STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002612	A. BUILDING: _____ B. WING _____	C 05/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DU PAGE CONVALESCENT CENTER	400 N COUNTY FARM RD PO BOX708 WHEATON, IL 60187

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S 000	Initial Comments Complaint Investigation #1672375/IL85216	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. 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:	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

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. (Section 2-107 of the Act)

These requirements were not met evidenced by:

This applies to two (R2 and R3) of three residents reviewed for falls with injuries.
The findings include:
R2 's Admission Face Sheet showed R 2 has a diagnoses including Parkinson's disease, psychosis, dementia, anxiety disorder and glaucoma. R2 's MDS (Minimum Data Set) of February 17, 2016 showed R2 needs extensive assistance of one person during transfers and ambulation. R2 's Fall Assessment on February 11, 2016 showed " High Risk for fall due to Parkinson's, dementia, depression and anxiety " with a score of 18.
The facility's Incident report log and R2 's Nurse 's Notes showed R2 had two incidents of falls

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S9999	Continued From page 2	S9999		

within two months. On April 25, 2016 and May 2, 2016. On May 5, 2016 at 3:10 PM, E3 (Registered Nurse) said on those two occasions, the bed alarm sounded but by the time staff got to the resident's room, the resident was already on the floor. E3 stated on May 2, 2016, he (E3) was in another room when the alarm sounded. As soon as he got to R 2's room and turned on the light switch, R2 's curtain was closed around her bed so he did not see anything but just heard a " thud " sound. E3 said he saw R2 on the floor on her left side and noted a bruise on R2 's left shoulder and complained of pain to the area.

The facility Accident/Incident report dated April 25, 2016 and signed by the CNA and Nurse (Insight Report) showed a recommendation to move R 2 closer to the nurse's station to prevent another fall incident. This recommendation has not been followed.
On March 10, 2016 at 4:08 PM during a phone interview, E5 (Assistant Director of Nursing) said there was no available room closer to the nursing station, that's why this recommendation was not implemented. E5 stated, " We just try to respond as soon as possible. "

R 2's fall care plan was not revised after R 2's fall on April 25, 2016. No specific interventions were implemented to address R2 's fall or to prevent R 2 from sustaining additional falls. On May 10, 2016 during a phone interview, E13 (RN, Care Plan Coordinator) explained and faxed a copy of R 2's care plan dated March 8, 2016 and was not revised until May 2016.

On May 2, 2016 R 2 had another fall and was admitted to the hospital with a diagnosis of fracture to the left Humerus (long bone of the

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arm).
On May 11, 2016 at 9:57 AM during a phone interview, Z1 (R2 ' s Attending Physician) said that R2 has agitation, marked mobility dysfunction and sustained a fracture from a second fall while in the facility. Z1 stated that he agreed with the staff 's recommendation after the first fall, to place R2 closer to the nurse's station. Z1 stated that would have helped prevent the second fall that caused the fracture. Z1 stated, " I will make that recommendation myself to the Director of Nurses. "

R3 's Physician Order Sheet (POS) dated May 2016 showed R3 's diagnoses to include Parkinson's disease, weakness and hypotension and showed an order of transfer assistance due to weakness.
R3 's MDS of April 19, 2016 showed supervision and set-up for transfer and limited assistance of one person during ambulation off the unit, hygiene and bathing. R3's Fall Assessment Risk for February 27, 2016 was high at 10 related to fall history prior to admission, antidepressant use and slight impaired mobility secondary to Parkinson's disease.
On May 06, 2016 at 9:25 AM, E14 (RN) said that R3 needed a standby assistance of one person during shower before the April 25, 2016 fall incident. E15 (CNA) stated R3 needed a one person assistance with showers and limited assistance and supervision with ADLs and transfers.
The facility's Incident Report Log and R3 's Nurse's Notes showed R3 had fall incidents on April 21, 2016, April 25, 2016 and May 4, 2016. R3 was sent out to the hospital after the April 25, 2016 fall with the diagnosis of Left Hip Fracture. R3 ' s nurse's notes showed " On April 25, 2016

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S9999	Continued From page 4 at 7:40 PM, found on floor in shower room semi-sitting position. Stated she bent over to fix her slippers and got off balanced and ended up on the floor close to her wheelchair. Able to move left leg but said it hurts when she steps on it ...sent to ER (Emergency Room) and admitted for left hip fracture. " R3 's last care plan review date was prior to the fall incidents was February 2, 2016. R3's fall care plan showed interventions such as " Bed and chair alarm, transfers one assist, ambulates with assist, staff provides oversight for safety due to short term memory, easily distracted thought process, bathing/grooming/personal hygiene/shower weekly by CNA-assist upper and lower body. " R3 ' s April 21 and April 25, 2016 documentation did not reflect that any of these interventions were done to help prevent the fall. R3 ' s latest fall care plan review date was May 2, 2016. There were no changes made to the fall interventions since the last review date of February 2, 2016 even after the two fall incidents. (B)	S9999		