STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145039	A. BUILDING _____ B. WING _____	C 05/20/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE AT PEORIA	**5600 GLEN ELM DRIVE PEORIA, IL 61614**

(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) COMPLETION DATE
F9999	Continued From page 29 LICENSURE VIOLATION 300.1210 a) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must 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 assessment and plan of care. 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. This REGULATION is not met as evidenced by: Based on record review, interview and observation, the facility failed to follow their own assessment and care plan for assistive device (alarmed self-releasing seat belt) for 1 of 1 high fall-risk residents. R6 slipped out of wheelchair onto the floor and was found in front of the wheelchair with the seat belt around her neck. R6 was pronounced dead at the time of the incident. Findings include: Incident Report of 4/22/08 outlines "Res. (resident) noted halfway on floor from w/c (wheelchair). Head on w/c sit (sic). W/c belt on around res. (resident's) neck. Res. (resident's) neck bent to left side." Nurses Notes 4/22/08 6:30 p.m. outline "CNA (Certified Nursing Assistant) came to me said you have to come right now. I ran to rm (room) ... found res.	F9999		

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(resident) strapped to w/c. Head/neck held by w/c belt. Body slid out of w/c. I called other nurses to help perform CPR (cardiopulmonary resuscitation), later found DNR (do not resuscitate) on res's (resident's) chart." Nurses Notes 4/22/08 6:35 p.m. state "Res. (resident) pronounced dead by 3 other nurses." The incident report and the Nurses Notes were documented by E16 (Licensed Practical Nurse/LPN).

Z8 (Coroner) was interviewed at 3:35 p.m. on 4/30/08 and stated that cause of death was not yet available. Z8 did state that R6 had a visible abrasion on the side of her neck.

In an interview on 5/12/08 11:18 a.m., E14 (CNA) said that she saw (R6) in her wheelchair at the nurses station talking to another resident on 4/22/08, "6:00 - 6:15 p.m." E14 continued that "At approximately 6:30 p.m." E14 came out of a resident's room when she heard E15 (CNA) page the nurse, E16. "(E15) motioned for me to come and said 'It's (R6).' I said 'What's the matter with (R6)?' (E15) said '(R6) is dead.' I said 'How do you know that?' (E15) said, 'She looks like it.'" E14 continued "Nurse (E16) and I entered Room ... at the same time. Resident sat on the floor with the seat belt around her neck. The seat belt was not undone. The new pressure relieving cushion did not move from the seat area of the wheelchair."

E15 (second shift CNA) was interviewed 5/15/08, 2:00 p.m. E15 said, "I got (R6) up from her nap and placed her in the Hospice wheelchair. The wheelchair had a snap belt. (In order to release the belt, top and bottom devices need to be pushed down at the same time.) I don't think it

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was alarmed nor was there another alarm on the wheelchair. I had not seen (R6) open the snap belt...." "After the evening meal... I pushed (R6) and other residents' wheelchairs into the hallway. I went on break afterwards. I was looking for (R6) after I came back from break because I had rooms ... to ... and I always do my residents in order. (R6) was the next one up. I looked down the halls and in the dining room and did not see her; then I went from room to room. When I came to Room ..., I saw the back of a wheelchair and went around to see who was in it. (R6) was on the floor sitting in front of the wheelchair with the seat belt on one side of her neck. I don't think the seat belt was unfastened."

According to the Physician Order Sheet for April 2008, R6 was an 89-year-old resident with left hip fracture, left shoulder soft tissue injury, and mild dementia, among other diagnoses.

Latest Minimum Data Set of 4/2/08 outlines that R6's cognitive skills for daily decision making were "moderately impaired," and that resident needed physical assistance by one person for transfers, walking and eating.

Latest Fall Care Plan, dated 4/9/08, outlines "At risk for falls due to hx (history) of falls, DM (diabetes mellitus), mild dementia, HTN (hypertension), urinary incontinence. (R6) removes all of her safety devices and slides herself to the floor from the w/c (wheelchair) and the bed." Interventions, among others, are "Seat belt with alarm while in w/c." The initiation date is listed as 10/17/07.

Review of Dietary Progress Notes showed that R6 weighed 150.7 lbs. 10/1/07; 115 lbs. 3/17/08;

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F9999	Continued From page 32 and 111.4 lbs. 4/14/08. Uniform Do-Not-Resuscitate (DNR) Order Form, signed 3/26/08 by health care power of attorney was found in R6's medical record. Interview with E17 (Registered Nurse and Special Care Unit Coordinator) took place 5/13/08, 9:15 a.m. E17 said that R6 had numerous falls, would slide out of the wheelchair "with her buttocks on the floor." E17 continued "Resident ambulated well in the beginning; later (R6) was too weak, could do 5 - 6 steps only. She always needed staff assistance to ambulate." E17 went on that resident was capable of undoing the seat belt from the beginning until the day of the incident. Therefore, facility started using the alarmed seat belt. Facility also started using the pressure sensitive pad under the cushion, which sounds when resident gets up. "On the day of the incident, resident undid the seat belt during breakfast and dinner (the midday meal), standing up saying things like 'I want something to eat,' 'I want something to drink.'" On 5/13/08, 1:30 p.m., E17 acknowledged that the Hospice had supplied a wheelchair that did not have an alarmed belt. "It (the wheelchair) was accessible to staff since we have no place to lock it up. I have never seen her (R6) in it." Interview with E20 (first shift Licensed Practical Nurse / LPN) took place 5/13/08, 10:50 a.m. E20 said that R6 "was confused, but could tell me if she had a pain and where it was." E20 continued that R6 also "had conversations with her daughter. Resident always liked to lie down. Toward the end, she was weak, did not want to eat and talked about her mother. At that time,	F9999		

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F9999	Continued From page 33 resident had lost much weight." E20 said that R6 had 2 wheelchairs towards the end: the facility wheelchair with alarmed Velcro belt that resident could take off at will and the Hospice wheelchair with a buckle seat belt. "I remember the facility wheelchair better because that's what we used on my shift. When (R6) undid the Velcro seat belt, the alarm went off. (She did not have to get up.) Before she got weak, (R6) got up many times after releasing the belt, wanting to go to the toilet, wanting to lie down, wanting a cup of coffee, etc. Even towards the end, (R6) still got up from the wheelchair, but not as often." E20 stated on 5/13/08, 1:38 p.m., that the Hospice wheelchair did not have an alarmed belt and that the wheelchair was accessible to staff. E18 (first shift Certified Nursing Assistant/CNA) was interviewed 5/13/08, 10:00 a.m. E18 said, "During the last 2 weeks, resident was in bed much during first shift. At meal times, we got her up last and put her to bed as one of the first ones...." "When (R6) was well, her Velcro belt restraint alarm went off regularly. Resident thrust her body forward; Velcro became loose and it alarmed." E19 (CNA) was interviewed 5/13/08, 10:20 a.m. E19 said "(R6) had an alarmed seat belt restraint toward the end of her stay. She could undo it and did so regularly. The alarm would go off when she undid it. Usually, resident stood up, then sat back down. Usually, (R6) said 'I want to lie down.'" Z7 (Hospice Registered Nurse) was interviewed	F9999		

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F9999	Continued From page 34 5/13/08, 2:05 p.m. Z7 said that Hospice wheelchair had been delivered 3/31/08. "It was a standard wheelchair: 18 inches with front anti tippers and seat belt. Our policy is that we do not supply alarms with the seat belt. It is up to the facility to provide the alarms. I saw resident in this wheelchair at least 3 times during the 6 visits I made after delivery of the wheelchair." E14 (second shift CNA) was interviewed 5/12/08, 11:18 a.m. E14 said that "(R6) generally moved the wheelchair all over the Unit, including other residents' rooms. The (Hospice) seat belt had a buckle, but (R6) could not undo it. Resident complained of the seat belt, saying "Will you take this thing off me?" "...When (R6) sat in the wheelchair upright, the seat belt was around her waist. Sometimes she would stretch her legs and the seat belt was above her waist. I have never seen the seat belt as high as directly under her breasts." During 5/13/08, 2:30 p.m. interview, E14 said that the "Hospice wheelchair was used on second shift regularly because (R6) was more comfortable with the new pressure relieving cushion. I don't think this wheelchair had any alarms on it. (R6) could not undo the seat belt buckle, and there was no pressure sensitive pad under her cushion. On 4/22/08 second shift, all 3 CNAs checked all residents' alarms (in Special Care Unit) as soon as we started the shift, approximately 2:15 p.m. As I remember, the only alarm for (R6) was on her bed. (R6) was in her Hospice wheelchair when found later." Surveyor tried to make observations of the alarmed Velcro seat belt and the Hospice snap seat belt as well as the wheelchairs. Several	F9999		

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F9999	Continued From page 35 staff, including E1 (Administrator) and E2 (Director of Nurses/DON) said that there are no restraints at the facility, that they would have to get restraints from a sister facility. On 5/15/08, approximately 1 p.m., E2, showed surveyor a still-packaged Velcro seat belt without an alarm. This Velcro seat belt could be easily undone by placing one hand on the left and the other hand on the right end and pulling the 2 ends apart. During 5/15/08 2 p.m. interview, E15 (CNA) identified the snap belt as a restraint the ends of which snap together. E15 pointed to a similar restraint located on the back of a wheelchair. In order to release the belt, top and bottom devices needed to be pushed down at the same time, which may be difficult to figure out for a resident with moderately impaired cognition such as R6. The wheelchair that was identified by E2 as R6's Hospice wheelchair had anti-tip bars in front and a thick cushion in the seat area. When asking E15 whether this was R6's wheelchair, E15 was not sure. (A)	F9999		