STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145674	A. BUILDING _____ B. WING _____	C 05/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEROY MANOR	**509 SOUTH BUCK ROAD, PO BOX 149 LE ROY, IL 61752**

(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 323	Continued From page 14 skid slippers and call light was not on. A plan of care intervention dated 4/30/12, documents Personal alarm to wheelchair, attach box under seat where (R2) cannot reach it. An Accident and Incident Report policy dated 10/02, documents incidents must be documented on Form NH-137 (Event Report), as well as in the Nurses Notes.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1010h) 300.1210b) 300.1210d)3) 300.3240a) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care	F9999		

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F9999	Continued From page 15 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by:	F9999		

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F9999	Continued From page 16	F9999		

Based on observation, interview, and record review the facility failed to monitor increased confusion and pain for one of three residents (R1) reviewed for falls in a sample of three. R1 complained of pain, but did not receive an x-ray until two days later. Xray documented that R1 had a fractured left humerus.

Findings include:

A Minimum Data Set dated 2/28/12, documents R1 scored eight out of fifteen on the Brief Interview for Mental Status and has diagnoses which include Fractured Humerus, Hypertension, Depression, Dysrhythmia, Osteoporosis, Fatigue, and History of Back Pain.

On 4/30/12 at 11:40 a.m., R1 was lying in bed with an immobilizer on left arm. R1 stated "it's uncomfortable and my arm hurts. I'm miserable. I don't want to eat." R1 pointed to her left upper arm to show area of pain.

On 4/30/12 at 1:05 p.m., E5 (Certified Nurse Aide) stated "I took care of (R1) on Saturday, 4/14/12." E5 stated R1 was up in her wheelchair when (E5) heard "commotion" coming from R1's room. E5 stated R1 was in the bathroom attempting to transfer to the toilet. E5 stated R1 had her left hand on the grab bar and her right hand on the doorknob. E5 stated staff applied a gait belt to R1 and gently sat her on the toilet. E5 stated R1 complained of hearing a "pop" in her arm. E5 stated a nurse was called to come assess R1. E5 stated R1 had "some pain" when the nurse moved her left arm. E5 stated that later in the day on 4/14/12, R1 was using her left arm in her wheelchair. E5 stated on 4/15/12 a nurse

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F9999	Continued From page 17	F9999		

asked if she had noticed any bruising or swelling to R1's left arm. E5 stated she had not seen any bruising because R1 was able to dress her upper body independently. E5 stated R1 did not allow staff to do a lot with her on 4/15/12 due to increased pain. E5 stated staff transferred R1 with a mechanical lift and used a bed pan on 4/15/12 due to increased pain. E5 stated R1 complained left arm pain on 4/15/12 but R1 did not remember anything about the "pop" she had heard in her arm the day before. E5 stated she did not work on 4/16/12 and when she returned to work on 4/17/12, she was told R1 had a fractured left arm.

On 5/1/12 at 12:45 p.m., E5 (Certified Nurse Aide) stated R1 had exhibited increased confusion for approximately one and a half weeks prior to the 4/14/12 incident. E5 stated R1 was saying things such as, she was out in the garden and a snake bit her and that her husband had been in visiting. E5 stated that was not usual behavior for R1. E5 stated the family, Nurses, and other certified Nurse Aides were aware of this change in condition and had been discussing it on a daily basis. E5 stated Z4 (R1's daughter) was in the facility visiting on 4/15/12 and went to the nurses station and asked E4 (Licensed Practical Nurse) what had happened to R1's left arm because she was not moving it and it was bruised and swollen. E5 stated she was at the nurses station during the conversation between E4 and Z4. E5 stated that Z2 (R1's Power of Attorney/Daughter) also came in on 4/15/12 after Z4 called and told her about R1's arm.

On 5/1/12 at 1:30 p.m., E8 (Certified Nurse Aide) stated she did not work on 4/14/12 or 4/15/12.

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F9999	Continued From page 18	F9999		

E8 stated R1 complained of specific left arm pain the morning of 4/16/12. E8 stated R1 had increased confusion for a least a week prior to 4/14/12. E8 stated R1 had really shown a decline in condition and the Nurses and Certified Nurse Aides had been discussing it.

On 4/30/12 at 12:55 p.m., E3 (Licensed Practical Nurse) stated she was standing at the nurses station on 4/14/12 when E5 (Certified Nurse Aide) asked her to come help with R1. E3 stated E5 explained to her that R1 was complaining of shoulder pain. E3 stated R1 was sitting on the toilet when she got to the room. E3 stated R1 told her she heard her arm pop. E3 stated she did not observe any swelling in the left shoulder area. E3 stated she left the room to get R1's nurse and had no further care of R1 until the following week.

On 5/1/12 at 2:25 p.m., E4 (Licenses Practical Nurse) stated that on 4/14/12 E3 reported the incident with R1 in the bathroom. E4 stated she assessed R1 and observed no swelling or bruising. E4 stated R1 complained of left arm pain but was able to move the left arm. E4 stated R1 had no apparent injuries. E4 stated she was not aware of any increase in confusion because she had not ever taken care of R1 to have any comparison. On 4/30/12 at 2:25 p.m., E4 (Licensed Practical Nurse) stated "I don't remember what I did after I left (R1's) room. If I had done something, I would have documented in the nurses notes." E4 stated R1's daughters were in on 4/14/12 and 4/15/12. E4 stated she did not recall R1 complaining of pain or talking to R1's family on 4/15/12. E4 stated "I would typically notify the Physician of any occurrence or

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F9999	Continued From page 19 change in condition." On 5/1/12 at 9:30 a.m., E2 (Director of Nursing) stated R1 has a history of vague pain. E2 stated her investigation of R1's incident of 4/14/12, showed no range of motion issues and nothing flagged the nurses that anything was wrong until 4/16/12 when the swelling and bruising to the left arm was noted. E2 stated "I was not aware of (R1's) increased confusion or I would have followed up with the nurses." E2 stated R1 did not fall on 4/14/12 so an Incident Report would not have been completed and notification would not have been required until the bruising and swelling was noted on 4/16/12. E2 stated R1's incident should be documented in the nurses notes. E2 stated when a resident has a change in condition the Physician should be notified. On 4/30/12 at 10:55 a.m., Z2 (R1's Power of Attorney/Daughter) stated she visited R1 the morning of 4/14/12 and R1 had no complaints of arm pain. Z2 stated the bathroom incident must have occurred after she left the facility. Z2 stated Z4(R1's daughter) was at the facility visiting with R1 on 4/15/12 and noticed R1's arm was bruised and swollen and R1 was complaining of pain. Z2 stated Z4 called her and reported the observation of R1's arm and the pain R1 was in. Z2 stated she went to the facility to see R1's arm and find out what had happened. Z2 stated she is R1's Power of Attorney and had not been notified of any issues with R1's left arm or any pain. Z2 stated on 4/15/12 R1's left shoulder area was twice the size of the right shoulder area. Z2 stated "(R1) was in horrible pain." Z2 stated R1 had an increase in confusion over the "past week or so" prior to 4/14/12 and R1 was extremely	F9999		

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F9999	Continued From page 20	F9999		

confused on 4/15/12. Z2 stated she was not aware of any nurse assessing R1's pain and confusion on 4/15/12. Z2 stated on 4/16/12 she attempted to contact R1's Physician to report R1's change in condition. Z2 stated on 4/16/12 the facility "finally" notified R1's Physician and he came to see (R1) and ordered an x-ray.

On 5/1/12 at 1:21 p.m., Z4 (R1's daughter) stated on 4/15/12 R1's left arm/shoulder area was bruised and swollen and R1 was in severe pain. Z4 stated she called Z2 (R1's daughter) and asked if she knew about R1's arm and what had happened. Z4 stated that Z2 was not aware of anything happening to R1's arm. Z4 stated R1 "thought I was her mom." Z4 stated she went to the nurses station and asked the nurse (name unknown) what had happened to R1's arm. Z4 stated she also reported to the nurse that R1 was extremely confused and felt like a urinalysis needed to be obtained. Z4 stated the nurse handed her a specimen cup and stated "there's the bottle." Z4 stated she collected R1's urine and returned it to the nurse. Z4 stated R1's urine looked like "iced tea." Z4 stated R1 had been more confused over the previous week. Z4 stated a nurse (name unknown) came in and looked at R1's arm but to Z4's knowledge nothing else was done by the facility on 4/15/12.

On 5/1/12 at 10:05 a.m., Z3 (R1's Physician) stated he would expect the facility to notify him if a resident was exhibiting symptoms of increased confusion or pain. Z3 stated the facility contacted him the morning of 4/16/12 regarding R1's arm pain and confusion. Z3 stated he was not aware of any problems R1 was having until that time. Z3 stated "I didn't expect (R1) to be as bad as she

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F9999	Continued From page 21	F9999		

was when I came to see her on 4/16/12." Z3 stated that when he saw R1 on 4/16/12, R1 was comfortable if there was absolutely no movement to the left arm. Z3 stated if there was slight movement to R1's left arm, she was in severe pain. Z3 stated R1 had discoloration on the inside of the left bicep and "that's when I ordered an x-ray." Z3 stated the x-ray dated 4/16/12, documented a left humerus fracture. Z3 stated the urinalysis report dated 4/18/12, documented R1 had a urinary tract infection and and antibiotic was started. Z3 stated the urinary tract infection could have caused R1's increased confusion.

R1's nurses notes dated 4/6/12 through 4/20/12 were reviewed. No nursing documentation was present for 4/14/12. E4's (Licensed Practical Nurse) nurses note dated 4/15/12, documents "writer spoke with family who requested that we do a (urinalysis) on resident to address recent increase in confusion, fax sent to (Z3-R1's Physician) asking for order." E3's nurses note dated 4/16/12, documents" (Z3) in to see (R1) today, continues to (complain of) left shoulder pain with some bruising (and) swelling present, (Z3) spoke with family and all agreed on sending resident to (Emergency Room) for x-ray and necessary treatment."

An x-ray report dated 4/16/12, documents a fracture to R1's left humerus. A urinalysis report dated 4/18/12, documents R1 had a Urinary Tract Infection.

(B)

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F9999	Continued From page 22	F9999		

300.610a)
300.1210a)
300.1210b)5)
300.1210c)
300.1210d)6)
300.1220b)3)
300.3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility,

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F9999	Continued From page 23	F9999		

with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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. Restorative measures shall include, at a minimum, the following procedures:

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

c) Each direct care-giving staff shall review and

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F9999	Continued From page 24 be knowledgeable about his or her residents' respective resident care plan. 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 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.	F9999		

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F9999	Continued From page 25	F9999		

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on observation, interview, and record review the facility failed to follow plan of care interventions and failed to implement new plan of care interventions after resident falls for one of three residents (R2) reviewed for falls in a sample of three. R2 sustained a right clavicle fracture and a laceration to the head requiring staples as a result of these falls.

Findings include:

A Minimum Data Set dated 3/20/12, documents R2 has severely impaired cognitive skills and diagnoses which include Diabetes Mellitus, Depression, Dysphagia, Difficulty Walking, Osteoporosis, Anxiety Disorder, Tremor, Hypertension, and Chronic Pain.

A Fall Risk Assessment dated 3/20/12, documents R2 scored 18, indicating a high risk for falls. A Minimum Data Set dated 3/20/12, documents R2 is unable to ambulate and requires assistance of one staff for transfers and

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F9999	Continued From page 26	F9999		

toileting needs.

The Plan of Care dated 3/29/12, documents staff are to get R2's clothes out of the closet and set them out, ensure placement of non-skid shoes prior to transfer, ensure mobility monitor is in place and functioning on bed and wheelchair, and remind R2 to use the call light.

On 4/30/12 at 10:40 a.m., R2 was up in wheelchair at bedside with an upper body immobilizer in place. R2 did not respond appropriately to questions. No type of alarm was visible on wheelchair or bed.

On 4/30/12 at 10:30 p.m., E8 (Certified Nurse Aide) stated R2 is a fall risk and requires assist of one for all transfers. E8 stated "we have to keep a close eye on her." E8 stated R2 does not cooperate with alarms and removes them. E8 stated R2 is not to be up without assistance of one and a gait belt.

On 4/30/12 at 1:35 p.m., E10 (Care Plan Coordinator) stated the floor nurses are supposed to put the new care plan interventions in place after a resident fall. The nurses are then to message E10 with what was put in place. E10 stated the care plan in the computer is up to date. E10 stated an up to date hard copy of the care plan is kept at the nurses station for the Certified Nurse Aides to use. E10 stated the fall evaluation notes are done in the computer and do not always end up on the care plan. E10 stated the fall evaluation notes are not kept where the Certified Nurse Aides have access to them. E10 stated R2 has had frequent falls and difficult to "figure out." E10 stated she has asked for advice

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(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 27	F9999		

from the Corporate office regarding R2's frequent falls. E10 stated R2 has had two recent injuries due to falls. E10 stated some of the evaluation notes are repeat interventions instead of a new intervention.
E10 stated R2's care plan could have old interventions that should have been removed.
E10 stated R2's falls are usually from attempting to stand independently.

On 5/1/12 at 10:50 a.m., E2 (Director of Nursing) stated new interventions should be put in place on plan of care after each resident fall. E2 was aware of R2's frequent falls and two recent falls with injury. E2 stated plan of care interventions that are no longer valid should be removed. E2 stated the fall evaluation notes are not accessible to the Certified Nurse Aides unless they are put on the actual plan of care.

Accident/Incident logs dated 12/1/11 through 4/28/12, document R2 fell on 12/2/12 (8:30 a.m.), 12/2/12 (7:28 p.m.), 1/3/12, 1/27/12, 2/2/12, 3/3/12, 3/12/12, 3/17/12, 3/21/12, 4/10/12, 4/12/12, and 4/27/12.

An Event Report dated 3/3/12, documents R2 had an unwitnessed fall. The Incident log dated 3/3/12, documents R2 was sitting forward in wheelchair putting shoes on. The Plan of Care dated 3/29/12, does not reflect new interventions were implemented.

An Event Report dated 3/12/12, document R2 slid out of the wheelchair. The Incident log dated 3/12/12, documents R2 was getting out of wheelchair and fell. The Plan of care dated 3/29/12, does not reflect new interventions were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145674	A. BUILDING _____ B. WING _____	C 05/01/2012

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F9999	Continued From page 28	F9999		

implemented.

An Event Report dated 3/17/12, documents R2 fell assisting self to the bathroom. The Plan of care dated 3/29/12, does not reflect new interventions were implemented.

An Event Report dated 3/21/12, documents R2 was observed on the floor with a two centimeter laceration on the back of head. R2 was transferred to the Emergency Department and required three staple to the laceration on the back of her head. The Event Report dated 3/21/12 is incomplete and does not document the details of the fall, including pain assessment, body assessment, neurological check, mental status, contributing factors or measures immediately taken. The Incident log dated 3/21/12, documents R2 was reaching for a soda on the bedside table and fell out of wheelchair. The Plan of Care dated 3/29/12, does not reflect new interventions were implemented.

An Event Report dated 4/10/12, document R2 was sitting on the side of the bed and slid off to the floor. The incident log dated 4/10/12, documents R2 stated she was sitting up and fell. The Plan of Care dated 3/29/12, does not reflect new interventions were implemented.

An Event Report dated 4/13/12, documents R2 was found on the floor. An Incident log dated 4/13/12, documents R2 stated she was hanging up her clothes and fell. Nurses notes dated 4/14/12, documents R2 continued to complain of severe pain in right shoulder and had bruising to shoulder and surrounding area. Xray report dated 4/14/12, documents right clavicle fracture.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F9999	Continued From page 29 An Event Report dated 4/27/12, documents R2 fell in the bathroom. R2 was not wearing non skid slippers and call light was not on. A plan of care intervention dated 4/30/12, documents Personal alarm to wheelchair, attach box under seat where (R2) cannot reach it. An Accident and Incident Report policy dated 10/02, documents incidents must be documented on Form NH-137 (Event Report), as well as in the Nurses Notes. (B)	F9999		