STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145740	A. BUILDING ______ B. WING ______	02/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER OF ELGIN	134 NORTH MCLEAN BOULEVARD ELGIN, IL 60121

(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 497	Continued From page 28 of employee personal files and facility inservice tracking system.	F 497		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210b) 300.1210b)2) 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 and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 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 regulations are not met, as evidenced by the following: Based on record review, interview and observation the facility failed to assure pain medication was available for one resident (R12)	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145740	A. BUILDING ______ B. WING ______	02/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER OF ELGIN	134 NORTH MCLEAN BOULEVARD ELGIN, IL 60121

(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	F9999		

who had been assessed as experiencing high levels of pain and failed to provide and utilize lymphedema pumps as ordered by the physician.

This failure led to (a) R12 experiencing pain at a 7 (on a scale of 1-10) following therapy and while in dialysis.

This is for one of 6 residents (R12) in the sample who has pain.

Findings include:

Review of admitting full Minimum Data Set (MDS) dated 2/10/12 shows R12 is 72 years old, alert and oriented to all spheres with diagnosis including ESRD (end stage renal disease), lymphedema, venous insufficiency and receives dialysis. This MDS triggered Care Area Assessment to include Pain. The facility did not conduct an assessment to address his pain.

On 2/21/12 E3 (nurse) entered R12's room to pass his midday medications at 11:10am. R12 asked E3 "What about the pain pill I requested over an hour ago?" E3 told R12 he does not have any pain meds available and he (R12) would have to wait until later tonight to get it, when pharmacy delivered it. R12 stated he is having a lot of pain after physical therapy, especially in his right hip. He cannot now go sit for four hours in dialysis without the pain medication, which he is scheduled for in 20 minutes. R12 also stated he has lymphedema and his lower extremities are very painful. Surveyor instructed E3 that R12 needed to receive pain medication prior to dialysis. E3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145740	A. BUILDING ______ B. WING ______	02/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER OF ELGIN	**134 NORTH MCLEAN BOULEVARD ELGIN, IL 60121**

(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 30	F9999		

stated "It is quite a process and will take at least 20 minutes." E3 obtained the "contingency box" which she stated contained emergency medication but would have to get clearance from pharmacy by way of a combination to open the lock. This would be obtained once pharmacy received a script from the physician for the narcotic. At this point, E3 stated she had to leave the facility. E2 was notified of the situation and went into R12's room and said: "We talked about this the other day. There have been congressional hearings about the laws the DEA (drug enforcement agency) passed regarding obtaining narcotics in nursing homes..." R12 interrupted E2 stating that he does not care about congressional hearings, "I shouldn't have to wait until you run out of my pain medication to reorder it and in the meantime, have to lie here in pain and then go sit for four hours, still with no relief. I've been here for two weeks now and you should know that this is how I manage my pain. Some days I take two pills and other days when I'm not in dialysis, I take 1. What is so hard about that? I just can't be in that much pain while I'm sitting in dialysis." R12 told surveyor his pain was at least a 7 now.

R12 received his pain medication at 11:50am, 1 hour and 40 minutes since he first requested it from E3 after returning from therapy.

Review of R12's pain assessment dated 2/10/12 is not accurate or comprehensive. The location of R12's pain on this form states it is overall joint pain with no mention of hip or lower extremity pain (from the lymphedema) and the section on how it affects his daily activities is blank. It shows R12's pain is acute, internal and frequent,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145740	A. BUILDING ______ B. WING ______	02/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER OF ELGIN	**134 NORTH MCLEAN BOULEVARD ELGIN, IL 60121**

(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 31 presently rated at a 7 (on a scale of 1-10) with it reaching an 8 at times. Additional information is not completed on the back of this form. There is a written comment stating "prefers a pain med prior to dialysis and will request." The pain care plan dated 2/4/12 is not being followed. The goal is for R12 to ask for pain med as needed and the approach is to give pain meds as ordered and to educate with early intervention of pain medication. Neither of these approaches are followed if the facility does not have the medication available when requested and the resident has to wait 1 1/2 hours for it to be obtained and administered. Review of R12's POS (physician order sheet) contains an order dated 2/9/12 stating "To use Lymphedema pump BID." R12 was asked on 2/22/12 if he had the pumps somewhere in the room and R12 stated he did not and has not had any pumps since he was admitted on 2/3/12. E2 confirmed on 2/23/12 R12 had not been using any lymphedema pumps and said R12's wife said she was going to bring in the pumps from home but has not yet. B 300.1210d)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145740	A. BUILDING ____ B. WING ____	02/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER OF ELGIN	**134 NORTH MCLEAN BOULEVARD ELGIN, IL 60121**

(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 32	F9999		

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 regulations are not met, as evidenced by the following:

Based on observation, record review and interview the facility failed to develop and implement individualized and specific interventions including the use of call lights to prevent residents from falling and wandering out of the facility.

As a result:

- R16 who has history of falling, sustained right distal radial fracture when she was found on the floor near her bath room.

- R13 on 11/15/11 exhibited confusion and disorientation. On 11/16/11 at 2:00 pm R13's nurses notes indicated she returned to facility in a cab accompanied by the police. No one noticed when R13 wandered out of the facility. The facility did not determine the date, time, and how R13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145740	A. BUILDING ______ B. WING ______	02/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER OF ELGIN	**134 NORTH MCLEAN BOULEVARD ELGIN, IL 60121**

(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 33	F9999		

left the facility. There was a potential danger for the health and safety of R13 when she left the facility.

- On 2/1/12 R18's motorized chair tilted while he was seated in it and transported in the facility bus. R18 sustained hematoma on left leg medially below the knee; and his left shoulder had hematoma and abrasion.

- R1 sustained a fracture to right humerus and laceration to the head;

- R2 sustained a fracture to left femur of unknown origin.

Findings include:

1. The facility documented an incident indicating R16. On 6/23/11 at 8:20 am she tripped on the wheel of her electric wheel chair when she was transferring herself from the wheel chair to her bed and fell on her right side.

The incident investigation indicated diagnoses of morbid obesity, intermittent confusion, lower extremity wounds, weakness and self transfer attempt were the contributing factors for the fall. Even though the investigation indicated interventions to include room near nurses station; this intervention was not added to R16's plan of care plan until 7/24/11. The only intervention that was added to R16's fall care plan on 6/23/11 was monitor her for medication side effects.
The facility also documented an another incident on 7/23/11 at 9:00 pm staff noted R16 on floor of room near bath room with her back against edge

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145740	A. BUILDING ____ B. WING ____	02/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER OF ELGIN	134 NORTH MCLEAN BOULEVARD ELGIN, IL 60121

(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 34	F9999		

of dresser; and it appears R16 attempted get to bath room without assistance and fell. R16 was admitted to the local Hospital with diagnosis of right distal radial fracture.

Again the incident investigation indicated morbid obesity, intermittent confusion, lower extremity wounds and recent loss of independence were the contributing factors for the fall.

R16's 5/5/11 fall care plan interventions are generalized and not specific to her functional ability including her activities of daily living.

R16's 4/23/11, 6/23/11 and 7/23/11 fall risk assessment noted she is at risk for falling. The risk factors included were history of falls, ambulation and elimination status was limited, gait and balance, medications and predisposing diseases. The facility did not evaluate these risk factors in developing care plan interventions, especially the assistance required in the area of activities of daily living since her last fall.

2. On 2/23/12 at 11:00 am R13 stated she called a cab and left the facility in the morning of 11/16/11. R13 said the cab driver called the police on her and brought her back to the facility, because she did not know where she was going and had no money to pay for the cab. R13 continued to say that she had difficulty with her medications.

R13's 11/16/11 at 2:00 pm Nurse Notes noted she returned to the facility after the police had been notified by a cab driver, because she ran up the cab fare up to $50.00 and was delusional, confused in conversing with the cab driver. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145740	A. BUILDING ____ B. WING ____	02/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER OF ELGIN	**134 NORTH MCLEAN BOULEVARD** **ELGIN, IL 60121**

(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 35	F9999		

police called the facility and confirmed R13 is a resident of the facility. R13 believed she lived somewhere else. The Nurses Notes also indicated the staff examination determined that she is delusional, disoriented and paranoid. The facility sent her for acute psychiatric hospitalization.

The facility neither documented R13's wandering out of the facility on 11/16/11 as an unusual occurrence report nor conducted investigation. The facility did not determine when and how R13 left the facility or if the staff was negligent in monitoring her. The facility Director of Nurses confirmed this significant incident was not reported to the Department and had conducted no investigation.

The facility has system for the residents to sign in and out of the facility by signing release of responsibility for therapeutic home visits. The sheet the facility had on record for R13's movement in and out of the facility was not consistent for the year 2011. There was no entry to reflect R13 leaving the facility on 11/16/11. This was confirmed by the facility Director of Nurses.

On 11/15/11 R13's Psychiatry progress notes indicated she presented with new and intensified confusion. R13 was confused about recent events by asking for medication that were just given, confused to time and is talking about random past events.
On 2/23/12 at 11:00 am over telephone the Physician Assistant (Z4) stated R13 did present with the confusion, but did not think R13 would leave the building. Z4 also stated the staff should have known R13's movements in and out of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145740	A. BUILDING ______ B. WING ______	02/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER OF ELGIN	**134 NORTH MCLEAN BOULEVARD ELGIN, IL 60121**

(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 36	F9999		

Continued From page 36

facility.

On 2/23/12 at 2:30 pm E14 the Psychiatric Rehabilitation Service Counselor (PRSC) stated R13 was not in right frame of mind when she left the building on 11/16/11, her medications needed adjustment, that is why the facility sent her for emergency psychiatric hospitalization. E14 also stated she needed to be supervised closely and should have known her leaving the building.

The facility after the incident, conducted no assessment of R13's behavior of wandering out of the facility or developed any plan of care that guides the staff to monitor her.

The facility failed to monitor R13 when she wandered out of the facility on 11/16/11.

3. On 2/1/12 at 1:50 pm it was noted in R18's Nurses Notes indicating he had an accident in side the facility bus during his transportation; he bumped his left leg below the knee medially. The area was swollen, painful to touch, bleeding was minimal. At the local hospital R18 received treatment for hematoma on left leg medially below the knee; and for his left shoulder had hematoma and abrasion.

On 2/23/12 at 1:10 pm R18 who is alert and oriented stated that the bus driver did not know how to restrain his motorized chair with straps in the bus. As he was getting late for the doctor's appointment they proceeded to drive the bus without restraining his motorized chair. The driver took a sharp turn, which made R18's whellchair tip over and R18 got hit in several places on his body.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145740	A. BUILDING ______ B. WING ______	02/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER OF ELGIN	134 NORTH MCLEAN BOULEVARD ELGIN, IL 60121

(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 37	F9999		

On 2/23/12 at 3:30 pm E2, the Director of Nurses stated that when she got the call, she checked the chair in the bus and determined it was not easy to tilt the chair. E2 also stated the bus driver told her the chair was not strapped at R18's request. The facility did not conduct investigation of the incident to prevent such further occurrences.

4. Review of most recent full Minimum Data Set (MDS) dated 4/13/11 shows that R1 is 53 years old and admitted to facility on 4/9/11 with diagnosis including ESRD (end stage renal disease), stroke, hemiplegia and receives dialysis. The functional status section shows that R1 requires extensive physical assist for all mobility concerns including bed mobility. This MDS also shows that R1 is alert and oriented and speaks only Spanish. Review of Fall Risk Assessment dated 4/13/11 and monthly thereafter, shows R1 is a high risk for falls and had a fall on 5/18/11.

Review of incident report dated 10/11/11 states that R1 was helped to bed at 1:30pm by a nurse's aide who then went across the hall, heard a sound and found R1 lying on her stomach on the floor. Nurse's note dated 10/11/11 states R1 sustained a laceration to the right eyebrow and right upper arm. R1 was sent out to the ER and returned with a diagnosis of fracture to the right humerus.

Z1 (R1's family member) stated on 2/23/12 at 2:30pm (with R1 present) that the "My mom came

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145740	A. BUILDING ____ B. WING ____	02/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER OF ELGIN	134 NORTH MCLEAN BOULEVARD ELGIN, IL 60121

(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 38 here for rehab and ends up fracturing her good arm. The stroke had made her left arm pretty useless and now she can't even feed herself because she broke her good arm." Z1 translated for R1 and stated that R1 had been attempting to reach the call cord that was out of her reach on 10/11/12 and rolled out of bed, falling on the floor. Z1 stated that R1 also sustained facial bruising and a cut to her eyebrow as a result of the fall. R1 did not have the (quarter) siderails that are in place now on her bed. Z1 said that R1 complains of pain to her back often and that is why R1 was shifting herself in the chair presently and requesting to lie down. Z1 asked R1 if the pain keeps her awake at night and R1 stated "Yes." Review of the facility investigation only states that R1 was placed in bed by the CNA and when the CNA left the room she heard a noise and returned to find R1 on the floor with injury. There is no statement obtained from the resident who is assessed as being alert and oriented as to how she fell out of bed. Interview with E2 (director of nursing) on 2/24/12 at 10:45am stated that there had been no statements taken or any further investigation into this incident in an attempt to determine the cause of R1's falling out of bed. 5. Review of full MDS dated 1/24/11 shows that R2 is 83 years old, admitted to facility in November 2006 and has diagnosis including osteoporosis, dementia and dysphagia. R2 is totally dependent on staff for all activities of daily living and does not ambulate. Care plan for falls dated 1/27/10 through 10/22/11 states "potential for trauma related to decreased strength, poor sitting balance, increased weakness in upper/lower extremities.(R2) is alert, oriented to	F9999		

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) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145740	A. BUILDING ______ B. WING ______	02/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER OF ELGIN	**134 NORTH MCLEAN BOULEVARD ELGIN, IL 60121**

(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 39 her name only. Dependent for all ADL's. Oblivious to her safety needs. Assessed as high risk for falls. R2 will transfer safely with assist of two with hoyer lift." This was not achieved as R2 sustained an fracture to the femur of unknown origin sometime around 8/18/11. Observation of R2 on 2/22/12 at 2:10pm found her lying in bed. R2 was unable to answer simple questions but did maintain eye contact. Review of nurse's note dated 8/18/11 states R2's "left femur (thigh area) swollen, painful to touch, leg immobilized ... x-ray of leg ordered ... will continue to monitor." The next nursing entry is on 8/20/11 at 6pm, 2 days after observing the swollen and painful thigh, stating the xray shows a fracture to the left femur. It is unclear why there was a 2 day delay in diagnosing R2's fracture. There is no documentation indicating how staff delivered care to R2 during that time. E2 stated she did not know why there was a 2 day delay. E2 stated on 2/24/11 at 11:00am that "It looks like I didn't complete an investigation or report this to the state. I don't know what happened." The facility did not conduct staff interviews to assist in determining possible causes for this injury of unknown origin or to rule out the possibility of abuse. 6. E2 stated on 2/23/12 at 2:45pm that R5 was in a motor vehicle accident years ago leaving him a quadriplegia with traumatic brain injury. The current cognitive care plan originally dated 5/25/11 states R5 "doesn't appear to have recall after approximately five minutes. Seems to be forgetful of detailed information. Needs verbal	F9999		

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) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145740	A. BUILDING ______ B. WING ______	02/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER OF ELGIN	**134 NORTH MCLEAN BOULEVARD ELGIN, IL 60121**

(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 40 cues to help provide a general framework for orientation." Another current care plan dated 5/25/11 states R5's assessment reveals a greater than normal risk for falls related to diagnosis of quadriplegia, up in electric wheelchair. This care plan continues on stating that R5 was out of facility on Larkin Avenue on 7/1/11 at 2:00pm when he started sliding out of his wheelchair. He hit a pot hole the wheelchair tipped over. R5 complained of numbness to both wrists and left shoulder. X-rays ordered to rule out fractures. This same care plan contains an entry dated 9/21/11, 4pm, in which R4 was outside facility in his electric wheelchair, riding on the sidewalk. He hit a bumpy area on the ground and the wheelchair caused R5 to fall forward on the grass. Approaches listed on this fall care plan state "Lap belt on when up in wheelchair per resident's request and Advised resident to use the county transport when going out." These 2 approaches have not been implemented to assist in maintaining R5's safety when out of facility. When asked if R5 has been assessed for safety concerns when leaving the facility on his own in his electric wheelchair, E2 stated no, but it will be done shortly. B	F9999		