STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145893	A. BUILDING _____ B. WING _____	C 11/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF PALOS HEIGHTS WEST	**11860 SOUTHWEST HIGHWAY PALOS HEIGHTS, IL 60463**

(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
F 323	Continued From page 3 According to R1's hospital record dated 10/31/2012, a Computed Tomography (CT) scan indicated extensive left sided frontal and periorbital hematoma, edema and a non-displaced right C1 lateral mass fracture. Z1, Medical Doctor, stated on 11/28/2012 at 11:20 AM, " (R1) is alert and oriented, no question about that, she is with it. (R1) can be demanding at times and is attention seeker. Has history of Depression but the subdural hematoma that (R1) sustained is from the fall when she hit her head. However the fracture is hard to say."	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by	F9999		

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F9999	Continued From page 4 written, signed and dated minutes of such a meeting. 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 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. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to follow their gait belt policy and care plan for transfers, for 1 of 3 residents (R1) reviewed for transfers in a sample of 3. This failure resulted in R1 falling face first to the floor, R1 was transported to the hospital and assessed and treated for a subdural hematoma. Findings include:	F9999		

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F9999	Continued From page 5	F9999		

R1 was admitted to the facility 2/5/2012, a review of the plan of care initiated 2/6/2012 notes to use gait belt to facilitate safe transfer. A review of R1's minimum data set dated 8/2/2012 section G/Functional Status notes that R1 requires extensive assistance from staff for balance and transfers and that staff are required to provide weight bearing support, one person physical assist.

According to the facility incident report dated 10/31/2012, R1 was being assisted by facility staff Z2, Certified Nurse Aide (CNA), while ambulating. R1 was about to be transferred from the wheelchair to the bed, as the certified nurse aide locked the wheelchair R1 leaned forward fell hitting her forehead on the floor.

Interview with R1 on 11/28/2012 at 10:30 AM, R1 stated, "was walking in my room and the girl (Z2) let loose of the gait belt and I fell forward on the floor on my face, this happened about three weeks ago."

Review of Z2's written statement as interviewed by E5, Registered Nurse-PM Supervisor (RN) on 10/31/2012 at 9:00 PM denotes "I (Z2) started walking patient (R1) with walker after gait belt placed on patient, we walked from patient room to nursing station. I was holding patient gait belt and pulling wheelchair. Then we came back to patient room. And what happened? She (R1) walked with her walker to her bedside, she said she was ready to sit. Patient (R1) was standing with her walker I locked wheelchair and she (R1) grabbed wheelchair and she started sitting, but she leaned forward and fell to the face on floor. I was standing on right side of the patient (R1) and

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F9999	Continued From page 6	F9999		

wheelchair. I did not grab the resident nor did I grab the gait belt in time. It was very unexpected. Did you hold gait belt on patient? I did not have time, it was so quick ."

E2, Minimum Data Set Coordinator stated on 11/28/2012 at 11:10 AM that R1 needed extensive assist by one person. E2 stated the gait belt helps staff to provide support to the resident when they are transferring a resident.

On 11/28/2012 at 12:15 PM E5, RN, stated, "I was on the first floor when the second floor nurse calls me that a resident fell in her room. I went to second floor and found patient (R1) on the floor next to the bottom of her bed lying on her left side." E5 stated she instructed staff to call 911 immediately and not to move R1 but monitor R1 until paramedics arrive. E5 stated she asked Z2 what happened, and Z2 explained that R1 wanted to sit in her wheel chair and she was standing behind R1's wheel chair and locked the wheel chair. Then Z2 explained that she walked around the wheel chair while R1 was sitting down but did not have time to grab belt before the resident fell.

E1, Administrator stated on 11/28/2012 at 9:40 AM that the CNA (Z2) was suspended on first day of the fall, during the investigation. E1 stated it was determined Z2 did not use the gait belt and was fired.

Review of Z2's employee discharge notice dated 11/2/2012 denotes previous warning: "yes". Describe the action that made it necessary to prepare this notice; "Failure to follow facility policy and procedure regarding transferring patients using gait belt. 10/31/2012 while transferring a

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F9999	Continued From page 7 patient (R1), gait belt was on but employee was not holding belt, patient leaned forward and fell to floor". Review of the facility gait belt policy denotes "to safely and effectively transfer or ambulate a patient Equipment: Gait Belt, ambulate by maintaining hold on belt, lower into chair by grasping belt at patient's left and right side and bending knees as sitting occurs." According to R1's hospital record dated 10/31/2012, a Computed Tomography (CT) scan indicated extensive left sided frontal and periorbital hematoma, edema and a non-displaced right C1 lateral mass fracture. Z1, Medical Doctor, stated on 11/28/2012 at 11:20 AM, " (R1) is alert and oriented, no question about that, she is with it. (R1) can be demanding at times and is attention seeker. Has history of Depression but the subdural hematoma that (R1) sustained is from the fall when she hit her head. However, the fracture is hard to say."	F9999		