STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012157	A. BUILDING: _____ B. WING _____	C 03/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEROY MANOR	509 SOUTH BUCK ROAD, PO BOX 149 LE ROY, IL 61752

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S 000	Initial Comments Incident Report Investigation to Incident of 2/10/17/IL92460 STATEMENT OF LICENSURE VIOLATIONS:	S 000		
S9999	Final Observations 300.610a) 300.1210a) 300.1210b)5) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 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: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.	S9999		

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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. (A, B) (Section 2-107 of the Act)

These regulations were not met as evidenced by:

Based on interview and record review, the facility failed to safely transfer R1 to the toilet resulting in R1 falling to the ground and sustaining multiple rib fractures. This failure affected one resident (R1) of three reviewed for falls in the sample of three.

Findings include:

R1's 2/13/2017 Face Sheet documents diagnoses including: Pain, Muscle Wasting and

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Atrophy, Abnormal Gait/Mobility, Low Back Pain, and Abnormal Posture. R1's Minimum Data Set (MDS, 1/28/2017) documents R1 requires extensive assistance with transfers and staff assistance with toileting. The same MDS documents R1's balance getting on and off of the toilet is not steady and R1 is only able to stabilize with staff assistance and has both lower and upper extremity range of motion impairments. R1's 12/4/2016 Fall Risk Assessment documents R1 is at high risk for falls.

R1' 12/22/2016 care plan documents R1 has a history of falls, poor safety awareness, an unsteady stance, generalized weakness, and decreased mobility related to generalized weakness. The same care plan documents R1 requires the use of a gait belt and one staff assist for transfers and ambulation.

The facility Final Report of Resident Fall with Rib Fracture (2/15/2017) documents R1 fell at 7:20 PM on 2/10/2017 while being toileted by E3 (Certified Nurse Aide). The Report documents E3 escorted R1 with a walker to the restroom without a gait belt on. As E3 bent down to remove a trash can from the restroom, R1 fell backwards and landed between the wall and toilet. The report documents R1 complained of rib pain the next day on 2/11/2017, x-rays were ordered, and the facility was notified R1 had acute fractures to the seventh and eighth ribs. The report documents "Immediate education performed with aide involved regarding gait belt placement, stand by assist, use of walker and eyes on resident when toileting."

E3's Statement by Witness (2/14/2017) documents: "On Feb 10th, 2017 at 7:20 PM, I assisted (R1) to the bathroom. (R1) was

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positioned too far away from the toilet. R1 did not have a gait belt on. I had removed my hand from (R1) to move the trash can out of the bathroom for me to empty later. (R1) reached to pull (R1's) pants down. (R1) lost her balance and fell backwards, landing between the wall and the toilet."

R1's Radiology Report (2/11/2017) documents a fracture involving the posterior portion of the right ribs with minimal displacement and acute seventh and eighth right rib fractures.

On 3/17/2017 at 10:02 AM, Z1 (R1's attending physician) acknowledged R1's rib fractures were caused by R1's fall on 2/10/2017.

The Event Report (2/11/2017) documents at 7:00 AM on 2/11/2017 R1 was up in a wheelchair "crying out in pain to right middle rib area" and R1 was unable to sit in the wheelchair without pain which was rated at 8 on a scale of 1-10. The Report documents Z1 (R1's attending physician) was contacted with a request to have R1's right ribs x-rayed. The Report also documents at 2:00 PM on 2/11/2017 nursing staff reported R1 had experienced a rib fracture from R1's fall on 2/10/2017 and R1 had severe, sharp and shooting pain and was unable to ambulate due to the pain.

On 3/16/2017 at 2:00 PM, E3 acknowledged assisting R1 to the bathroom on 2/10/2017. E3 reported positioning R1 in front of and facing away from the toilet and then began removing the trash can from the bathroom to the bedroom. E3 reported seeing R1 reach forward towards her walker as R1 fell backwards towards the floor. E3 reported being unable to catch R1 before R1 fell to the floor and landed between the toilet and

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wall. E3 said R1 groaned when she hit the ground and complained of right side pain after being put into bed after the fall. E3 acknowledged R1 was care planned to be toileted with a gait belt. E3 acknowledged not using a gait belt for R1's transfer to the toilet that resulted in R1's fall and rib fractures.

The facility Gait Belt policy (12/02) states: "...all direct care staff shall use a gait belt when transferring or ambulating residents...No resident will be transferred or ambulated without the use of a gait belt..." The facility Safe Resident Handling Policy (11/12) states "When physically transferring residents, gait belts will be used to maintain appropriate transfer techniques."

On 3/16/2017 at 3:10 PM, E2 (Director of Nursing) said E3 should have had a gait belt on R1 when toileting R1.

On 3/17/2017 at 2:50 PM, E2 acknowledged E3 did not follow R1's care plan to use a gait belt when transferring R1 on 2/10/17. E2 said E3 did not follow facility policy for gait belt use and staff should always have their hands on residents during transfers unless the resident is evaluated and deemed independent with mobility.

(B)