STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012173	A. BUILDING: _____ B. WING _____	C 06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTCHESTER HEALTH & REHABILITATION	2901 SOUTH WOLF ROAD WESTCHESTER, IL 60154

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S 000	Initial Comments Complaint #1592678/IL77332	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 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 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:	S9999		

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S9999	Continued From page 1 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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 These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to have an alarm or other methods in place to alert staff when a dementia resident, high risk for falls, was attempting to transfer self from a wheelchair and have two staff members available for physical support during a resident's shower and/or transfer to prevent a fall. This applies to two of three residents (R1, R3) reviewed for falls in the sample of five. As a result, R3 a dementia resident, had an unwitnessed fall and fractured the right distal femoral shaft (leg fracture). R1 slid from a chair in the shower and obtain a head injury and a laceration to the left forehead. Findings Include: 1. May 26, 2015 at 1:05 pm, R1 was sitting in the dining room in a chair with a soft helmet on head.	S9999		

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R1 had a dressing to the left forehead from the fall incident on 5/13/15.
R1's Fall Risk Evaluation: March 5, 2015 and May 18, 2015 had a score indication R1 was at high risk for falls. In March, R1 was admitted post craniotomy with a head injury.
Care Plan - March 6, 2015 and 5/12/15 notes R1 as a 2 people assist with showers at all times.
Minimum Data Set (MDS) dated 3/12/15 and 5/27/15; documents Transfer is 4/3 indicating -Total dependence with 2 person assist. Toileting and bathing is 4/3 indicating -Total dependence with 2 person assist.
Nursing Notes: May 12, 2015 at 4:10 pm documented: E5 (nurse)was called to the shower room. E5 arrived and found R1 naked on the shower floor in the stall bleeding from the left side of the head. Another nurse (E7) was in the shower room providing first aid. The left eyebrow area was cleansed and a pressure dressing applied by E7. E7 left the shower room when E5 the primary nurse for R1 arrived.
May 28, 2015 at 2:30 pm E7 (nurse) stated, I am the nurse on unit 1, because the shower does not work on unit 2, the residents from unit 2 (R1) used this shower. I heard a loud cry for help from E6 (nurse aide)coming from the shower room. When I arrived to the shower room, R1 was sitting on the floor bleeding from the head. E6 stated that R1 had fallen on top of her back when E6 was cleaning feces off the floor and R1 slid out of the shower chair. I cleaned head and applied a cold compress and a pressure dressing. I left after R1's nurse (E5) arrived.
May 28, 2015 at 1:20 pm E6 (nurse aide) stated, I took R1 into the shower room and soaked her body with soap and water. R1 had a bowel movement on the floor while I was showering; so I bent down to clean it up so that R1 would not slip in it. Before I could rise back up R1 was

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sliding out of the shower chair and fell on top of me. R1 hit head on the rail in the shower. E6 was asked if she knew R1 was a two person assist in bath. E6 stated her colleagues had their own residents to take care of. E6 was asked if a communication book is available to tell how residents are transferred or cared for. E6 responded we do not have any book or anything to tell us about the resident. E6 stated this was her first time showering R1. I did not know R1 was a two person assist. I feel very bad that I hurt R1, I like R1 ' s family and was just trying to clean R1 up.
May 28, 2015 at 2:16 pm E5 stated, while passing medications on unit 2; I was called to unit 1 for an emergency. I went to unit 1 shower room, R1 had fallen the shower. Another nurse E7 had given first aid to (R1). I took over the treatment; E5 was still with me in the shower. R1 was sitting on the floor naked and very soapy. R1's head was hit on the safety bar when R1 fell out of the shower chair. R1 was assisted to the wheel chair by 4 staff; because R1 was very slippery from being soaped up in the shower. E5 was asked if E6 was made aware of R1 ' s two person assist when bathing/transferring. E5 stated we usually bath R1 in the bed because R1 moves so much. R1 was assessed, physician and family made aware of the incident and injury. Physician requested that R1 be sent to the local hospital for evaluation.
June 3, 2015 at 12:02 pm, Z1 (Primary Physician) stated I am very shocked regarding R1's injuries/incident falls. R1 is very high risk for falls; R1 came to us a couple months ago with a helmet on head from a previous craniotomy. R1 has to wear the helmet all the time. " Due to R1's weight and weakness, R1 is too weak and the staff needs to be more attentive and assist more frequently when needed. R1 needs to always

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have two people to help with bathing/transfer. " I was made aware of the injury when it happened; I ordered the patient be sent out chair while being to the hospital right away.
Incident/Accident Report: May 12, 2015 at 4:10 pm, R1 in shower stall on floor with gash on left eyebrow, abrasion to left eyebrow.
Incident Reporting to Public Health: Initial and Final documents dated 5/13 and 5/18/15; R1 propelled self out of shower chair. Hit head on floor causing lacerations. Resident sent to hospital and returned with three sutures.
Hospital Emergency Room Records dated May 12, 2015 documented the following: Impression- 87 years old with head injury and laceration to the forehead from a fall in the shower at nursing home. Computerized Tomography (CT) scan was performed without intravenous contrast. R1 had a subdural hematoma from a previous surgical procedure (craniotomy) in March 2015. An acute infarction may not be apparent on CT for up to 24-48 hours. No fracture of the spine is indicated. Three sutures applied to the left forehead.
2. May 27, 2015 at 11:10 am, R3 was in the dining room sitting in wheel chair. R3's left upper lip was very swollen, under the nose the entire bottom part of face is swollen with discoloration of redness.
Incident Report May 25, 2015 at 6:10 pm indicated, R3 was noted sitting on floor in front of bathroom door, bleeding from mouth and bridge of the nose.
Nurse Notes May 25, 2015 at 10:00 am, R3 noted with swollen lip bruising under the left eye and redness to bridge of the nose status post fall at 6:00 am.
The fall Investigation Report: Notes nurse was making rounds at 5:45 am and found residents sitting on floor bleeding, fall was un-witnessed.

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Care Plan- Falls: R3 has history of falls, balance problem with standing, decreased muscle coordination, seizures and osteoporosis. Bed and chair alarm to be applied.
SBAR Communication Form: Status Post Fall, resident noted with swollen lip, bruising under the left eye and redness across the bridge of the nose.
Interdisciplinary Post Fall Review: Resident stated she was going to washroom, noted in sitting position in bathroom doorway. Bleeding noted from mouth and bridge of nose is red. Bed alarm applied to bed.
Another incident Report dated November 26, 2014 documented: R3 observed in sitting position in bath area, resident got up to go to the bathroom to get dressed. No apparent injuries noted.
Nursing Notes: No documentation on the incident for 11/26/2014 from any shifts.
Nursing Notes 11/27/14 10- 6 shift (not indicated if am or pm); resident aroused for signs and symptoms of discomfort. No pain rating was documented, no other information documented.
Nursing Notes 11/28/2014, 10-6 shift (not indicated if am or pm) resident observed sleeping in bed, complaining of pain in right knee area. Tylenol 650 mg. was given. X-ray negative for fracture. Faxed to Z1 (physician), family made aware of the incident.
Nursing Notes 11/28/14 at 10:10 am, Z1 called regarding swelling and pain to knee. Z1 ordered R3 be sent to local hospital.
Nursing Notes 11/28/2014 at 2:30 pm, facility received call from local hospital that R3 was admitted to the hospital for a leg pain and hip fracture.
Incident reporting to Public Health: Initial Report -November 28, 2014, Resident attempted to self transfer from bed. Final Report December 3,

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2014, Resident attempted to self transfer from bed.
Interdisciplinary Post Fall Review: November 26, 2014- R3 was observed in sitting position on bathroom floor, resident got out of bed unassisted. Tab alarm for bed and chair. Place pad alarm to bed.
Fall Risk Evaluation: November 2014 = 17 - May 2015 = 18. Total score of 10 or above represents High Risk for fall.
Fall Care Plan - R3's care plan was not updated since 3/13/15, R3 had another fall on 5/25/15. E1 (Administrator) and E2 (Acting Director of Nursing) was asked for the policy and procedures of updating care plans after an incident. E1 and E2 stated the facility has no such policy.
Minimum Data Set (MDS) Assessment dated 3/20/14 and 5/29/15, R3 was scored as a 3= Extensive assistance in self performance and a 2= One person physical assist.
R3's hospital record for the admission 11/28/2014 documented: 88 years old with multiple medical problems including dementia for evaluation of femur fracture after a fall in nursing home. Plain films femur fracture with distal femoral shaft. Resident is unable to relate any information related to the fall.
12/02/14- Underwent a surgical procedure - Percutaneous repair of right distal femur fracture. R3 was discharged from the hospital back to the facility on December 4, 2014.
June 3, 2015 at 12:05 pm, Z1 (Physician) stated it was shocking to hear about the fall on 12/4/14. R3 is very dementia and requires that the staff watch her more closely and frequently address her needs. Z1 stated R3 needs more supervision because of the age, weakness and dementia. I was made aware of the fracture of the femur. Z1 was asked if resident is able to get up and go to the bathroom by self. Z1 stated no, R3 is too

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S9999	Continued From page 7 weak and frail. Z1 stated the incident on 5/25/15 resident is too weak and requires a two person assist to help with all care all the time. Z1 stated I do not feel these residents can transfer themselves without 2 person assist due to age and weakness. (B)	S9999		