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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145936 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 02/01/2013 |
| NAME OF PROVIDER OR SUPPLIER HIGHLAND PARK NURSING & REHAB | | | STREET ADDRESS, CITY, STATE, ZIP CODE 50 PLEASANT AVENUE HIGHWOOD, IL 60040 | | |
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| F 323 | Continued From page 3 R2's careplan but she did lower R1's bed to the lowest position and switched on the bed alarm when she was asked about them. E1 also stated R1 understands a little English but does not use the call light. | F 323 | | | |
| F9999 | FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210b) 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. 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: | F9999 | | | |

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| F9999 | <p>Continued From page 4</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY:</p> <p>Based on observation, interview and record review the facility failed to adequately supervise R2, 1 of 3 sampled residents reviewed for falls. This failure resulted in R2 falling out of bed and sustaining a right hip fracture.</p> <p>Findings include:</p> <p>According to the medical record R2 is a 76 year old female who was admitted to the facility on 10/19/12 for rehabilitation due to a left hip fracture after a fall at home. R2's other admitting diagnoses include Coronary Artery Disease, Carotid Artery Stenosis and Arthritis. R2 is Polish speaking and understands very little English.</p> | F9999 | | | |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F9999 | Continued From page 5 A fall risk observation dated 10/19/12 placed R2 at risk for falls. R2 was also triggered for falls in the initial MDS (Minimum Data Set) dated 10/31/12. Review of facility incident/accident reports contained the following: On 10/29/12 at 9:30am R2 was found on the floor of her room next to the bed lying on her right side. No apparent injury noted. The incident was unwitnessed. On 10/29/12 at 9:30pm R2 was again found on the floor in her room next to the bed. No apparent injury and the incident was unwitnessed. R2's careplan for falls dated 10/30/12 (after the first two falls) lists the following interventions: Observe, record and report unsafe conditions and situations. Encourage resident to ask for assistance, instruct resident on use of adaptive equipment. Place stuffed animal on call light to increase resident's ability to find cord. Bed pad alarm. Bed in lower locked position. On 11/06/12 at 4:40am R2 was found on the floor of her room. R2 communicated to staff that she was trying to go from her bed to the wheelchair when she fell. R2 did not use the call light. This fall was unwitnessed by staff. R2's careplan update after the fall of 11/06/12 lists the following interventions: Nurses, encourage resident to ask for assistance, especially at night. Staff to offer toileting assistance every two hours. | F9999 | | | |

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| F9999 | <p>Continued From page 6</p> <p>There was no follow up documentation in the incident report or the careplan of the use or effectiveness of the bed pad alarm, the stuffed animal or other interventions listed in the careplan.</p> <p>On 11/08/12 at 7:20pm R2 was again found on the floor of her room by the bathroom. On assessment R2 complained of pain to her right hip and right lower leg. An x-ray was ordered and R2 was transferred to the hospital with a diagnosis of right hip fracture. There was no mention in the record of the use or effectiveness of R2's bed alarm, the position of the bed or the other interventions already in place. This fall was also unwitnessed.</p> <p>On 12/01/12 at 4:00pm R2 was again found on the floor of her room. The incident report noted, "unable to provide teaching due to some confusion and language barrier. Call light system provided."</p> <p>E2, DON (director of nursing) who is also the MDS coordinator was asked on 02/01/13 why R2 was left unsupervised in her room after multiple unwitnessed falls while in bed. E2 stated the family is in the facility a lot and often visit with R2 in her room. We asked them to let the staff know when they leave so we can make sure R2 is closer to the nurses station.</p> <p>There were no further fall prevention interventions listed in the careplan after the fall of 11/08/12. There was also no evaluation of the effectiveness of previous interventions.</p> <p>On 02/01/13 at 10:30am R2 was observed alone</p> | F9999 | | | |

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| F9999 | Continued From page 7 in her room. She was lying in bed with a half siderail in place. The bed was not in the lowest position. R2's bed alarm was in place but the switch was turned off and there was no stuffed animal near the call light. E1, LPN (licensed practical nurse) was asked about R2's careplan interventions for falls. E1 was unable to produce R2's careplan but she did lower R1's bed to the lowest position and switched on the bed alarm when she was asked about them. E1 also stated R1 understands a little English but does not use the call light. (B) | F9999 | | |