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 EAST	7850 WEST COLLEGE DRIVE 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) COMPLETE DATE
S 000	Initial Comments Complaints: 2090670/IL119569 - F684G 2090458/IL119346 - F689G	S 000		
S9999	Final Observations 1) Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c)3) 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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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)	S9999		

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These Regulations were not met as evidenced by:

Based on interview and record review, the facility failed to follow their "Pain Practice Guide," and evaluate and monitor for side effects for a resident (R4) after administering Morphine (pain medication) for one resident (R4) reviewed for reassessment after administering pain medication. This failure resulted in R4 having an unreported change in baseline of feeling groggy, then being found on the floor with a laceration to the forehead and absence of vital signs.

Findings Include:

A note dated 1/25/20 at 12:56PM documents R4 visited by the hospice nurse and educated on need and use for ordered opioid pain medication. R4 understands this medication is for mild pain and shortness of breath. A note dated 1/25/20 at 10:43PM documents R4 found lying face down on the floor on the right side of the bed without movement or respirations at 5:10PM. R4's head was lying in blood due to a left forehead laceration. R4's call light and bed control were lying underneath R4. Vital signs assessed and were absent. R4 lifted back into bed.

The Fall Report dated 1/26/20 documents R4's medications as antianxiety, antidepressant, and narcotic analgesics. R4's disease and conditions are the following: cardiac dysrhythmias, congestive heart failure, decline in functional status, incontinence, muscle weakness, and fatigue putting R4 at risk for falls.

The Investigation Report dated 1/30/20

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documents R4 found on the side of the bed expired.

On 2/7/20 at 11:09AM, V13 (LPN) stated, "I know activities was doing rounds and went down there and found R4 on the floor. I walked in and saw R4 face down on the floor. There was blood around her face and when we flipped R4 over we then saw it was coming from a laceration on R4's left forehead. Before we decided to move R4, we called R4's name and checked for a pulse and couldn't find one. R4 was blue when we flipped her over and not moving at all. I was with R4 since 7am that morning and R4 was her normal self. R4 had a visit from hospice and the hospice person told me R4 was complaining of pain and shortness of breath. I went down there and around one I gave her morphine for pain and shortness of breath. R4 normally took the Tylenol for pain because R4 told me before R4 didn't like the way the morphine or Ativan made R4 feel. R4 said it made R4 feel funny but that is all I know. R4 really didn't say more about that. I last saw R4 at 1 P.M. when I gave the morphine to R4. I never got a chance to check on R4 again. If R4 was still having pain or something the CNA that checked on R4 would tell me. There wasn't a change after R4 got the morphine that I know of. R4 was always A&O (alert & oriented) X3 (Alert to person, place, & time). R4 could tell you exactly what R4 wanted and have a conversation with you. R4 liked to control the bed. R4 knew how to make the bed go up and down and she knew how to use the call light too. R4 liked the head of her bed raised because it helped R4's breathing. That day when I went in the room it was maybe 45 degrees and the bed was probably 3 to 3 and a half feet off the ground. I know the call light was on when the activity person went in the room. R4 didn't have side rails on the bed. No one has

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side rails on their bed here."

On 2/7/20 at 11:27AM, V12 (Activity Aide) stated, "I was doing my rounds. I saw the call light on and I went in to see if the first lady needed anything she told me no and I looked around the curtain and found R4 on the floor. She was not calling out or moving at all. R4 was face down. As soon as I saw R4 and the blood I ran and go the nurse. I know the head of the bed was raised but I couldn't tell you how much. R4 always had R4's bed like that; it was R4's preference. I did see R4 earlier that day and when I saw her R4 was sleeping. The last time I saw her she was sleeping around 2 or 2:30PM. R4 was never confused. I didn't talk to R4 that day though. The light was already on when I started my rounds. I'm not sure how long the light was on for before that."

On 2/7/20 at 11:54AM, V14 (CNA) stated, "I last saw R4 at 4:45PM. I went in R4's room to help take her roommate to the bathroom. When I came out I checked on R4 too since I was in the room. I know they were giving R4 morphine that day. R4 was more groggy than usual. R4 was talking to me telling me what R4 wanted but R4 wasn't opening her eyes when R4 talked to me. R4 was speaking with a softer voice too this time. Normally, R4 would talk to you with her eyes open when you were helping R4 get comfortable. R4 was always alert times 3. I didn't tell anyone R4 was like that. I tried to put R4's head of the bed down a little when I was leaving. It was close to being all the way up but R4 told me R4 wanted it up because it made R4's breathing better. R4 always sat with the head of the bed up. The height of the bed was to my mid-thigh probably and I am 5'6". R4 didn't have any side rails on the bed."

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On 2/7/20 at 1:52PM, V15 (Physician) stated, "I remember I got a call from hospice that evening tell me the resident expired and was a DNR so I gave the order to release the body to the funeral home. I think hospice or someone called me the next day wanting me to sign the death certificate. I found out that R4 fell and was found down and R4's death might not have been from natural causes so I didn't feel comfortable signing it. I never saw this patient in my life. I have no idea what she was like and then hearing what happened I didn't want to put my name on that. Like I said I can't really say what the person was like because I didn't know R4. The least they should have done is notify hospice if R4 showed a change from R4's baseline. There are many side effects of morphine. It is a powerful medication for someone that doesn't get it often. Some side effects are depressed respiratory and cardiac function, a change in mental status or an increase in confusion. It could have made her more sleepy than usual."

The Death Certificate dated 2/3/20 documents the cause of death as subdural hematoma and probable fall. The manner of R4's death is ruled an accident.

The Physician Order Sheet (POS) dated 2/7/20 documents an order to call the hospice company for an emergency or a change in condition noted. The Medication Administration Record (MAR) for 01/2020 documents R4 received an ordered as needed opioid pain medication on 1/24/20 and 1/25/20. No documentation of reassessment noted on 1/25/20. The Minimum Data Set (MDS) dated 12/10/2020 reviewed. Section C of the MDS documents R4's Brief Interview for Mental Status (BIMS) score as a 13 (no cognitive

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impairment). Section G of the MDS documents R4's functional status as needing extensive assistance with two person physical assist.

The "Pain Practice Guide," dated 11/2011 documents, " FYI - Obtain pain scale scores daily and before and after administration of PRN analgesics. Scores are documented on the MAR. Patients receiving opioid analgesics are routinely evaluated and monitored for side effects which include, but are not limited to: confusion/delirium, constipation, hallucinations, myoclonic jerking, nausea/vomiting, pruritis, respiratory depression, and sedation. If adverse side effects are noted, the physician is promptly notified for additional orders or interventions."

The policy titled, "Change in Condition," dated 11/2016 documents, "CMS requires, a facility must immediately inform the resident; consult with the resident's physician; and notify consistent with his or her authority, the resident representative when there is: a significant change in the resident's physical, mental, or psychosocial status (that is a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications). According to the American Medical Directors Association Clinical Practice Guideline - Acute Changes in Condition in the Long Term Care Setting, immediate notification is recommended for any symptom, sign or apparent discomfort that is acute or sudden in onset and a marked change in relation to usual symptoms and signs, or is unrelieved by measures already prescribed."

(A)

2) Statement of Licensure Violations:

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300.610a)
300.1210b)
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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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. Restorative measures shall include, at a minimum, the following procedures:

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the

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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)

These Regulations were not met as evidenced by:

Based on interview and record review, the facility failed to develop fall risk interventions to reduce the risk of falling for a resident with a cognitive impairment and known impulsive behavior for one (R3) resident reviewed for falls. This failure resulted in R3 falling sustaining a left hip fracture after falling while attempting to get out of bed

Findings Include:

A note dated 1/9/20 documents R3 attempted to get up alone while in the bathroom and fell hitting R3's head. R3 is not to be left in the bathroom alone. R3 sent to the hospital for evaluation. A note dated 1/11/20 documents R3 had an unwitnessed fall. R3 denied pain or injury at the time of the fall. R3 noted with a bruise to the left thigh. R3's family member called the nurse notifying the nurse that R3 called the family member reporting R3 was in pain. R3

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complained of pain when reassessed and complained of severe pain with movement in the left leg. R3 was sent to the hospital.

The Ambulance Run Sheet dated 1/11/20 documents R3 appears in some distress wincing in pain. R3 rated pain to the left leg 9 out of 10. R3 reported changing clothes to get ready for bed when R3's left leg slipped from under R3 and R3 fell onto the left hip. R3 reported falling into "kind of a splits" position. Bruising noted to left medial thigh. The Hospital Records dated 1/11/2020 document R3 reported getting ready for bed and slipped and fell onto the left side. Left leg appears shortened. X-ray of the pelvis shows a left displaced fracture through the left femoral neck.

On 2/6/2020 at 2:31PM, V7 (CNA) stated, " I was coming out of my resident's room I was taking care of and I saw R3 on the floor. The call light was not on. R3 was sitting up near the foot of her bed but R3 was facing the head of her bed. R3's legs were kind of in a folded position away from the bed. R3 was a fall risk. All fall risks have to be monitored either in the lounge area or in front of the nurse's station until they go to bed for their safety. That is our protocol here for fall risks. R3 was in R3's room at the time of the fall. I don't know who put her in R3's room. I know R3 didn't get back there alone because R3 wasn't able to maneuver the wheelchair alone. I don't know any of R3's interventions because R3 wasn't on my set. I just know R3 was a fall risk and R3 wasn't supposed to be in R3's room alone."

On 2/6/2020 at 3:04PM, V8 (CNA) stated, "I gave R3 the night time care and put R3 in bed around 8 to 8:30PM. This is the only fall I know of that R3 had. R3 was not a high fall risk. They have a

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band on their wrist if they are a high fall risk. R3 didn't have one on. We always put the high fall risks at the nurse's station because they need to be watched until the night shift comes on. R3 is confused at times. R3 won't listen to directions if you give them to R3. I can't think of any risk factors that R3 would be a fall risk. We are told for all residents that have a fall they go in front of the nurse's station until the night staff comes because they will get up from their bed. If you put a high fall risk in bed you must stay with them so they do not get out of bed. The only interventions we have for high fall risk is watching them at the nurse's station until it is time for bed."

On 2/6/2020 at 3:22PM, V9 (Agency LPN) stated, "The CNA came to get me and told me the patient was on the floor. I asked R3 what R3 was trying to do and R3 told me to get back in bed but R3 couldn't tell me what R3 was doing before then. R3 was a high fall risk because R3 was on neuro checks for a previous fall like a day or 2 before. I can't tell you what interventions they had in place for R3. I just remember being told in report R3 fell like 2 days before. It was my first time in the building as well so I didn't really know R3 or what they do there. I only knew the residents that had a fall recently from report. No, I wasn't told about her needing to be monitored because of R3 being a fall risk. I'm not sure but I know R3 was probably supposed to be at the nurse's station from other nursing homes I have been to. That is what they do. They watch the high fall risks until they are all put to bed."

On 2/7/2020 at 9:56AM, V10 (Nurse Supervisor) stated, "I was not here during the time of the fall. We usually have the nurse doing the paperwork put in an intervention right away. If the nurse is some an agency they are put in by me the next

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day. The intervention we put in depends on the circumstances of the fall. We gear it to what the root cause of the fall was. I know the first fall she was put in the bathroom and R3 got up alone. I felt R3 was confused. I interviewed R3 after the first fall and R3 couldn't answer the questions I was asking. R3 was alert enough to feel more independent and felt R3 could do a little more than R3 could. We have hired extra staff to sit with them until they go to lie down for the night. We have all the residents that we need to watch that can't follow directives to call for help. I don't know when that was started when R3 was here or not. I didn't think R3 was able to follow the direction to use the call light. That was twice R3 didn't wait for help. There is nonstop movement in the halls and constant eyes moving down the halls to check on the residents so we really don't have a set time on when they should round."

On 2/7/2020 at 10:45AM, V11 (Physician) stated, "I don't remember this patient at all. I don't know what the facility policy is on their falls so I cannot say what else could have been done to prevent something like this. From what you told me, R3's comorbidities do make R3 more prone to falls more specifically because R3's inability to function independently."

The Investigation Report dated 1/16/20 documents V8 (certified nurse aid) put R3 to bed after providing care around 8:30PM. V7 (CNA) found R3 on the floor sitting next to the bed. No call light was on. This was R3's second fall. Both falls R3 got up without waiting for assistance from staff.

The Minimum Data Set (MDS) dated 1/9/2020 Section C of the MDS documents R3's Brief Interview for Mental Status (BIMS) score as an 11

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(moderate cognitive impairment). Section G of the MDS documents R3's functional status as needing extensive assistance with two person physical assist. The Care Plan dated 1/11/2020 documents an intervention for R3 after the fall on 1/9/2020 as the following: staff will wait outside the bathroom door when R3 is in the bathroom. R3 is not to be left alone in the bathroom.

The Physical Therapy Evaluation dated 1/3/20 documents R3's safety awareness as impaired. During the evaluation, R3 demonstrates left upper and lower extremity weakness, poor standing balance, poor trunk control, and requires max assist with transfers. R3 is at risk for: compromised general health, decreased ability to return to prior living environment, decrease in level of mobility, decrease leisure task participation, decrease participation with functional tasks, falls, immobility, pressure sores, and limited out of bed activity.

The facility reported not having any specific policy or protocols for residents that are cognitively impaired and a high fall risk.

(A)