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 _____	07/19/2012

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
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.690a) 300.1210b) 300.1210d)6) 300.1220b)3) 300.3240a) Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. 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	F9999		

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F9999	Continued From page 22 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. 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)	F9999		

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These requirements are not met as evidenced by:

Based on record review and interview, the facility failed to conduct complete fall investigations and failed to develop interventions to prevent falls for one of eight residents (R14) reviewed for falls in the sample of 16. This failure resulted in R14 falling from her wheelchair and requiring hospital treatment for Closed Head Injury and sutures.

Findings include:

According to the Physician's Order Report for 1/2012, R14 was admitted to the facility on 11/23/11 with diagnoses including Dementia, Parkinson's, Depression, Anxiety, Transient Cerebral Ischemia, and Urinary Tract Infection (UTI). The Minimum Data Set of 11/30/11 assesses R14 with memory problems and severe cognitive impairment, requiring extensive assistance for activities of daily living, and history of falls.

On 12/1/11 at 2:03pm, Nursing Progress Notes state that R14 was slumped forward in her chair, and she was put in bed. At 8:40pm that evening, "a scream was heard coming from pt's (patient's) room. Pt who had been sitting in her wheelchair was found on the floor lying on her left side. . .pt stated she bumped her head but no bruising or bumps noted. . . "

This fall was not listed on the Accident and Incident Report log provided by the facility. The

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Event Report for this date did not include any further investigation or circumstances or root cause analysis. Interventions noted on the report were rest and personal alarm.

On 12/23/11 at 3:09pm, the Event Report indicates a fall in R14's bathroom. There is no description of the incident as to what happened and the nursing progress notes do not include any information as to the fall, only after the fall. This fall is not listed on the incident log. On 7/19/12 at 9:20am, E20 (Support Services) confirmed that there is no investigation or additional information related to this fall.

On 12/25/11 at 1:40pm, Nurses Progress Notes by E4 (nurse) state "while CNA (Certified Nurse Aide) was wheeling resident down hallway, resident through (sic) her body forward. resident fell face down on the floor. When writer arrived resident was still face down with pool of blood around face. . . " R14 was sent to the hospital where she received six sutures for the laceration on the forehead. The Computerized Tomography scan showed no fractures or intracranial hemorrhage. R14 returned to the facility at 8:30pm with diagnosis of Closed Head Injury and UTI (Urinary Tract Infection).

Nurses notes on 12/28/11 states "Spoke with POA (power of attorney) regarding Fall Prevention intervention. Will evaluate resident for {geriatric} chair with tray."

The investigation file presented by the facility includes the initial report that E18 (CNA) was propelling R14 in the wheelchair with R14's feet on the footrests, when R14 "picked up her feet

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and placed them on the floor. {R14) then fell forward onto the floor hitting her head. . . ." This file did not include any additional investigation or staff interviews, only physician's notes and subsequent care.

On 7/18/12 at 2:00pm, E17 (Corporate) stated she thought she did more investigation but could not find it. E28 (Human Resources) stated at that time that she found no evidence that E18 was disciplined or counseled regarding the incident. In the closed record file were undated statements by E4 and E19 (Activity Aide). E19's statement said that "she heard {E18} tell {R14} to sit back in her chair or she would fall out. . ." Just after that E18 came up to E19 and said that R14 had fallen, and E19 found E4 to respond to the fall. The statement by E4 states that upon response R14 was on her stomach with the left side of her face on the floor, bleeding.

On 7/18/12 at 1:40pm, E4 confirmed her written statement regarding the circumstances of the fall. E4 recalls that E18 was returning R14 from the shower, and that the footrests were not on the wheelchair at that time. E4 stated R14 was confused and not able to follow directions.

On 7/19/12 at 10:00am, E22 (Corporate Rehabilitation) stated that she had evaluated R14 after the 12/25/11 fall. E22 stated they decided to put a cover over the footrests to prevent R14 from putting her feet on the floor. E22 stated that at that time E23 (previous Director of Nursing/DON) assured E22 that the footrests were on the wheelchair at the time of the fall. E22 stated that in addition to leaning forward, R14 did tend to put her feet on the floor around

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F9999	Continued From page 26 the calf rests, but E22 did not put the footrest covers in place until after the 12/25/11 fall. On 7/19/12 at 10:25am, E2 (Interim DON) stated that she also responded to the incident on 12/25/11, and that the foot rests were on the wheelchair. E2 stated that R14 had put her feet on the floor between the footrests. E2 also confirmed that R14 tended to put her feet on the floor while in the wheelchair prior to the fall. E2 stated she had made a statement for the investigation at that time, and that E2 would look for it, but no additional information was provided. The careplan includes the problem of falls dated 12/6/11, stating the R14 "is at risk for falls {related to} dementia and leaning forward in wheelchair. . . .fall from wheelchair 12/23/11, fall from wheelchair 12/25/11. The approach dated 12/26/11 states "Reclining high back wheelchair with leg board on foot pegs at all times." The remaining approaches are dated 12/6/11 and include monitoring, placing R14 at the table with wheels locked, assist with transfers, proper footwear, and clutter-free environment. The 12/1/11 fall was not addressed. Nothing is addressed regarding R14 putting her feet on the floor around or between foot rests on the wheelchair. (B)	F9999		