STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145893	A. BUILDING _____ B. WING _____	C 11/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF PALOS HEIGHTS WEST	**11860 SOUTHWEST HIGHWAY PALOS HEIGHTS, IL 60463**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Investigation 1696428/IL89763 - F323 1696556/IL89899 - No deficiency	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to have two staff members perform a two person transfer using the mechanical lift while transferring a resident to avoid a fall with injury. This applies to one of three residents (R1) reviewed for accidents in a sample of three. As a result, R1 sustained a right hip fracture and required surgery to repair it. Findings include: R1 is 89 year old admitted to facility with diagnoses of right femur fracture and osteomyelitis, right artificial knee joint, Parkinson's and hypertension. Facility "Incident Report" completed on 10/14/16 at 3:30 a.m. documents E4 (RN) registered nurse was called to R1's room and noted right thigh/hip swollen and (RLE) right lower extremity shorter than (LLE) left lower extremity. R1 complained of	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MANORCARE OF PALOS HEIGHTS WEST	**11860 SOUTHWEST HIGHWAY PALOS HEIGHTS, IL 60463**

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F 323	Continued From page 1	F 323		

pain if touched. Z3 (attending physician) made aware, order to transfer R1 to (ER) emergency room. Z1 (family) not answered the phone.
On 11/22/16 at 3:00 p.m. E4 (RN) registered nurse stated E5 (C.N.A) certified nursing assistant transferred R1 by self, just pivoted resident to bed and was supposed to be a two person mechanical lift transfer. E5 urged R1 to go to bed. R1 did not fall.

At 3:30 p.m. E5 stated "I transferred R1 to bed, who told me to be careful because the leg was twisted. I just took R1 from wheel chair and pulled resident who told me had leg twisted before I moved resident. I was supposed to use mechanical lift for R1; I didn't know, it was my first time taking care of R1 and I did not ask. You must have two people and use the machine to transfer R1 and patients like R1."

Facility "Minimum Data Sheet" (MDS) documents on 10/26/16 under section G - functional status:

B. Transfer 3/3 - extensive assist, two + person physical assist.

Facility "Care Plan" documents on 10/10/16 under:

Focus: Requires assistance/potential to restore function for transferring from one position to another related to disease process contusion of right knee.

Goal: Will be transferred by staff without injury and will be able to transfer with assistance two persons.

Interventions: Transfer using a mechanical lift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 2 Therapy evaluation and therapy as ordered Transfers: Provide two persons for supervision/physical assist. On 11/23/16 at 10:30 a.m. E2 (RN) stated "They are educated to use two staff assistance with mechanical lift. E5 did not follow the two person transfer; they should follow resident kardex to ensure resident safety." On 11/22/16 at 12:30 p.m. R1 stated "They twisted my leg here, it hurt." Facility "Mechanical Lift" policy dated 1/14 documents as being advisable to have two staff members present to stabilize and support the patient. R1's Local Hospital "Orthopedic Trauma Surgery Operative Note" documents 10/15/16 at 1:20 p.m. Pre-operative diagnosis: 1. Right peri-implant femoral shaft fracture. 2. Right lower extremity infection. Post-operative diagnosis: 1. Right peri-implant femoral shaft fracture. 2. Right lower extremity infection. 3. Right distal femoral shaft non union secondary to implant failure. 4. Right supra-condylar femur non union secondary to infection. Procedure: 1. Irrigation and debridement right femur. 2. Removal of hardware right femur. 3. Open reduction internal fixation right femur.	F 323		