DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUILDING		G	R	
		14G077	B. WIN	IG			8/2007
NAME OF PROVIDER OR SUPPLIER SEGUIN RCA HARVEY HOUSE				33	EET ADDRESS, CITY, STATE, ZIP CODE 309 SOUTH HARVEY AVENUE ERWYN, IL 60402		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
{W 154}	rule out neglect, no between the fall and visit resulting in the fracture. The facility that E2 investigated during this time per FINAL OBSERVAT LICENSURE VIOLATION STATE VIO	exither verified that he did not r did he look at the time d the Emergency Department diagnosis of closed left radial v did not provide any evidence d R5's lack of pain medication iod. IONS ATION esident Care Policies have written policies and ing all services provided by hall be formulated with the administrator. The policies of the staff, residents and the en policies shall be followed in y and shall be reviewed at health Services provided all services necessary to dent in good physical health. In the provide immediate health needs of each resident fessional nurse or a licensed he equivalent.	{W 1				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUI	LDIN	IG	R	
		14G077	B. WIN	1G _			8/2007
	ROVIDER OR SUPPLIER	E		3	REET ADDRESS, CITY, STATE, ZIP CODE 309 SOUTH HARVEY AVENUE BERWYN, IL 60402		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
{W9999}	or agent of a facility resident. b) A facility employ aware of abuse or immediately report administrator. d) A facility administrator. d) A facility administrator who becomes awaresident shall also in Department. These Requirement by: Based on record refailed to implement prevent neglect for with medical needs started exhibiting situouched on her left Emergency Department who was concerned touched on 12/11/0 closed left radial frafficial fragrangement from the profound Mental Reference of 1 profound Mental Reference of	ee, administrator, employee of shall not abuse or neglect a shall not abuse or neglect a shall not abuse or neglect a shee or agent who becomes neglect of a resident shall the matter to the facility strator, employee, or agent re of abuse or neglect of a report the matter to the strator the matter to the sample (R5). R5 fell on 12/5/06 and igns of not wanting to be arm. R5 was taken to the ment for x-ray by her mother diabout her not wanting to be 16. R5 was diagnosed with a acture. The strator of the strator than the sample of the strator of the s	{W99	99}			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION NG	(X3) DATE SU COMPLE	ATE SURVEY OMPLETED	
		14G077	B. WIN				R 8/2007	
NAME OF PROVIDER OR SUPPLIER SEGUIN RCA HARVEY HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 3309 SOUTH HARVEY AVENUE BERWYN, IL 60402			<i>3</i> 2301	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		(EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
{W9999}	Left arm sore to tou Emergency Departs closed radial fractu R5 to go to orthope be applied." The incident report nurse assessed R5 mom's decision for sore arm" The 12 reviewed. It docum- right knee after a fa direct result of anot while she was walk nursing it documen right knee with n/s (Applied cool pack a nose for bleeding. I cleansed nose with time." E5, Program Mana 1/11/07 at 3:34pm. two days after R5 for touch her arm. She chest. It didn't look redness on the fore kept noticing that si from the left to right right hand. R5 was hand (prior to the fa reported her observ answered, "I report looks like her arm is maybe on the seco	Report) done to reflect fall. Inch. R5 taken to the ment. X-ray done: revealed a re. Ace bandage applied, and redic in the morning for cast to further documented, "This this morning and agreed with client to be evaluated for left /5/06 incident report was ented, "R5 has an abrasion on all, also a nose bleed as a her client grabbing her ankle ing causing her to fall." Under ted, "Cleansed abrasion on (normal saline), no bleeding. and slight pressure to bridge of Minimal amount of blood, water, no bruising at this ger, was interviewed on E5 stated, "I noticed about tell that she won't let anybody would hold it close to her swollen to me, but there was tearm. R5 is left handed, and I he was transferring her food at then eat and drink with her always eating with her left fall)." Surveyor asked if E5 vations to the nurse. E5 ed it to the nurse that R5 is hurting, I probably reported it and or the third day (after the ne nurse looked at it and	{W99	99}				
	noted that she does	sn't want anybody to touch; must be in pain but not in too						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION NG	COMPLE			
		14G077	B. WI	NG _			R 8/2007		
NAME OF PROVIDER OR SUPPLIER SEGUIN RCA HARVEY HOUSE				3	REET ADDRESS, CITY, STATE, ZIP CODE 3309 SOUTH HARVEY AVENUE BERWYN, IL 60402	,	0,200.		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
{W9999}	reported it to." Survidocumented her obadded, "I probably daily report log)." The daily report log were reviewed. It dentries on R5: 12/5/06 - no mention 12/6/06 - took a fall bridge of nose. No abrasion. 12/7/06 - R5-has sarm swelling or red 12/11/06 - R5-mon There were no report 10, 2006. The facility documentation regards as change in behavior of December with orders for: Ibut day as needed and times a day as needed and times	emember which nurse I reyor then asked if E5 reservations anywhere. E5 didn't put it in there (in the state of the state	{W99	99)					
	me that morning (1) the radial artery. R5	2/7/06), there was a bruise by 5 let me look at it and touch it. acing or pulling her hand							

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	E CONSTRUCTION (X3) DATE SU COMPLE		
		14G077	B. WIN	IG			⊰ 8/2007	
NAME OF PROVIDER OR SUPPLIER SEGUIN RCA HARVEY HOUSE			•	3	REET ADDRESS, CITY, STATE, ZIP CODE 309 SOUTH HARVEY AVENUE BERWYN, IL 60402			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
{W9999}	hands folded and wrather would sit on asked E4 when sta answered, "Maybe added, "(12/11/06) touch her hand. Mosomething was bro Z1 was interviewed 9:32am. Z1 stated, holding her arm. The visiting R5 and saw (staff) said she has (staff) that I will be Emergency Departic confirmed that on 1 emergency department was the first time the When I got there Sowith R5's arm, staff sprain." Z1 further a should have taken Department when is it was nothing, especially and the should have taken be a should have ta	that she walked with her rould not sit on the couch but the chair." Surveyor then ff noticed that change. E4 that afternoon (12/7/06)." E4 R5 was not letting anybody m was concerned if ken." via phone on 1/16/07 at "I was concerned that R5 was at Sunday (12/10/06), I was her holding her arm and they been doing that. So I told her coming back to take her to the ment on Monday." Z1 then 2/11/06, she took R5 to the nent. Z1 added, "That Sunday at I saw R5 after her fall. unday and was concerned told me, maybe R5 had a added, "I just thought that they her to the Emergency thappened rather than saying ecially for non verbal clients." ger, was interviewed on E3 stated "R5 won't let you e would favor her other hand." when he noticed this. E3 I noticed it after she fell. I he fell, They (staff) just told me	{W99	99}				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		14G077	B. WIN	IG _			R 8 /2007
NAME OF PROVIDER OR SUPPLIER SEGUIN RCA HARVEY HOUSE				3	REET ADDRESS, CITY, STATE, ZIP CODE 3309 SOUTH HARVEY AVENUE BERWYN, IL 60402		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
{W9999}	Investigating Stand defined neglect as adequate medical or maintenance, which mental injury to an deterioration of an imental condition." The facility's job de documents the follow "Is responsible to produce as specificated and procedures and procedures and procedures and procedures and procedures and elementation of nur department and agree petermination of status. Identification a actual/potential proprofessional, QMRI members"	and Neglect:Reporting and ard Operating Procedure "The failure to provide or personal care or a failure results in physical or individual or in the individual's physical and scription for the nurses owing: rovide nursing and necessary Agency participants receiving and by current agency policies applicable regulations. Islude: Ising care in accordance with ency standards including: In individual participant health and communication of blems to designated medical P, participant, and family implement their policy when they failed to seek	{W99	99}			