STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016281	A. BUILDING: _____ B. WING _____	C 05/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWBROOK MANOR - LAGRANGE	339 9TH AVENUE LA GRANGE, IL 60525

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S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1210a) 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. 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least	S9999		

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restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.
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 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 are not met as evidenced by:

Based on interview and record review the facility failed to have a side rail, used as a safety device, in a correct position to prevent a resident from falling out of a bed during care. This failure applies to one of three residents (R1) reviewed

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S9999	Continued From page 2	S9999		

for falls in a sample of three. As a result, E1 (certified nurse aide) rolled R1 to the side during incontinence care and R1 fell onto the floor. R1 sustained a laceration to her forehead and experienced a Subarachnoid hemorrhage.

Findings Include:

Facility's fall prevention program (bee safe program) undated denotes for high fall risk resident, the following interventions:
1. Monitor and assist following daily schedule routine.
2. Supervise and or assist bedside sitting, personal hygiene and toileting as appropriate.
3. Keep safety device in place and functioning.
4. Staff to check for proper placement and function of safety devices every shift.

R1's care plan initiated 4-7-15 denotes the resident is high risk for falls related to decreased mobility and cognition. Interventions included all staff to provide safe environment and educate family and staff on the importance of keeping safety device in place and functioning.

An incident report dated 5-4-15 denotes CNA (certified nurse aide) called nurse to R1's room observed R1 on floor face down with acute bleeding to right forehead. CNA stated she turned R1 and she rolled off the bed. Steps taken to prevent recurrence: take more precautions when turning residents, use side rail down when turning residents.

R1' s minimum data set dated 4-7-15 denotes for bed mobility (how resident turns side to side and positions body while in bed or alternate sleep furniture) requires extensive physical assistance by two or more person. "

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S9999	Continued From page 3 On 5-13-15 at 3:00 pm E1 (Certified Nurse Aide) stated she went in to assist R1 with her ADL (activity of daily living) and was changing her incontinent brief. E1 stated R1 was facing the window leaning on her right side and holding the side rail on the right side of the bed. E1 stated she was standing behind R1 on the opposite side (left side). While she was removing the incontinent brief, R1 let go of the raised side rail and rolled off the bed and hit the floor. E1 stated called for help and the nurse (E2) came. E1 stated they did not remove R1 and ambulance attendants came shortly and put her on the stretcher. E1 stated when the side rails are not being used by a resident they are in the up position. E1 stated she will now make sure the side rail is down before repositioning or changing any resident for now on. On 5-13-15 at 3:30 pm E2 (Licensed Practical Nurse) stated she was in hallway on 5-4-15 doing medication pass when CNA (E1) called for assistance in R1's room. She went and saw R1 on the floor on the right side of her bed. E2 stated she noted that R1 was bleeding and the side rail was up in the air. E2 stated she got a 4 x 4 gauze and applied pressure to her head. E2 further reported, E1 informed her that she was getting ready to get R1 up for breakfast. She (E1) rolled R1 on her side and R1 fell out of the bed. E2 stated when the side rails are not being used they are in the up position. E2 stated they are supposed to pull the side rails down so they are in place so the residents can grab them, when they are repositioning or changing them. E2 stated R1 is very dependent and weak and needs staff to assist all her ADLS.	S9999		

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S9999	Continued From page 4 R1's hospital record dated 5-4-15 denotes Computed Tomography (CT) Scan impression: new 4 x 3 area of high density at right frontal cortex, consistent with a small hemorrhagic contusion. Comment: There are some linear areas of high density within the Subarachnoid space adjacent to right frontal/temporal lobes. Admission physical exam forehead lacerations currently sutured. On 5-13-15 at 4:45 pm Z1 (Doctor) stated, R1's fall caused R1 to sustain the laceration to her forehead and the trauma of the fall contributed to her subdural bleed. On 5-13-15 at 3:50 pm E3 (Director of Nursing) stated E1 should have had R1's side rail down when she was providing care to R1 on the day (5-4-15). She (R1) rolled out of the bed. When the side rail is up, it is much shorter than when it is down. E3 believes the cause of R1's fall was that the CNA did not have the side rail down and R1 rolled out of the bed. (B)	S9999		