

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 01/03/2017
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NAME OF PROVIDER OR SUPPLIER MEADOWBROOK MANOR - NAPERVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 720 RAYMOND DRIVE NAPERVILLE, IL 60563
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(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
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S9999	<p>Final Observations</p> <p>STATEMENT OF LICENSURE VIOLATIONS</p> <p>300.610a) 300.1210b) 300.1210d)6) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,</p>	S9999	<p style="text-align: center;">Attachment A Statement of Licensure Violations</p>	
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Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X8) DATE 01/18/17
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NAME OF PROVIDER OR SUPPLIER MEADOWBROOK MANOR - NAPERVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 720 RAYMOND DRIVE NAPERVILLE, IL 60563		
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S9999	<p>Continued From page 1</p> <p>seven-day-a-week basis:</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>THESE REGULATIONS WERE NOT MET AS EVIDENCED BY:</p> <p>Based on interview and record review the facility failed to assess and implement specific safety interventions for showering one resident (R3) with a diagnosis of dementia and high risk for falls. This failure resulted in R3 falling on wet tile and fracturing the left hip requiring surgical intervention.</p> <p>This failure applied to one resident (R3) out of three reviewed for falls.</p> <p>A facility incident accident statement form showed that while R3 was cleaning her private parts E7 was holding the shower head to R3 for rinsing when R3's left foot slipped forward on the wet floor and R3 landed in a seated position on the floor</p> <p>R3 was admitted to the facility December 3, 2016 per the admission face sheet. The physician order sheet dated December 3 through December 31, 2016 showed that R3 had diagnoses of Alzheimer's disease, dementia, hypothyroidism, kyphosis of the back and anxiety. The facility summary log for falls for the Month of</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>December showed that R3 fell on December 22, 2016. The log showed that R3 went to the hospital for treatment and was hospitalized. The log showed that R3 had a fracture and had risk factors of behaviors and safety. Nursing admission assessment showed that R3 was restless and agitated. The assessment showed that R3 wore glasses and was ambulatory with or without assistance. The admission assessment did not address showering R3.</p> <p>A history and physical dated December 8, 2016 by R3's physician showed that R3 used a walker for ambulation and had no prior falls. Under review of systems the physician documented that R3 had confusion, poor safety awareness and gait disturbance. The review of psychiatric system showed that R3 was not oriented to time, place, person or situation and had poor judgment and insight.</p> <p>Care plans initiated December 13, 2016 showed that R3 was at risk for falls due to confusion, gait balance, impaired judgment, poor safety awareness, wandering and psychotropic use. The care plan showed that R3 required extensive one person assist to dress, a safe environment with even floors free from spills and or clutter and hand rails on walls. The care plan also showed that the staff was to ensure that R3 was wearing non skid shoes or socks when ambulating or mobilizing in wheelchair. The care plan did not have an assessment for showering under fall prevention.</p> <p>The fall risk assessment dated December 3, 2016 showed that R3 required the assistance of a device such as a cane, walker wheelchair or furniture. The assessment showed that R3 had taken psychotropic's during the last seven days. An assessment dated December 3, 2016 showed that R3 had an alteration in safety awareness due</p>	S9999		

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NAME OF PROVIDER OR SUPPLIER MEADOWBROOK MANOR - NAPERVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 720 RAYMOND DRIVE NAPERVILLE, IL 60583		
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S9999	Continued From page 3 to cognitive decline and that R3 was using the side rail in bed for support. A physician order dated December 5, 2016 showed that R3's physician ordered physical therapy and occupational therapy for four weeks to activities of daily living training, functional transfer training, Bilateral upper extremity strengthening, safety, endurance, gait training and to use back brace as needed. An Occupational therapy note dated December 21, 2016 showed that R3 needed contact guard assist during bathing due to resident unsteadiness especially for the lower body. An incident report dated December 22, 2016 showed that 10:00 am R3 was found in the shower room sitting on the floor with E7 CNA (certified nursing assistant) supporting the upper torso. The report showed that R3 stood up from the shower chair to wash private parts and that E7 held onto the shower chair and held shower head to R3 to rinse. The note showed that R3 slipped on the wet floor and landed on the buttocks. The note showed that the physician and Power of attorney were notified. The note showed the facility called 911 and R3 was sent to the hospital at 11:00 am per ambulance. The note showed that R3 was admitted to the community hospital with a left hip fracture. A nursing note dated December 22, 2016 showed that R3 got off the shower chair while E7 was holding the shower chair when the resident slid and fell. On December 28, 2016 at 3:50 PM in the conference room E4 LPN (Licensed Practical Nurse) Restorative Nurse said that a rolling walker should have been used in the shower for R3. E4 stated, "R3 should have used the hand bars while showering." E4 said that this should be reflected on the care plan. E4 said that all new admissions are assessed for fall risk.	S9999		

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S9999	<p>Continued From page 4</p> <p>On December 28, 2016 at 4:08 PM in the conference room E5 Physical Therapist said that for lower body care R3 needed to be sitting or staff needed to have contact assist. E5 said that R3's goals were not met with physical therapy and that she still required supervision and standing assist. E5 stated, "I think hand bars would have helped steady R3 for her task. If we know a resident is having trouble we would recommend staying in the chair if the balance is less than fair, or to use a grab bar or walker."</p> <p>On January 3, 2017 at 10:15 am E6 LPN said via telephone that R3 was found on the shower room floor in the sitting position with E7 CNA supporting R3's trunk. E6 could not recall if there was a rubber mat on the floor but did recall "Lots of towels and bath blankets on the wet tile floor." E6 could not recall if the shower chair was locked. E6 said that there were hand bars in the shower room.</p> <p>On January 3, 2017 at 10:44 am in the conference room E7 CNA said that R3 got up from the shower chair and started to wash her private parts. E7 said that she was holding the shower head to rinse R3's back side when all of a sudden R3's left foot slid forward and R3 fell to the floor in the sitting position.</p> <p>(A)</p>	S9999		

IMPOSED PLAN OF CORRECTION

NAME OF FACILITY: Meadowbrook Manor-Naperville

DATE AND TYPE OF SURVEY: 01/03/2017, Complaint

Investigation: 1677354/IL90630

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

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. (Section 2-107 of the Act)*

Attachment B
Imposed Plan of Correction

THIS WILL BE ACCOMPLISHED BY:

The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. 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 by conducting the following:

1. Conducting in-services on preventative interventions to prevent resident falls.
2. Review and revise policies emergency response policies
3. Documentation of in-service training and preventative maintenance records will be maintained by the facility.
4. The Administrator and Director of Nurses will monitor Items I through IV to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Seven (10) days from receipt of the Imposed Plan of Correction.

[REDACTED]