

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145087</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/16/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>MANORCARE OF OAK LAWN WEST</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>6300 WEST 95TH STREET</b> <b>OAK LAWN, IL 60453</b>		
(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	
F 309	Continued From page 5  Interview with E2 (nurse) about the 11/20/11 incident. E2 stated, "As identified on the 11/21/11 employee discipline E11 employee was rendering care independently in bed, patient (R5) is identified as a two person bed mobility. As a result patient (R5) reached beyond p ___ p ___ and fell to floor; 911 first aid rendered. Patient (R5) was to be cared for by two people while rendering care to a patient in bed. One person on each side of the bed while patient was being changed."	F 309			
F9999	According to hospital records, on 11/20/11 one of the diagnosis was Forehead Laceration and a 11/21/11 indicate Subarachnoid Hemorrhage. FINAL OBSERVATIONS  LICENSURE VIOLATION:  300.1210b) 300.1210d)6) 300.3240a)  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.  d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following	F9999			

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F9999	<p>Continued From page 6 and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These regulations are not met as evidenced by the following:</p> <p>Based on record review and interview, the facility failed to provide the necessary assistance for one of seven sampled residents (R5) in accordance with the plan of care, by failing to obtain assistance from another staff with resident care.</p> <p>Findings include:</p> <p>R5 is a 85 year old with a diagnosis which include Muscle Weakness.</p> <p>On 11/20/11 at 10:40am, E11 reported to the charge nurse that R5 fell on the floor during patient care washing. Stated R5 was turned, reached out hand, then R5 rolled out of bed. R5 on left side of bed on the floor, laying on R5's right side. Bleeding noted from right side of head, ice applied.</p> <p>At 10:45am, 911 called. 11/20/11 admitted to</p>	F9999			

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

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FORM APPROVED  
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F9999	<p>Continued From page 7</p> <p>hospital with diagnosis of Hemorrhagic Contusion, according to nurse's notes.</p> <p>Per review of R5's clinical care profile, R5 is usually a two person assist with extensive level of assistance.</p> <p>An incident report dated 11/20/11 at 10:40am stated, CNA (E11) performing ADL (activities of daily living) and states patient reached out and rolled off side of bed. Assessment completed. First aid provided. Patient left in position till 911 arrived, to hospital per 911.</p> <p>An employee warning notice dated 11/21/11 stated, "Employee (E11) was rendering care to R5 while in bed. R5 identified as two person bed mobility per the PIW and POC (plan of care). Care was rendered independently and patient was turned away from employee (E11) resulting in patient rolling from bed to floor." Description of counseling received by employee, "B-6 comply with all health and safety standards including infection control and not commit unsafe conduct or acts which result in minor injury to self or others."</p> <p>Unable to interview E11 because E11 is no longer employed by the facility.</p> <p>Interview with E2 (nurse) about the 11/20/11 incident. E2 stated, "As identified on the 11/21/11 employee discipline E11 employee was rendering care independently in bed, patient (R5) is identified as a two person bed mobility. As a result patient (R5) reached beyond p ___ p ___ and fell to floor; 911 first aid rendered. Patient (R5) was to be cared for by two people while</p>	F9999			

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