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 11/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 Complaint: 2091797/IL120824 -F684 G & F689 G	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 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 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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: 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. 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.	S9999		

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S9999	Continued From page 2	S9999		

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 follow their Falls Practice Guide, failed to keep the resident safe while toileting. This failure resulted in R3 being left alone in the bathroom where the resident attempted to ambulate resulting in a fall and failed to properly assess and notify a Physician after a fall for 1 resident (R3) reviewed for falls. R3 was not assessed for over 12 hours after a fall. R3 was hospitalized and diagnosed with multiple pelvic fractures, a fracture of the left hip and the spine.

Findings Include:

The care plan dated 3/12/19 documents that R3 is a fall risk related to decreased strength, endurance, balance, and history of a right hip fracture. Interventions include staff assisting R3 with ambulation and transfers. The Minimum Data Set (MDS) dated 2/24/20 documents that R3 was cognitively intact but required extensive assistance and 1 person physical assist with toileting related to lower extremity weakness.

The Fall Report dated 3/2/20 at 12:22am documents that R3 had a fall on night shift related to gait problems and impaired balance. There was no documentation of a full body assessment done at the time of the fall and no documentation

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S9999	Continued From page 3	S9999		

of Physician and family notification. The Medication Administration Record (MAR) and Pain Assessments were reviewed and there is no documentation of the resident's pain being assessed and managed after the fall.

The Nurse's Notes dated 3/3/20 at 1:42pm documents that R3 had pain while getting dressed and informed staff of a fall that took place at night on the previous shift. R3 was left alone in the bathroom and stated that the fall occurred while trying to get back into the wheelchair after using the bathroom at bedtime. The family was made aware and requested that the resident be sent out for evaluation. The Physician was notified and R3 was transferred to the local hospital for evaluation.

The hospital records dated 3/3/20 documents that R3 was admitted after a fall the evening prior and has complaints of pain to the left hip that radiates up the back. R3 is unable to ambulate due to pain related to the fall. R3's x-ray of the hips showed an inferior and superior rami (pelvis) fracture on the left. A CT scan was done of the abdomen and pelvis and showed a large displaced fracture of the left iliac bone (pelvis) extending to the iliac crest (pelvis) and the roof of the acetabulum (hip) with bilateral fractures of the sacrum. R3 also has a compression fracture of the L2 spine.

On 10/13/20 at 11:40am, V1 (Administrator) stated "The incident with R3 occurred on the night shift. The Nurse caring for the resident at the time was aware of the fall and did not notify anyone that the resident had fallen. The Nurse just put R2 back in bed after the fall. The Nurse was terminated for failure to notify the administrative staff or the Physician. The Nurse

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S9999	Continued From page 4	S9999		

did not follow our Fall Protocol. The Nurse was a really good staff member that just made a very poor decision. It is outlined clearly in the computer that the Physician should be notified after a fall but the Nurse did not follow those prompts."

On 10/16/20 at 3:20pm, V8 (CNA) stated "At the start of the morning shift I went in to see the resident. I remember seeing blood on the top of the resident's underwear. I tried to move R3 but the resident complained of hip pain. R3 told me that there was a fall that took place on the night shift. R3 was transferred to the bathroom and fell trying to get back into the wheelchair. I informed the night Nurse at that time. I'm not sure what the Nurse did after that. That Nurse no longer works here."

On 10/16/20 at 2:10pm, V6 (Physician) stated "This was not my resident but the Nurse should definitely call the Physician caring for the resident after a fall. There is a fall protocol for the Nurse to inform the Physician so that the resident can be assessed for pain, or x-rays and also notify the family. This is the normal protocol after a fall."

The Falls Practice Guideline documents that an evaluation is completed timely following a fall or change in patient condition that increases the patient's risk for falls. Upon the completion of the evaluation, the Physician is notified and orders are documented, noted and implemented, as indicated. The family and responsible party is notified of the fall event or change in fall risk factors and the patient's current condition.

(A)