STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145650	A. BUILDING _____ B. WING _____	C 03/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALOS HILLS HEALTHCARE	**10426 SOUTH ROBERTS PALOS HILLS, IL 60465**

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F 323	Continued From page 2 R7 had a diagnosis of Cirrhosis of the Liver and Cancer of the Liver. The resident was put into hospice, 6/21/2011. At the time of the 9/4/2011 incident, R7 was taking psychotropic drugs and potent pain medication. A 7/26/11 at 10:31 hours states that R7 is noncompliant with his walker. However, no update to his care plan. 3/14/2012 at approximately 1PM, during a Daily Status report, E1 (Administrator) admitted that the resident was out of the facility for the fall of 9/3/2011. "He took himself out." R7's sister had Power over Health for the resident and should have been consulted before allowing the resident out by himself.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION: 300.1210a) 300.1210b)5) 300.1210c) 300.1210d)6) 300.1220b)2)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, 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	F9999		

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F9999	Continued From page 3	F9999		

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 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

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F9999	Continued From page 4 Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 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 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 requirements were not met as evidence by: Based on interview and record review, the facility failed to provide adequate supervision for one (R7) of 3 residents with multiple falls in a sample of 9 residents. R7 fell, 9/3/2011 resulting in a hospital emergency room visit. R7 was diagnosed with a Fracture of the right Orbital Floor, Nasal Fracture and Dental Trauma.	F9999		

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F9999	Continued From page 5 Findings Include: 1. Z1 (Sister of R7) was interviewed by telephone 2/28/2012 in the AM. Z1 was R7's POA. Z1 stated that she received a call from the facility that her brother had fallen and fracture a bone in his face. "My family had planned a picnic for Labor day (9/5/2011) and they called the day before, 9/4/2011. I talked to a CNA (E5). E5 said that she saw my brother and some other residents go out of the facility. E5 told me that my brother walked from the facility (104th & Robert's Road) down to some banquet hall passed 95th & Robert's Road. A wedding party was going on. They (wedding guest) knew that he didn't belong there because he had on his pajamas. My brother fell and they called an ambulance." During the phone interview, Z1 stated that her brother was not to leave the facility accept with staff or family. A progress note dated 9/3/11, 21:57 hours written by E4 (CNA) stated that R7 had fallen and was taken to the emergency room for treatment. Both his Physician and family was notified. E 4 could not be interviewed concerning the fall, because she no longer works for the facility. The facility submitted an incident report dated 9/5/11 that was sent to the Illinois Department of Public Health (IDPH). The incident report does not contain any information about where the fall took place; who called for an ambulance; or whether or not staff knew the resident was out of the facility. An emergency room hospital record dated, 9/4/2011, substantiates that R7 was treated for a Fracture of the right Orbital Floor, Nasal Fracture and Dental Trauma. 9/5/2011, the facility initiated a care plan for elopement for R7.	F9999		

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F9999	Continued From page 6 R7 had a care plan for falls originally dated 6/7/11. It was updated 7/21/2011 because of a fall. R7 was found on the floor in his room. R7 had misjudged where the bed was when he tried to sit down. His fall assessment for this fall states that R7 has a balance problem when walking. Previous to this fall, he had fallen 1 to 2 times in the last 3 months. A note was added to approaches, about feeling the bed with the back of his legs before sitting down. Another note was added to the resident's fall care plan, 8/23/2011. "R7 to be escorted by staff or family for walks." R7 had a diagnosis of Cirrhosis of the Liver and Cancer of the Liver. The resident was put into hospice, 6/21/2011. At the time of the 9/4/2011 incident, R7 was taking psychotropic drugs and potent pain medication. A 7/26/11 at 10:31 hours states that R7 is noncompliant with his walker. However, no update to his care plan. 3/14/2012 at approximately 1PM, during a Daily Status report, E1 (Administrator) admitted that the resident was out of the facility for the fall of 9/3/2011. "He took himself out." R7's sister had Power over Health for the resident and should have been consulted before allowing the resident out by himself. B	F9999		