STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010912	A. BUILDING: _____ B. WING _____	C 06/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF PALOS HEIGHTS EAST	7850 WEST COLLEGE DRIVE PALOS HEIGHTS, IL 60463

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S 000	Initial Comments 1793138/IL94276 1793235/IL94388 1793407/IL94566	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)6) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

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. (Section2-107 of the Act)

These requirements were not met as evidenced by:

Based on observation, interview and record review the facility failed to put interventions in place to prevent falls and failed to provide supervision for one of four residents (R1) reviewed for falls. This failure resulted in R1 being hospitalized with a distal humerus fracture with possible radial head fracture, and acute bilateral nasal bone and nasal septal fractures with mild leftward angulation.

Findings Include:

R1's face sheet diagnoses include history of falls, dementia, glaucoma, chronic obstructive pulmonary disease and atrial fibrillation.

On 6/12/17 at 10:28 am, Z1 (R1's family) stated that R1 expired on 5/18/17. Z1 stated that he received a call on 5/13/17 at around 9:30 pm informing him that R1 had fallen and was being transferred to the hospital. Z1 stated that he had spoken with staff on several occasions concerning R1's risk for falling. Z1 stated that the family requested restraints or alarms for R1's safety and was informed that the facility is restraint and alarm free. Z1 stated that he was notified on two occasions that R1 was observed

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S9999	Continued From page 2	S9999		

walking around with the rolling bedside tray without calling for assistance. Z1 stated that he is concerned because the facility did not put safety measures in place after R1's family expressed concerns for R1's safety.

R1's incident report dated 5/13/17 indicates R1 was face down on the floor; face was bloody; unable to assist up; called 911 emergency.

On 6/12/17 at 2:46 pm, E12 Certified Nursing Assistant (CNA) stated that R1 would constantly get up alone to go to the bathroom. E12 stated that R1 would be re-directed to call for assistance when getting up. E12 stated that R1 was sometimes confused and did not always seem to understand. E12 stated that R1 pushed himself into the bathroom using the rolling bedside tray table approximately one week prior to falling.

On 6/13/17 at 9:41 am, E9 CNA stated that R1 was sitting up in the chair in his room and the nurse had just given him medication. E9 stated that on 5/13/17 around 9:30 pm she was doing rounds to check the residents when she observed R1 lying on the floor in his room in a puddle of blood. E9 stated that R1 seemed confused and stated, "get me up". E9 stated that R1 was a fall risk and was always getting up without assistance. E9 stated that she would check on R1 every 30 minutes while he was awake in his room because he often tried to get up. The facility could not provide documentation of frequent rounds.

E9's written statement dated 5/13/17 includes the following: E7 Registered Nurse (RN) went in to give R1 medication; he was sitting in his chair; when E9 made rounds R1 was found face down on the floor; he tried to get up on his own, which

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he has been doing lately and was told repeatedly not to get up without help.

R1's hospital records dated 5/13/17 includes the following: R1 states that he slipped and fell onto his face and right side; R1 is complaining of right elbow, right shoulder and left knee pain; R1 was bleeding from the nose profusely initially; x-ray to right elbow revealed a distal humerus fracture with possible radial head fracture.

R1's computated tomography scan (CT scan) of sinus facial bones indicates R1 suffered acute bilateral nasal bone and nasal septal fractures with mild leftward angulation.
On 6/13/17 at 1:25 pm, E7 RN stated that on 5/13/17 she was the nurse for R1. E7 stated that she had just given R1 his evening meds and asked him if he needed anything, which he did not. E7 stated that R1 was sitting up in the wheelchair when she left the room. E7 stated that approximately 10-15 minutes after she left R1's room, E9 CNA informed her that R1 had fallen. E7 stated that R1 was observed face down on the floor with blood appearing to be coming from his nose. E7 stated that R1 seemed dazed but stated, "I'm ok". E7 stated that she could not get vitals or do an assessment on R1 because he was too heavy to move. E7 stated that 911 emergency was called and R1 was taken to the hospital. E7 stated that R1 never tried to get up without assistance while she was caring for him.
R1's patient admission/readmission screen undated indicates that R1 has a history of falls.
R1's skilled nursing note dated 5/1/17 at 4:42 pm includes the following: R1 has a fear of falling and his family was concerned. The family said he never said that at the hospital. Writer was informed by the family that we get him up a lot for

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S9999	Continued From page 4 therapy, toileting, and meals and that it is a valid concern that patients have. R1 also has dementia and forgot what we were discussing as he started to make jokes. On 6/14/17 at 9:30 am, E2 Director of Nursing (DON) stated that R1 had increased visual supervision due to his fall risk. The facility did not provide documentation to support increased visual supervision for R1. On 6/18/17 at 3:50 pm, E2 DON stated that all residents are at risk for falls and the facility does not use a scale to rate residents level of fall risk. E2 stated that each residents plan of care is individualized to the meet the needs of the resident. (B)	S9999		