Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014518	A. BUILDING: _____ B. WING _____	11/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWBROOK MANOR - NAPERVILLE	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 Annual Licensure and Certification Survey VALIDATION SURVEY FOR SUBPART U: ALZHEIMER UNIT The Meadowbrook Manor-Naperville is in substantial compliance with Subpart U: Alzheimer Unit, 77 Illinois Administrative Code, Section 300.7000 for this survey	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.1210b) 300.1210d)6) 300.1220 b)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	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 on interview and record review the facility failed to provide supervision in the Memory Care	S9999		

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dining room for 1 confused resident with a history of falls known to have impulsive behavior. This failure affected 1 resident (R193) out of 7 reviewed for falls out of a sample of 35. This failure resulted in a fall,after R193 was left alone in the dining room, resulting in a fractured right hip.

Findings include:

R193 is an 89 year old female originally admitted to the facility 6/30/17 with numerous diagnoses including Late onset Alzheimer's disease; Dementia with Behavioral disturbance; Major depressive disorder, recurrent; anxiety disorder, hypertension ; atrial fibrillation and history of falls. R193 resides in the locked memory care unit.

Incident report for R193 dated 3/13/18 timed at 6:00 AM documents that R193 was observed in the dining room lying on the floor on her back. She complained of pain to her right hip and limited range of motion was noted. Post Fall Report of the same date documents that R193 sustained a fractured right hip as a result of this fall.

Page 1 of the incident report contains a section which reads, "Initial intervention to prevent recurrence". The handwritten response to this query reads, "place in area with increased staff supervision", Page 1 of the Post fall report indicates the following regarding R193 and her fall: fall was unwitnessed; attempting self-transfer; last observed at 5:50 AM and last toileted at 5:45 AM; when last observed she had been sitting in a chair. R193 was described as impulsive requiring assistance but not asking for assistance. She was described as alert, oriented to person, confused and forgetful. At time of fall,

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S9999	Continued From page 3 post fall report form indicates R193 was "alone/unattended". At 11:45 AM on 10/30/18, V24 (Fall Coordinator) stated that as fall coordinator, part of her role is to monitor the residents who fall and make sure their care plans get updated after a fall. She looks into the circumstances of the fall to try to determine the cause. With regard to the fall for R193 in March, she recalled that the CNA observed R193 trying to get out of bed early in the morning. The CNA toileted R193. Because R193 had a history of falls and also had a history of trying to get up by herself and impulsive behavior, the CNA got R193 up and dressed. The CNA then took R193 to the dining room. The CNA told R193 she would be back. CNA left to get another resident up. A few minutes later, the CNA heard the alarm sounding and went to investigate. She found R193 on the floor in the dining room. She is aware residents are to be supervised in the dining room The night nurse was not in the unit at the time. The night nurse was covering both the memory care unit and the unit outside of the memory care unit, which is the remainder of the third floor. On 10/31/18 at 12:30 PM, V19 (CNA) stated that she recalled the incident back in March with R193. She recalled R193 was trying to get out of bed around 5:30 AM. V19 was doing rounds and heard R193's alarm. She went to check on R193. V19 found V1936 still in bed but trying to get up. V19 got R193 up and toileted. After dressing R193, V19 took her to the dining room. V19 stated that she didn't want to leave R193 alone in her room since she was known to try to get out of bed. V19 placed her in the dining room and continued doing rounds. V19 can't recall who, if anyone, was in the dining room. At that point in	S9999		

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time, on the night shift, the usual staffing was either 1 or 2 CNAs (certified nursing assistants) in the alzheimer's unit and 3 outside of the unit on third floor. That night there had been a call off for the Memory Care Unit leaving V19 as the only CNA. Help would come from the CNAs outside the memory unit if needed. While doing rounds V19 heard R193's alarm and went to check on her in the dining room. She found R193 on the floor next to her wheel chair. At the time, the nurse was outside of the unit, proiding coverage on the rest of the 3rd floor. R193 was awake and talking. V19 went and called the nurse who came to assess R193. R193 couldn't stand and the ambulance was called.

On 10/31/18 at 12:35 PM, V20 (RN), stated that she vaguely recalls the incident back in March with R193. V20 recalled the fall happening at the end of the night shift,. At that time, she was covering both the memory care unit and 3rd floor which is outside the memory care unit. Currently the nursing supervisor helps cover the units, but there was no nursing supervisor that night. V20 stated she was pretty sure she was outside the unit when the CNA came to get her to tell her that R193 fell. She did not witness the fall. She went in to the unit to assess R193. She thinks the resident was sitting on the floor. R193 was awake and talking. she can't recall if they got her up.

On 10/31/18 at 10:25 AM, V26 (scheduler) stated that there was a time when the night nurse assigned to the Memory Care unit would also cover the third floor unit outside the memory care unit. After reviewing the schedule for the night shift for 3/12/18, V20 stated that V25 would have been the CNA who would have helped out on the memory care unit.

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S9999	Continued From page 5 On 10/31/18 at 4:10 PM, V25 (CNA) stated that she didn't recall an incident with a resident falling in the memory care dining room. V25 denied being present or witnessing any resident fall in the Memory care dining room in March. V25 has been assigned in the past to the outside unit and been asked to assist in the memory care unit because of a call in. When a CNA from the Memory Care unit calls in, one of the outside CNAs go in to help out but that person does not remain in the unit; she floats between the 2 units. Sometime the nurse would cover both third floor units. On 11/1/18 at 11:00 AM, V21 (LPN) stated that she recalled the morning that R193 fell, although she did not witness it. V21 stated she worked days that day, and started work at 6:00 AM. When she was just arriving to the unit, she saw the night nurse also outside of the unit. As soon as V21 entered the memory care unit V19 told her that R193 had fallen and was on the floor. V21 stated that both she and the night nurse assessed R193. On 11/1/18 at 10:30 AM V2 (Assistant Administrator) stated that the facility does not have a formal policy on supervision in the dining room, but stated that their practice is to assign staff to the dining room on a rotating basis. There is to be supervision when residents are in the dining room at all times. On 11/1/18 at 12:15 PM, V22 (Nurse Practitioner) for R193 stated she recalled being called when R193 fell. The staff told her that it was obvious she had a fracture, so she ordered R193 to be evaluated at the hospital. V22 stated she believes the facility's policy is to provide supervision in the dining room and thinks that the facility should	S9999		

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S9999	Continued From page 6 follow their policy. On 11/1/18 AT 12:35 V23 (MD for R193) stated that he does follow R193 and saw her about a month ago. He does recall that R193 sustained a fractured hip as a result of her fall. The type of fracture she had is consistent with a fall. R193's fall care plan created on 7/12/17 indicates she is at high risk for falls and indicates that R193 has poor safety awareness. Nursing notes of 3/13/18 timed at 6:00 AM states "Found on floor by CNA in dining (room) in front of w/c (wheel chair). Chair alarm in use. W/C unlocked. Resident was unsupervised at time of fall...". R193's BIMS score (Brief Interview for Mental Status) dated 3/26/18 indicates R193 has a score of 3, reflecting severe cognitive impairment. (A)	S9999		