

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014518	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 03/01/2018
NAME OF PROVIDER OR SUPPLIER MEADOWBROOK MANOR - NAPERVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 720 RAYMOND DRIVE NAPERVILLE, IL 60563		
(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 Report Investigation of 2/21/18/IL100599 - no deficiency Complaint Investigation Survey # 1871298/IL100628 - F 689 and F580	S 000			
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)6) 300.1220b)3) 300.3240a 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. Restorative measures shall include, at a minimum, the following procedures: 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:	S9999			
	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				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	Continued From page 1 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. These requirements were not met as evidenced by: Based on record review and interview the facility failed to ensure proper transfer technique for a resident who is totally dependent for transfer and requiring assistance of two staff. This incident resulted in the resident sustaining laceration to the right leg which required thirteen staples. This applies to 1 of 3 residents (R4) reviewed for incident with injuries in the sample of 13	S9999			

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S9999	Continued From page 2 residents. The findings include: R4 is an 80 year old who has multiple medical diagnoses which include vertigo. R4's Minimum Data Set (MDS) dated 1/8/18 showed R4 is totally dependent for transfer with two staff assistance requiring use of mechanical lift. Incident report and progress notes dated 1/27/18 showed: R4 was being assisted by V11(CNA-Certified Nurse Aide) to bed, as R4 was approaching the bed R4's knees buckled causing R4's right lateral leg to hit the side rail/frame of the bed. The incident resulted to a laceration in the right lateral leg which measured as Length (L) 8.0 centimeter (cm) x Width (W) 2.0 cm x Depth (D) 0.5 cm. R4 was sent to the hospital for further evaluation and returned from the hospital with 13 staples in the right lateral leg. On 2/28/18 at 10:17 AM, V11 (Certified Nursing Assistant/CNA) gave the following statement: R1 was sitting in her wheelchair when she requested to go back to bed. V11 assisted R4 to get up and as R4 was getting up, R4 leaned forward, then swayed unsteadily to her right side. R4's knees buckled which resulted to R4's right leg hitting the bottom of the side rail of the bed which cut her skin. V11 checked R4's care card prior to assisting R4's transfer. There were two instructions in the care card; one with use of a mechanical lift. The other instruction was one staff assistance with one staff on standby, with the former crossed with a pen. V11 assumed that since the one with mechanical lift was penned across, she used the one staff assistance with a standby. There was another CNA staff on standby at the time of the incident.	S9999			

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S9999	Continued From page 3 On 2/28/18 at 1:07 PM V13 (Nurse Practitioner/Health Provider) gave the following statement: R4 has a diagnosis of vertigo. If there is an order or policy for R4 that staff should use mechanical lift during transfer then staff should have followed order. Incident could have been prevented if the staff used mechanical lift for transfer. R4 would not have been caught in the bed frame and would have been transferred safely on top of the bed. On 2/28/18 at 1:35 PM V15 (Nurse) stated, R4's laceration had a slight bleeding at the time of the incident. There was more fluid secretion related to R4's pitting edema. The wound was open and showed the layers of the skin, tissues and fats. V15 provided the first aid treatment and sent R4 to the hospital for further evaluation. V15 received the report from the hospital the facility that R4 was heading back to the facility with 13 staples to her wound. Facility's Transfer Protocol dated 7/22/15 showed: Policy: It is the policy of the facility to attempt to protect both its residents and employees from injury in the course of transferring residents. Procedure: - The transfer technique that is appropriate for each resident will be listed on the "Special Care Needs Sheet" and posted on the inside door of the resident's wardrobe. - No resident is to be transferred without first verifying the transfer technique assigned to that resident to know what type of transfer is required by that resident on that day.	S9999		

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