STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010912	A. BUILDING: _____ B. WING _____	C 03/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF PALOS HEIGHTS EAST	7850 WEST COLLEGE DRIVE PALOS HEIGHTS, IL 60463

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S 000	Initial Comments Complaint Investigation: 1891474/IL100826 -- F558, F677, F686, and F689 cited	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210a) 300.1210b) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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:

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

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S9999	Continued From page 2 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. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on interviews and record reviews, this facility failed to have an individualized plan of care for monitoring and supervising a cognitive impaired resident at risk for a fall and failed to provide visually or direct supervision for re-directing a resident who had behaviors that put the resident at risk for a fall. This applies to one resident at high risk for falls. This failure resulted in R2 sustaining a femur fracture due to a fall and requiring hospitalization. Findings include: According to R2's medical record, R2 has diagnoses including: Parkinson's disease, high blood pressure, low back pain related to lumbar vertebrae 1 fracture (not surgically repaired), dementia with behavioral disturbances, generalized muscle weakness, anemia, and history of falling. R2's initial MDS (minimum data set) assessment dated 1/13/18 denotes: R2 requires extensive	S9999		

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assistance of 2+ staff members with transferring and toileting. R2's MDS's also note R2 frequently incontinent of bowel and bladder.

R2's falls care plan, initiated 1/6/17 denotes: R2 is at high risk for falls in regards to decreased strength, endurance, balance, history of fall, low back pain, degenerative joint disease, Parkinson's disease, and possible untoward effects related to medications. Initial 1/6/2017 interventions identified include: administer Calcium and Vitamin D per protocol, administer medication per physician's order and bed in low position. 1/14/2017 initiated interventions included: Reinforce wheelchair safety as needed such as locking brakes, have commonly used articles within easy reach, provide assist to transfer and ambulate as needed, reinforce need to call for assistance. 1/20/2017 initiated interventions included: Report development of pain, bruised, change in mental status, ADL (activities of daily living) function, appetite, or neurological status per facility guidelines post fall and evaluate medications if patient demonstrates charges in mental status, ADL function, appetite, neurological status etc.. 2/10/2017 initiated intervention: Fall risk- offer toileting during frequent rounding. 2/20/17 initiated intervention: Family educated to not leave resident alone in room. 2/24/2017 initiated intervention: Send to ER (emergency room),

On 3/6/18 at 1:40pm, V22 (family member) stated that R2 was evaluated by a neuropsychologist that informed V22 that R2 should never be left alone.

A neuro-psychology evaluation dated 2/01/2017 was completed for R2. The evaluation had the following information: Identifying Information and

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Reason for Referral include-R2 is at the facility for physical rehabilitation after a fall at home. R2 nurse reports he is frequently confused and has trouble sleeping making him a safety risk as he often tries to get out of bed on his own. Summary included-Altogether, his profile is characteristic of both Alzheimer's disease and Parkinson's related dementia, exacerbated by depression. In light of R2 's difficulties with memory and executive functioning, his ability to safely function independently is impaired. He will benefit from 24-hour supervision and managing of medication and meals. Recommendations- In light of R2's difficulties with memory and executive functioning, he requires 24 hour supervision and management of meals and medication.

R2's progress notes dated 2/23/17 denotes: R2 is alert and oriented x1. V23 CNA (certified nursing aide) entered room when V23 heard R2 ask for help. R2 was sitting on floor, became agitated when asked what happened. R2 complained of pain in left knee but no visible injury noted, R2 had legs straight out in front of R2 with left leg bent up. R2 put back to bed with mechanical lift. When R2 laid in bed, the left lower leg was rotated internally. R2 was transported to hospital, diagnosis: left femur fracture.

R2's fall initial investigation report, dated 2/23/17, notes V23 CNA exited another resident's room and heard R2 calling out. R2's door was closed. V23 proceeded to R2's room and opened the door, R2 was by the foot of the bed sitting on buttocks. V23 called for assistance and V24 CNA came. V23 had taken R2 out of room 10 minutes prior. V16 LPN (licensed practical nurse) was notified R2 goes into room and closes the door. R2 stated left knee hurt. V16 came to R2's room and performed a head to toe assessment. R2

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was assisted back to bed with a mechanical lift device. V16 notified after R2 in bed that R2's left leg was internally rotated. V24 stated V24 last saw R2 at 7:00pm watching television. There is no documentation of when V16 last saw R2. The timeline of events notes at 8:00pm, R2 was observed in R2's room and V23 brought R2 out of room; at 8:10pm, R2 was observed on floor sitting on buttocks; at 8:30pm, R2's physician and family member were notified; and at 9:30pm, R2 was transported to the hospital for evaluation and treatment. On 2/25/17, the summary of critical information obtained during the investigation notes on the dementia nursing unit R2 wanders around the unit into R2's room and will close the door. R2 is impulsive and has poor awareness of safety.

On 3/9/18 at 2:50pm, V12 CNA stated that she considers all residents on the dementia nursing unit to be at high risk for falls. V12 stated that residents are supervised at all times while in dining room or television area/nurses station. V12 stated that staff rotate throughout the shift supervising residents in the dining room and nurses station. V12 stated that if a resident needs toileting assistance, another staff member is notified to monitor residents while V12 assists that resident.

On 3/13/18 at 3:45pm, V16 LPN (licensed practical nurse) stated that she does not recall R2 or any details related to fall on 2/23/17. V16 stated that for residents that frequently get out of bed or wheelchair and try to ambulate unassisted, she will do frequent rounds or sit outside of resident's room watching resident. V16 stated that residents on the dementia nursing unit are supervised continuously. V16 stated that one staff will be with the residents in the dining room,

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S9999	Continued From page 6 one will be in television area/nurses station with those residents, and one staff will round on residents in their rooms. Residents are not left unattended in the dining room or television area. (B)	S9999		