall precautions intervention, to follow care plan intervention for falls for monitoring a resident, to provide staff training related to the facility's fall prevention program, to revised or review care

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plans after each resident's fall incident.
This failures affected two of three residents (R1, R2) reviewed for falls in the sample of three.
As a result R1 had a fall and sustained a nose fracture and cerebral bleed. Subsequently R1 had a functional decline and significant decline in activity participation.

Findings include:

1. Per face sheet, R1 was admitted to the facility on 11/25/07 with diagnosis of dementia, depressive disorder, hypertension and osteoporosis. R1 was discharged to the hospital on 6/1/15 and was re-admitted on 6/5/15.
R1's incident report of 6/01/15 documents in part that R1 was observed lying on the floor, in hall way, face down, with copious bleeding from open are on the bridge of the nose on 6/1/15, at 5:30PM. The type of incident was documented as, " Fall resulting in serious injury. " R1 was sent to the hospital via 911 paramedics.
Hospital emergency records, dated 6/4/15 documents R1's diagnoses, after the incident as: SAH (subarachnoid hemorrhage), nasal fracture and nasal laceration.
CAA (care are worksheet) dated 1/5/15 documents in part: R1 is at risk for falls due to multiple factors that include advanced dementia, inability to verbalize her needs, unaware of safety needs, inability to ambulate, requiring assistance with ADLs (activities of daily living), incontinence of bowel and bladder, meds and visual impairment.
R1' s fall care plan with a target date of 7/23/15 documents intervention in part: " Staff to keep visual contact on patient at all times; If staff has to leave area, ensure that another staff member is alerted and move patient to a safe area where monitoring can be effective; monitor closely as

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patient self-propel and prompt patient to remain seated in wheelchair when attempting to stand. " There is no evidence that the care plan was revised or reviewed upon return to address the recent fall incident on 6/1/15.
On 6/9/15, at 12:42PM, E3 (C.N.A. /nursing assistant) who took care of R1 on the day of incident on 6/1/15 was interviewed. E3 stated that he left R1 outside her room, in front of the nursing station, and E3 proceeded to assist another resident. E3 stated that there was no one at the nursing station at that time and E3 did not alert anyone before leaving R1 alone, unsupervised. When asked if E3 knew if R1 was at risk for falls, E3 stated, " I didn ' t know, but because (R1) had a low bed, I know something was up. " E3 also stated that he started to work at the facility in the past three months, and he did not receive any form of training pertaining to fall prevention at the facility. When asked if E3 knew the residents who are at risk for falls, E3 stated, " No one told me. " E3 also stated that E3 stared to work at the facility three months ago, but did not receive any training related to fall prevention.
On 6/9/15, at 12:50PM, E4 (C.N.A.) who worked with E3 was interviewed, E4 stated that before the incident, R1 was bending forward and appeared " like (R1) was catching something in the air. " E4 stated that she saw an empty wheelchair, with a gown on the floor, when she was at the end of the hallway, so she went and checked and that was when she found R1 on the floor. There was no staff at the nursing station at that time of the incident.
On 6/9/15, at 2:13PM, Z1 (attending physician) was interviewed via telephone. Z1 stated that R1 is " pretty out of it " secondary to her diagnosis of dementia. Z1 stated that R1 " definitely needs supervision to prevent falls. " Z1 also said that R1 has poor safety awareness, moves and

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stands on her own while sitting on a wheelchair. " Z1 added, " (R1) needs to be where you can see her. " Z1 also said, " I don ' t know what happened on that day. " When asked about the diagnosis at the hospital, Z1 confirmed the information obtained through record review of the hospital records and Z1 also said that the family made a realistic decision to place her on Hospice care because R1 may not tolerate surgery.
On 6/9/15, at 3:30PM, E9 (activity director) stated that R1 had significant decline with her activity participation since return from the hospital. E9 stated that since re-admission on 6/5/15, R1 was bedridden and the activity staff provides one-to-one visits due to R1 ' s current bedridden status. E9 presented documents titled " daily activity/recreation participation " of R1. The documents, dated 3/2015, 4/2015 and 5/2015, denote that R1 actively participated in the following activity programs which included exercise/physical activity, pet visits, sensory stimulation, and spiritual/religious events and enjoyed family visits. MDS (minimum data set) dated 4/2/15, section F documents that activities (related to music, animals/pets, group sessions, visits, religious and going out of the facility for fresh air) were very important to her. Per observation on 6/8/15, at 2:30PM, R1 was on bed, sleeping.
On 6/9/15, at 3:36PM, E8 (nurse manager) stated that R1 " is now on bedrest. " E8 said that there is an obvious significant decline of R1 before the incident and when R1 was re-admitted on 6/5/15. E8 said that R1 used to be alert and gets up on a wheelchair. E8 ' s statement was confirmed with review of R1's admission screening which documents in part that R1 is dependent with all her ADLs (activities of daily living). R1's MDS, section G, dated 4/2/15 documents that R1 needed staff assistance, mostly one-person

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S9999	Continued From page 5 assist with her ADLs prior to the fall incident that resulted to the injuries. 2. R2's per care plan dated 6/4/15, R2 is a " fall risk " . An incident report of 6/6/15 documents, R2 had a fall incident on 6/6/15. There was no care plan revision to address agitation and the fall incident on 6/6/15. On 6/9/15, at 10:54AM, E6 (charge nurse) stated that R2 used to have a care giver, but it was already discontinued. E6 stated that R2 was agitated again yesterday. There was no care plan created to address R2 ' s agitation. On 6/9/15, at 11:07, R2 was noted on bed, with pillows on the right side while sleeping, and the side of the bed was blocked with bed side table, night stand, and wheelchair. The observation was confirmed by E6 C.N.A. (nursing assistant) and E5 (nurse supervisor). E6 stated that she does not want R2 to fall, that's why the items were on the bedside. B	S9999		