STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146083	A. BUILDING _____ B. WING _____	04/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF PRINCETON	140 NORTH SIXTH STREET PRINCETON, IL 61356

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F 454	Continued From page 7 rate of two liters per minute. There were four other residents (R20, R21, R22, and R23) in the beauty shop at this time receiving hair styling services. On 4/18/12 at 8:48am, Z1 Beautician, stated that oxygen can be running in the beauty shop as long as a concentrator oxygen machine is used. On 4/18/12 at 942am, E1 Administrator, stated "I was under the impression that the oxygen concentrator being used in the beauty shop was all right". On 4/18/12 at 11:00am, E1 stated that the facilities beauty shop policy and procedure does not state anything about the use of oxygen in the beauty shop. The Facilities Oxygen Therapy Policy revised 09/08 under Safety Factors states "... Do not use electrical appliances on resident while oxygen is turned on...There must be no ...flame source used near oxygen".	F 454		
F9999	FINAL OBSERVATIONS LICENSURE FINDINGS: 300.670a) 300.670b)1)2)3)4) 300.670c)1)2)3) Section 300.670 Disaster Preparedness a) For the purpose of this Section only, "disaster" means an occurrence, as a result of a natural force or mechanical failure such as water, wind or	F9999		

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F9999	Continued From page 8 fire, or a lack of essential resources such as electrical power, that poses a threat to the safety and welfare of residents, personnel, and others present in the facility. b) Each facility shall have policies covering disaster preparedness, including a written plan for staff, residents and others to follow. The plan shall include, but not be limited to, the following: 1) All personnel employed on the premises shall be properly instructed in the use of fire extinguishers. 2) A diagram of the evacuation route shall be posted and made familiar to all personnel employed on the premises. 3) A written plan shall be developed for moving residents to safe locations within the facility in the event of a tornado warning or severe thunderstorm warning. 4) There shall be an established means of facility notification when the National Weather Service issues a tornado or severe thunderstorm warning that covers the area in which the facility is located. The notification mechanism must be other than commercial radio or television. Approved notification measures include being within range of local tornado warning sirens, an operable National Oceanic and Atmospheric Administration weather radio in the facility or arrangements with local public safety agencies (police, fire, ESDA) to be notified if a warning is issued. c) Fire drills shall be held at least quarterly for each shift of facility personnel. Disaster drills for other than fire shall be held twice annually for each shift of facility personnel. Drills shall be held under varied conditions to: 1) Ensure that all personnel on all shifts are	F9999		

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F9999	Continued From page 9 trained to perform assigned tasks; 2) Ensure that all personnel on all shifts are familiar with the use of the fire-fighting equipment in the facility; 3) Evaluate the effectiveness of disaster plans and procedures. This requirement is not met as evidenced by: Based on interview and record review, the facility failed to hold disaster drills twice annually on each shift. Findings include: Disaster drill log includes one tornado training/drill dated 2-17-12 at 1:30 PM. On 4-19-12 at 2:10 PM, E1/Administrator stated that the 2-17-12 was the only disaster drill conducted since the last survey.	F9999		

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F9999	Continued From page 10 LICENSURE VIOLATIONS 300.1210b) 300.1220b)3) 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. 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or	F9999		

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F9999	Continued From page 11 agent of a facility shall not abuse or neglect a resident. Based on observation, record review and interview the facility failed to implement interventions as planned and provide supervision in the bathroom for two of seven residents (R10, R2) at risk for falls in the sample of 18. These failures resulted in R10 sustaining a fractured elbow and R2 sustaining a laceration to the forehead which required sutures. These requirements are NOT MET as evidenced by: Findings include: 1. R10 was in a wheel chair with a tab alarm clipped to the back of her shirt at the following dates and times: 4-17-12 at 10:50 AM, 4-18-12 at 8:45 AM, and 4-19-12 at 10:05 AM. PT (Physical Therapy) recommendations for R10, dated 9-12-11, state that R10 requires supervision, verbal cueing, and demonstration, but no physical assistance to ambulate. R10's care plan includes an intervention, dated 9-16-11, of "(R10) is to ambulate with the walker and CGA (care giver assistance) in the problem titled "at increased risk for falls" and an intervention,dated 3-28-12, that states, "Stand by assist for all transfers." "Safety Event" documentation, dated 9-13-11, states that R10 slid from a WC (wheel chair) after removing a personal alarm. The documentation	F9999		

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also included "chair alarm" was the immediate measure to be taken at the time of the fall. Progress Note by E2/DON (Director of Nursing) on 9-13-11 at 3:11 PM states that (fabric to prevent sliding) would be placed in R10's wheel chair as an additional intervention.

Witness statement written by E10/RN (Registered Nurse), regarding an incident involving R10 on 10-9-11, indicates that E10 saw R10 slide out of a regular chair on to the floor. Incident investigation report regarding the incident, signed by E1/Administrator states,"CNAs (Certified Nursing Assistants) will apply (fabric to prevent sliding) to the chair when they transfer her from the wheelchair." On 4-19-12 at 2:45 PM, E1 confirmed that during the investigation of the incident it was determined that the (fabric to prevent sliding) was not transferred along with R10 from the wheelchair to the regular chair.

"Safety Event" documentation dated 10-16-11 states that R10 was sitting in rocking chair, stood up to transfer self into wheelchair, and fell. E1 stated on 4-19-12 at 2:45 PM that when R10 fell on 10-16-11 there was no personal alarm attached to R10 or the rocking chair to alert staff that R10 was attempting to transfer self.

"Safety Event" documentation dated 2-24-12 states that R10 had a fall at 2:48 AM, while going to the bathroom, and that the "Interventions-Immediate measure taken" was a bed alarm. Progress Note dated 2-24-12 at 1:40 PM, signed by E11/RN (Registered Nurse) states that R10 had a 5.5 cm (centimeter) X 3.3 cm bruise to the posterolateral L(eft) upper forearm." Progress Note dated 2-24-12 at 2:14 PM and

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signed by E2/DON states, "(R10) ambulated self to bathroom. She was observed on the bathroom floor." Care Plan problem for R10, titled "is at risk for falls..." includes an intervention, dated 9-12-11 that states, "Pressure alarm in place to bed," and an intervention dated 2-24-12 that states, "Do not leave in BR (bathroom) unattended."

Progress Note, dated 4-12-11 at 6:40 PM and written by E10/RN states, "this nurse saw (R10) walking from her bedroom towards the door without a walker and suddenly lost her balance and off to the floor."

"Safety Event" documentation dated 4-13-12 documents that R10 fell in the bathroom at 9:48 AM and that the immediate measures taken were a bed alarm and chair/wheelchair alarm. It also documents that R10 sustained bruising and a skin tear to the right elbow at that time. Progress Note dated 4-13-12 at 1:25 PM and written by E5/LPN (Licensed Practical Nurse) states, "hematoma to right elbow continues to fill with fluid and enlarge in size, resident c/o (complains of) pain to site, call place to Dr. (doctor) and order received to send to ER (Emergency Room)." Progress Note dated 4-13-12 at 4:14 PM and written by E12/LPN states, "resident returned from ER with diagnosis of right elbow fx (fracture)."

Incident Investigation Report, dated 4-13-12 and written by E7/Garden Court Coordinator states that the nurse responded to calls for help from R10 and discovered her on the bathroom floor.

On 4-19-12 at 2:45 PM, E1/Administrator

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confirmed that on the 2-24-12, 4-12-12, and 4-13-12 there were no alarms sounding at the times that R10 had falls. E1 was not sure if there were no alarms in place or if they were not functioning.

2. R2's Care Plan dated 3/1/12 notes R2 to have diagnoses to include: Dementia, Muscle Weakness, and Difficulty walking. R2's problem list on the care plan notes "Fall Risk" to be a potential problem, which was initiated on 1/24/06. A specific intervention initiated on 6/10/08 reads, "Take wheelchair out of bathroom when (R2) is in, staff is not to leave her in there alone".

R2's Nurse's Notes dated 9/24/11 at 8:07 A.M. states, "Res was on toilet, wheelchair was outside of the bathroom. CNA (Certified Nurse's Aide) came to me (Nurse) and stated that res (R2) was on the floor in her bathroom. Res had blood coming out of the left side of her forehead and a hematoma a little smaller than a tennis ball. "

R2's Nurse's Notes dated 9/24/11 at 10:20 A.M. reads, "Res just returned to facility with two sutures to the left eyebrow/forehead."

Employee Disciplinary Action form dated 9/24/11 reads, "(E9) assisted a resident (R2) into the bathroom. (R2) is a fall risk and has alarms and seatbelt. E9 left (R2) alone in the bathroom which resulted in a fall. It is our facility policy any resident that is a potential fall risk, that has alarms on is never to be left alone in the bathroom."

On 4/19/12 at 2:15 P.M. E2 (Administrator) stated that on 9/24/11, staff should not have left R2

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F9999	Continued From page 15 alone in the bathroom. E1 also stated that the employee was disciplined and inserviced. (B)	F9999		