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F 323	Continued From page 9 reads: is 90 y/o with diagnosis of dementia. Prior she was living alone and having difficulty being safe in her home. She (R4) has short term memory loss and needing cues for getting around the building ... R 4's Fall Care Area Assessment (# 11) dated 05-01-12 reads: is at risk for fall related to gait abnormality, muscle weakness, history of fall and multiple medical problems. Review of R 4's plan of care showed no individualized plan developed for fall prevention. Interview with E 12 on 09-07-12 at 3:10 PM, E 12 said " the CNA (E 13) took the patient (R 4) in the toilet, she sat her down then the CNA took the wheelchair out (of the bathroom) the patient fell face down. " On 09-14-12 at 3:00 PM, the CNA (E 13) assigned with R 4 on 05-06-12 stated " I put her in the toilet and she fell in the toilet on (floor) face down. I work at 3-11 shifts, the patient came back from dialysis, I took her in the toilet then I took the wheelchair outside. She ' s in a wheelchair but she walks sometimes but, she needs assistance. Someone needs to be with her because she's not steady. It 's unfortunate that she fell but that was not the first time that I took her. We leave her in the toilet by herself even after dialysis. I gave her the call light so when she finish, she call then I come. After the incident they (supervisor) said I should have stayed with her (R4)".	F 323		
F9999	FINAL OBSERVATIONS FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210b)	F9999		

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300.1210c)
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. Restorative measures shall include, at a minimum, the following procedures:

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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,

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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 Regulations were not met as evidenced by:

Based on observation, interview and record review, the facility failed to:
- provide supervision to residents (R 1, R 2, R 3 and R 4) who were identified as high risk for fall and to R1, R2 and R 3 who require supervision.
- follow and consistently implement the plan of care to provide assistive devices (1) call light and chair sensor pad to R 1 and (2) to follow R 2's plan of care to use gait belt during transfer.
- develop a plan of care to address R 3's risk for fall/ accidents.

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F9999	Continued From page 12 - monitor the effectiveness of the interventions for R 1, R 2, R 3 and R 4 and to modify the interventions consistent with the resident's specific needs to prevent further falls/incidents with significant injuries. - thoroughly investigate and analyze the root causes of R 1, R 2, R 3 and R4's fall incidents to prevent continuous fall incidents. These failures resulted in: (1) R 1 sustaining additional significant injury (fracture of left femur on 09-05-12). (2) R 2 and R 3 continued to fall after R 2 sustained fracture of the lumbar area (L1) compression fracture 05-02-12. (3) R 3 sustained a right hip fracture on 05-02-12 and (4) R 4 sustained contusion on the face, scalp/neck and fracture of the left 5th finger during toileting by the staff. This is for 4 of 9 residents (R 1, R 2, R 3, and R 4) who had incidents of falls and sustained significant injuries in the facility. Findings include: (I) Review of R 1's event report dated 09-05-12 at 8:08 PM under notes reads: resident (R1) heard by CNA calling for help from her room ...observed resident sitting on the floor leaning against her wheelchair. Complained of left hip pain (verbally expressed in Spanish) ... cannot move her left lower extremity ...911 called ...resident taken to hospital for evaluation ...admitted with diagnosis of closed fracture of the left femur ... Review of the CNA (E5) statement dated 09-06-12 reads: resident did not have the call light on. On 09-07-12 at 3:00 PM, the Director of Nursing (E 1) stated " she (R1) had a fall in her room on 09-05-12. She was sent in the hospital and	F9999		

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F9999	Continued From page 13 diagnosed with fracture of the left femur. They (hospital) did an Open Reduction Internal Fixation yesterday (09-06-12). She's still in the hospital right now. Yes, she has history of falls, she needs supervision. " Interview with R 1's husband (Z1) by phone on 09-07-12 at 6:42 PM, Z 1 claimed " she (R 1) always needs help to go to bathroom but there's no help. She (R1) said she wants to go (bathroom) but can't go by herself. She is not walking very well. She broke bone in the leg so they operated yesterday (09-06-12) at 7:15 PM. She fell a lot in the nursing home. She broke bones before (01-01-12 sustained fracture of the left humerus) this year and now again ((09-05-12 sustained fracture of the left femur). They even dropped her from the machine ... " Phone interview with the 3-11 shift (PM) Supervisor (E 2) on 09-07-12 at 7:15 PM, E 2 relayed " I was the PM supervisor at the time, around 5:00 PM, I got a call from the Nurse (E 4) and said patient's (R1) on the floor. The 2 CNA's (E3 and E 6) found her on the floor. I went to the patient's room and found her sitting on the floor leaning on her wheelchair near her bed ... she was holding her left leg, she was talking to me in Spanish. The two CNA' s (E3 and E6) translated to me that she' s (R1) complaining of pain on the left leg and when she move. I instructed the nurse (E 4) to call 911. In between (while 911 were working on R 1) the husband came in. " When E 2 was asked on R 1's cognition, E 2 replied and said " she's alert X1 or sometimes 2 with confusion ... she ' s not alert. She had fall(en) before. The CNA (E3 and E 6) said she was in her wheelchair in her room at 3:30 PM. The incident (happens) was around 5:00PM; we serve dinner at 5:00 to 5:30 PM ... "	F9999		

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F9999	Continued From page 14 On 09-07-12 at 7:40 PM via phone, the CNA (E3) assigned to R 1 stated " my shift starts at 3:00 PM, I saw her (R1) at 3:30 PM she was sitting on her wheelchair in her room. We heard someone screaming for help in Spanish ... we (E3 and E6) went to her(R 1) room and found her on the floor complaining of pain in her left hip. When we asked her (R1) what happened she said she was trying to go to the bathroom and tried to walk but she cannot walk that's why she fell. " E 3 also disclosed she didn't toilet R 1 and said "I didn't toilet her when I came in (at 3:00 PM), she's incontinent. She goes to dialysis you know! She doesn't pee that much. When I came in (at 3:00 PM) I asked her if she's okay. She was sitting in her wheelchair in her room. She said she's okay! No, I didn ' t ask her if she wants to use the washroom. " E 3 also described R 1's activities of daily living and stated " she (R 1) doesn't walk. She stands up with one assist. She transfers during dialysis days (Monday, Wednesday and Friday at 6:00 AM) they (night shift) use the lift, when they bring her to her dialysis only because she's weak. But we don't use the lift on my shift. She usually goes back to bed at around 7:00 PM or 7:30 PM. " On 09-08-12 at 12:35 PM, R 1's son (Z 2) stated " the facility is negligent! First they transfer my mom (R 1) on a (mechanical) lift and they drop her. She ends up with a fracture of her arm (on 01-01-12). This recent fall (on 09-05-12) she had to use the bathroom, she didn't get help on time. She doesn't walk by herself, she needs help and she's not capable of walking by herself. Her (R 1) roommate was sleeping and heard a noise and saw mom (R 1) on the ground. It was her dialysis day, so she's weak too. They're (the facility) not fully staffed as they should be. They're very	F9999		

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F9999	Continued From page 15 caring but they need more staff. They don't put her back to bed after dialysis. Her dialysis time is at 6:00 AM, she stays sitting on her chair until bed time. They need to watch her more. " Interview with R 1's roommate (R 5) on 09-08-12 at 1:10 PM, R 5 stated " I was here half awake; when I look she was standing up. She (R1) told me she had to go to the bathroom then, she started to stumble. I heard the loud noise when she fell. I know someone fell. I'm so sorry for her because this is her second time to break her bone so we were both screaming for help. I tried to use my call light but my call light doesn't work at times. What they did (facility) is to switch it with her call light. Normally when I press my call light, there's a wait, sometimes 20 to 30 minutes. If they're real busy it's longer wait and it depends on the group (who's working) ... " R 5's call light was observed non functional. When the red button's pressed it did not light up outside the resident's room. Phone interview with E 5 (CNA) on 09-08-12 at 2:00 PM, E 5 said " I was passing by the nursing station. I was working on the other side we heard someone screaming. We went looking every where then finally we found her (R1) the patient in room 114. All of us run looking where the screaming coming from. I saw the patient (R 1) at around 3:00 PM; I didn't see her call light with her. I didn't see the call light with her before the incident." On 09-11-12 at 1:15 PM the Restorative Nurse (E 11) said "I know she fell trying to go to the bathroom by herself ... This could be possibly be prevented if she was toileted. " Review of R 1 plan of care dated 08-18-12 reads: PROBLEM: high risk for falls due to both cognitive and functional impairments. Resident	F9999		

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F9999	Continued From page 16	F9999		

safety awareness poor at times, resident fell on 03-03-12, 01-01-12 at 10:15 AM, 12-31-11 at 8:30 PM, 12-10-11 on 7-3 shift and 11-08-11 at 3:00 AM. APPROACH: (A) The resident will have the following interventions in place chair sensor pad ... (B) Call light to be kept within reach ... (E) Ensure resident is wearing visual and auditory assistive devices ... and to monitor resident closely ...

These interventions were not followed and implemented based on interviews with the following staffs: E 5 (CNA) on 09-08-12 at 2:00 PM via phone, E 5 said " I didn't see her call light with her. I didn't see the call light with her before the incident. "

On 09-08-12 at 2:15 PM, E 1 confirmed and stated " I asked the staff; they said she (R 1) didn't have her call light. " And on 09-11-12 at 2:00 PM E 1 said " she didn't have an alarm at that time. Her (R 1) chair alarm was not on, the staff told me. "

E 11 stated on 09-11-12 at 2:20 PM declared " her (R1) care plan was not updated, some interventions are not appropriate. I was backed up with my work. The end of June 2012, she was discontinued from skilled therapy. Our problem happens when she was moved (from 2nd floor to 1st floor) there was a break in communication regarding the alarm, the chair sensor pad. It didn't remain on her after the move (June 2012), it wasn't communicated that she needed a replacement. No, she didn't have her chair alarm. "

"I was passing by the nursing station. I was working on the other side we heard someone screaming, we went looking every where then finally we found her (R1) in room 114. All of us run looking where the screaming coming from. I

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F9999	Continued From page 17 saw the patient (R 1) at around 3:00 PM. On 09-11-12 at 2:00 PM E 1 confirmed and stated "she (R1) didn't have her chair alarm, the staff told me. " R 1's room was six (6) rooms' away and 37 paces from her room to the nursing station. R 1 ' s Care Area Assessment: Care Area Assessment # 11 FALL: has history of multiple falls with injury, last fall been with multiple fractures. (R1) is non -ambulatory. Has poor safety awareness, poor cognition and confused ...High risk for fall. Care Area Assessment # 5 activities of daily living's functional status/ rehabilitation potential -dated 12-28-11 reads: Requires extensive to total assist with all care needs. Is a 2 assist Hoyer lift transfer ... Care Area Assessment # 6. Urinary incontinence and indwelling catheter stated: Is incontinent of B&B, total care is provided ... Review of the facility investigation form dated 03-30-12 reads: heard somebody yelling; found resident (R1) sitting on the floor. Had pad alarm intact but not sounding off. (II) Review of the facility fall tracking log showed that R 2 had 5 incidents of fall (1) 03-19-12, (2) 04-20-12, (3) 05-02-12 diagnosed with lumbar fracture, (4) 07-09-12 and (5) 07-16-12. On 09-11-12 at 3:00 PM, the Dementia Unit Coordinator (E 8) stated " she (R2) tries to stand up (from her wheelchair) when she wants to go to the bathroom. At times she can verbalize her needs, she ' s got Dementia; she needs supervision, she has had some falls. Yes, she is high risk for falls. " A functional deficit in transfer assessment was developed for R 2, dated 04-26-12, related to generalized weakness and cognitive impairments. The plan showed an approach to apply gait belt.	F9999		

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F9999	Continued From page 18 This intervention was not followed during toileting on 09-11-12 at 3:15 PM. R 2 was observed on the toilet with a CNA (E 9). E 9 was noted to put her arm under R 2's right under arm and then grabbed and pulled R 2's pants in order to lift R 2 from the toilet. E 9 stated " she (R2) needs supervision; she tries to stand up from her wheelchair. " Review of R 2's event (incident) reports reads as follows: 1. 03-29-12 at 4:23 AM- R 2 was found on the floor sitting ...tried to get up and fell off the bed. 2. 04-26-12 at 2:53 PM -heard screaming in her room ...laying on her left side on the floor ...urine noted on the bedside mattress ...she is alert and oriented to self, confused ...complaint of pain to right elbow and her back .... 3. 05-02-12 at 3:15 PM- complaint of low back pain and difficulty walking. Was noted to have hunchback posture ...MRI result-recent benign appearing fracture involving L1 ... MRI spinal cord result findings: L1 Compression Fracture. 4. 07-09-12 at 9:35 PM -had a fall in the nursing station. Complaint of lower back pain ... 5. 07-16-12 at 3:20 PM- found sitting on the floor in the dining room ... These incidents were not thoroughly investigated by the facility. R 2's plan of care disclosed that R 2 is at risk for falls indicating that this problem has been identified by the facility on quarterly care plans of 01-03-12 on 03-07-12 and on 06-21-1. However, the facility has not revised or implemented individualized interventions based on R 2's needs to prevent further fall incidents. This was confirmed by the E 11 during phone interview on 09-14-12 at 12:05 PM, "we implemented the	F9999		

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F9999	Continued From page 19 sensor pads (care plan dated 06-21-12). " Interview with E 12 by phone on 09-14-12 at 12:55 PM, stated " Yes, she didn't make any changes. " (III) R 3 ' s event report dated 05-02-12 at 12:00 AM read: heard a noise ...found patient on the floor in sitting position next to toilet. Per patient (R 3) she ' s heading to toilet to urinate but unable to reach the toilet, she urinated on the floor and slip down ... admitted in the hospital with diagnosis of right hip fracture... On 06-06-06 at 1:11 PM R 3 ' s event report showed found crawling out of bed. Found kneeling on the floor ...had removed her clothing and had been incontinent of stool ... Review of R 3 ' s plan of care dated 01-21-12 reads: has a memory/recall problem related to diagnosis of Dementia. Needs repeat communication to ensure understanding ... Review of R 3 ' s fall risk assessment dated 10-21-11 and 01-20-12 shows a score of 40. Both Director of Nursing (E 1) and E 12 confirmed score higher than 15 is considered high risk. R 2's incidents of falls were not thoroughly investigated and there were no plans of care developed to address R 3's risk for fall until 08-07-12. This was confirmed by E 1 by phone on 09-12-12 R 3 ' s Fall Care Area Assessment dated 05-14-12 reads: at risk for fall related to weakness secondary to right hip fracture, s/p Open Reduction Internal Fixation, history of fall ...Dementia and gait disorder ... IV. Review of R 4 ' s event report dated 05-06-12 at 8:57 PM and Investigation form reads: called by the CNA (E 13) resident (R4) is on the floor, face down. CNA said she	F9999		

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F9999	Continued From page 20 "transferred the resident from the wheelchair to toilet and she turned around to push the wheelchair out of the toilet". She (E 13) heard the noise and found her (R 4) on the floor ...noted bump on the right side of brow, laceration on the nose bridge, bruise on the right peri orbital area ... R 4 ' s progress note dated 05-07-12 at 4:32 AM showed: Back from hospital diagnosed with facial/scalp contusion and left finger fracture ... R 4's Cognitive Care Area Assessment (#2) reads: is 90 y/o with diagnosis of dementia. Prior she was living alone and having difficulty being safe in her home. She (R4) has short term memory loss and needing cues for getting around the building ... R 4's Fall Care Area Assessment (# 11) dated 05-01-12 reads: is at risk for fall related to gait abnormality, muscle weakness, history of fall and multiple medical problems. Review of R 4's plan of care showed no individualized plan developed for fall prevention. Interview with E 12 on 09-07-12 at 3:10 PM, E 12 said " the CNA (E 13) took the patient (R 4) in the toilet, she sat her down then the CNA took the wheelchair out (of the bathroom) the patient fell face down. " On 09-14-12 at 3:00 PM, the CNA (E 13) assigned with R 4 on 05-06-12 stated " I put her in the toilet and she fell in the toilet on (floor) face down. I work at 3-11 shifts, the patient came back from dialysis, I took her in the toilet then I took the wheelchair outside. She ' s in a wheelchair but she walks sometimes but, she needs assistance. Someone needs to be with her because she's not steady. It 's unfortunate that she fell but that was not the first time that I took her. We leave her in the toilet by herself even after dialysis. I gave her	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145819	A. BUILDING ______ B. WING ______	C **09/18/2012**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAREMONT REHAB & LIVING CTR	**150 NORTH WEILAND ROAD BUFFALO GROVE, IL 60089**

(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 21 the call light so when she finish, she call then I come. After the incident they (supervisor) said I should have stayed with her (R4)". (B)	F9999		