STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000343	A. BUILDING: _____ B. WING _____	C 03/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF OAK LAWN WEST	6300 WEST 95TH STREET OAK LAWN, IL 60453

(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 Investigation 2191175/IL131169	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210d)6) 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 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

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.

These regulations are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide safe bed mobility during resident care for 1 of 3 residents (R1), reviewed for falls in the sample of 12. This failure resulted in R1 falling from bed and sustaining a left tibia and fibula fracture.

The findings include:

R1's Medical Practitioner Progress Note dated 7/16/20 documents R1 with limited mobility, contractures, and a history of cerebral hemorrhage. This note further documents R1 with contractures to bilateral lower extremities and hands.

R1's December 18, 2020 Minimum Data Set showed R1 with severe cognitive impairments and totally dependent on two staff for bed mobility.

On 2/27/21 at 10:55 AM, R1 was observed in bed with bilateral lower extremity contractures, a right arm contracture and a left hand contracture with limited use of the left arm. R1 also had an immobilizer boot to left lower extremity.

A Facility Incident Report dated 1/26/21 documents a nursing assistant was changing R1's bed linen and incontinence brief when R1

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S9999	Continued From page 2	S9999		

began sliding off the bed and was lowered to the floor.

On March 1, 2021 at 10:13 AM, V4 CNA (Certified Nursing Assistant) stated at the time of the fall on 1/26/21, V4 rolled R1 towards V4 to provide care, turning R1 onto R1's left side and at the edge of the bed. V4 stated R1's legs are very contracted and R1's legs started going over the edge causing R1 to slide off the bed and V4 had to assist R1 to the floor. V4 stated R1's bed is not big enough to position R1 properly while turning.

On March 1, 2020 at 8:56 AM, V3 (Nurse) stated on 1/26/21, V4 had rolled R1 towards her in bed to provide care and R1 fell out of the bed. V3 stated R1 was a one person assist for bed mobility but confirmed R1 should have been a two person assist at the time of the fall. V3 stated R1 was changed to a two assist after this fall to ensure R1 does not fall from bed during care again.

On 3/1/21 at 10:45 AM, V2 (Director of Nursing) stated if V4 had properly placed herself along side of R1's bed to guard R1 while providing care R1 may not have fallen out of bed when V4 was providing care.

On 3/1/21 at 11:09 AM, V16 (Nurse Practitioner) confirmed R1 sustained a left tibia and fibula fracture after falling from the bed.

R1's hospital After Visit Summary dated 1/27/21 documents R1 with a diagnosis of left tibia and fibula fractures.

The facility policy Bed Positioning, dated 2/2019, documents when turning a resident from their

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S9999	Continued From page 3 back to a sidelying position move the resident so that when the resident is turned they are lying in the middle of the bed. "B"	S9999		