STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6011589	A. BUILDING: _____ B. WING _____	C 05/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF SOUTH HOLLAND	2145 EAST 170TH STREET SOUTH HOLLAND, IL 60473

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S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a)b) 300.1210d)6 300.3240a) 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 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	S9999		

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S9999	Continued From page 1 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 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident These Requirements are not met as evidenced by: Based on interview and record review facility failed to follow their falls practice guidelines for implementation of fall preventive interventions for one of four residents (R1) reviewed for falls, in a sample of four. This failure resulted in R1 falling out of bed and sustained a fracture of the arm	S9999		

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S9999	Continued From page 2 (distal humerus). Findings Include: R1's care plan created 2-21-14 denotes at risk for falls due to unsteady gait and cognitive impairment. Broad chair for poor trunk control staff to make frequent rounds while in gerichair. R1's fall report dated 3-10-14 R1 rolled out of bed to floor mat and attempted to roll out 11:00 pm, nurse no injuries doctor notified. Added intervention 3-10-14 Offered body pillow to aide in positioning. R1's fall report dated 6-10-14 heard R1 screaming for help and found on knees near mattress 4:30 pm no injuries doctor notified. Added intervention 6-10-14 staff to frequent checks for toileting and positioning in bed. R1's fall report dated 6-20-14 found on floor next to her bed 1 am no injuries doctor notified. Added intervention 6-23-14 have common used items within reach and staff do frequent toileting and positioning when in bed. R1's fall report dated 8-24-14 found on floor next to bed 4:18 am no injuries noted, doctor notified. Added intervention 8-24-14 monitor residents condition in bed. R1's fall report dated 4-26-15 denotes observed R1 lying on the floor beside the bed, bed low bed linen on floor bedside R1. No head to toe body check, no visible injuries doctor notified, X-ray right hip- no fracture. Last toiled by CNA at 10:26 pm. Approximately 1:13 am nurse observed R1 lying on floor next to bed. R1 was soiled at the time.	S9999		

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R1's intervention task sheet denotes last toileted on 4-26-15 at 2:00 pm.

R1's incident report dated 4-29-15 denotes R1 was visited by hospice nurse R1 complained that her right elbow was hurting. Doctor notified and X-ray ordered.

R1's radiology report dated 4-29-15 denotes right elbow lateral view there is an acute or subacute supracondylar fracture of the distal humerus with approximately 2 centimeters of overriding of the fracture fragments. With anterior displacement of the distal fracture fragment. Conclusion: Fracture of the distal humerous.

Z1 (Doctor) stated on 5-13-15 at 12:40 pm that R1's injury (fracture) had to be from the previous fall not a transfer. Z1 stated that her bone had a slight crack after the fall and then subsequent moving of her muscles the fracture became displaced.

E6 (Certified Nurse Aide/ CNA) stated on 5-14-15 at 11:20 was working the night shift (11-7) on 4-25/26-15 on the Medicare unit. E13 stated had started working for a few hours on the Medicare unit and was pulled to watch R1 and some other residents. E13 stated was told to come to R1's unit by the nurse because they were short staff. E13 stated was not assigned to R1 until after she had fallen.

E8 (Registered Nurse) stated on 5-13-15 R1 is confused and disoriented non ambulatory had history of rolling out of her bed and falling on the floor. E5 stated on 4-25/26-15 was working the night shift heard R1 call out and found R1 on her

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S9999	Continued From page 4	S9999		

side on the floor next to her bed. E8 stated got assistance, assessed R1 and they used the mechanical lift to put her back to bed also notified her doctor. E8 stated body pillow was not in place at the time of the fall or floor mat. E8 stated did not see any CNA go in R1' s room before the fall. E8 stated did not check if she was wet when she got to work at 11 PM because that's the duty of the CNA. E8 stated R1 was awake when she got to work and only asked her how she was doing but did not ask her if she needed to use the washroom.

Facility's assignment sheet dated 4-25-15 (11-7) denotes E8 and E6 assigned to R1 for 11-7 shift on 4-25-15.

E7 (Certified Nurse Aide) stated on 5-14-15 at 11:05 am was called to R1's room by the nurse (E8) and saw R1 on the floor next to her bed did not see a floor mat or body pillows. E7 stated nurse did assessment and rolled her onto the sling and they used the mechanical lift to transfer her to the bed. E7 stated did not see any bed bolster or body pillows. E7 stated was told that they could not use the floor mats and could not use the body pillows. E7 stated first time he saw R1 was that night was when she was found on the floor.

E2 (Certified Nurse Aide) stated on 5-13-15 at 11:15 am worked the pm shift 3-11 mainly was told on today (5-13-15) to start using bed body pillows for R1. E2 stated has known R1 had history of rolling out of her bed and falling on the floor. E2 stated they have not been using floor mats or body pillows for her.

E3 (Unit Manager) stated on 5-13-15 at 11:00am the body pillow was put in placed yesterday

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S9999	Continued From page 5 (5-12-15) for R1. E3 stated after each fall the resident is assessed then fall care plan is reviewed and new interventions should be in place or evaluated. E3 stated they do not use floor mats and bed alarms. E11 (Administrator) stated on 5-14-145 at 10:45 am that floor mats are not used unless clinically indicated. E11 stated does not know why the body pillows were not being used even though they were on R1 ' s care plan. E11 stated did not know if R1 needed the floor mats. Facility's falls practice guide denotes the purpose of the fall practice guide is to describe the process steps for identification of patient fall risk factors and interventions and systems that may be used to manage falls. The interdisciplinary team designs the patient' s care plan to focus on all the patient's issues including those associated with fall prevention and fall risk management. Regardless of the interventions that are put in place, key factor to success is the timely review of the interventions as the patient's condition and needs change. Provide nursing staff 24-hour access to supplies and equipment that may be needed for fall management interventions may include, but are not limited to low beds, bedside mats and positioning devices. The patient' s condition response to interventions and subsequent care provided is documented in the patient's clinical record. (B)	S9999		