STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145999	A. BUILDING ______ B. WING ______	C 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROSSE POINTE MANOR	6601 WEST TOUHY AVENUE NILES, IL 60714

(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 7 Clinical indication- Parenchymal contusion; subdural hematoma Impression- there is evidence for a trace amount of acute extra-axial hematoma in the left temporal region. The facility's policy regarding incidents- Reportable and Non-Reportable documents: All resident falls will be assessed and the resident ' s existing plan of care will be evaluated for needed changes. The resident's Fall risk Assessment shall be reviewed and revised as needed. The resident's plan of care shall be updated if additional care interventions are necessary.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION: 300.610a) 300.1210a) 300.1210b)5) 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	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145999	A. BUILDING ______ B. WING ______	C 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROSSE POINTE MANOR	6601 WEST TOUHY AVENUE NILES, IL 60714

(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 8	F9999		

least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145999	A. BUILDING ______ B. WING ______	C 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROSSE POINTE MANOR	**6601 WEST TOUHY AVENUE NILES, IL 60714**

(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 9	F9999		

Continued From page 9

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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.

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)

These regulations were not met as evidenced by the following:

Based on record review and interview, the facility failed to provide adequate supervision and implement adequate fall prevention measures for 1 (R1) of 3 residents from the sample of 3 reviewed for falls. This failure resulted in R1 receiving a hematoma and pubic remus bone fractures.

Findings include:

R1 is a 75 year old female, originally admitted to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145999	A. BUILDING ______ B. WING ______	C 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROSSE POINTE MANOR	6601 WEST TOUHY AVENUE NILES, IL 60714

(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 10 the facility on 10/11/10, with the following diagnoses: multiple compression fractures and Opioid dependence. R1's MDS (Minimum Data Set) dated 8/17/12 (Annual), and 2/1/13 (Quarterly) documents: Walk in room- requires supervision Walk in corridor- requires supervision Locomotion on unit- requires supervision Mobility device: walker The facility's Incident reports and Investigation summary for R1 documents the following falls: R1 sustained a fall on 6/15/11 at 10:15am, while trying to get out of bed to go to the bathroom. The investigation summary documents that R1 was sent to hospital, and returned on 6/21/11 with the diagnosis of right inferior pubic remus fracture." R1 sustained a fall on 11/26/11 at 9:22pm. The report documents that R1 got up too fast, and lost her balance. R1 was able to stand and ambulate with assistance; however, the facility implemented a low bed after this fall. R1 then sustained a fall on 12/12/11, sliding off the bed. At this time the facility documented the following intervention: " Correct height of bed applied, currently on low bed with 2 mattresses." On 7/14/12, R1 sustained a fall while trying to go to the bathroom. On 11/20/12 the facility's incident report/summary documents that the Certified Nursing Assistants (C.N.A's) heard a crash, and found R1 lying next to the door and bathroom. The report further	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145999	A. BUILDING ______ B. WING ______	C 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROSSE POINTE MANOR	**6601 WEST TOUHY AVENUE NILES, IL 60714**

(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 11	F9999		

documents that R1 was bleeding from the back of her head and stated she was sleep walking. The summary of the investigation documents that the fall was attributed to medications, and R1 was just administered Dilaudid 4 mg at 10pm, Xanax 0.25mg, Wellbutrin XL 300mg and Elavil 50mg at 9pm. R1's care plan documents that the facility implemented a bed alarm, however, R1 refused the alarm.

R1's MAR (Medication Administration Record) and POS (Physician's Order Sheet) for 11/1/12 documented the following medications: Aspirin 81mg daily; Elavil 50mg at bedtime; Wellbutrin XL 300mg at bedtime; Gabapentin 300mg 4 times daily; Xanax 0.25mg at bedtime; Dilaudid 4 mg every 8 hours as needed; and Xanax four times daily as needed.

R1 sustained another fall on 2/1/13 which documents that E9 (Certified Nursing Assistant/C.N.A) was making rounds and heard R1 calling for help. Upon entry into R1's room, E9 noted her sitting on the floor at her bedside. The conclusion of the investigation documents: "It was determined that the root cause of the occurrence that resulted to left SDH (subdural hematoma) and left pubic rami fracture can be attributed to the internal risk factor-medications (resident received Morphine Sulfate 15mg, Percocet 10-325mg, Xanax 0.25mg 2-5 hours before the incident).

R1's MAR and POS dated 2/1/12 documents the following medications: Aspirin 81mg daily; Elavil 25mg at bedtime; Wellbutrin XL 300mg daily; Lidoderm 5%, 2 patches to lower back daily; Morphine Sulfate ER 15mg every 12 hours;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145999	A. BUILDING ______ B. WING ______	C 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROSSE POINTE MANOR	6601 WEST TOUHY AVENUE NILES, IL 60714

(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 12	F9999		

Gabapentin 300mg four times a day; Xanax 0.25mg three times a day as needed; and Percocet 10-325mg every 6 hours.

On 3/5/13 at 1:07 pm, E11 (Licensed Practical Nurse/LPN) stated that R1 had floor mats and a bed alarm. E11 stated that R1 would get up and fold the mats and remove the alarm and walk in her room.

On 3/6/13 at 3:26pm, E7 (C.N.A) stated that R1 sustained a fall on 11/20/12, and he was the first respondent to her room. E6 stated that R1 told him she wanted to use the bathroom. E6 added "she is a fall risk". E6 also stated "I always complain to the nurse because one day, I saw her disconnect the alarms." E6 stated that R1 has to be monitored closely because she knows how to disconnect the alarms. E6 stated that R1 can walk and "we sometimes we ask if she wants to go to the bathroom, but she is not on a set schedule".

On 3/6/13 at 3:10pm, E6 (LPN) confirmed that R1 slid off her mattress in Dec/2011.

On 3/7/13 at 10:02am, E9 (C.N.A) stated that she is R1's regular C.N.A. E9 added that every time R1 fell, she would have slipped while walking. E9 stated that she has never assisted R1 to the bathroom. E9 stated that on 11/20/12 she had walked past R1's room and saw her walking. E9 stated "the door was a little bit opened and I saw her walking. I didn't see where she was going." E9 stated she did not enter the room to assist R1. E9 stated she was making rounds of the residents on the unit and that when she came back to R1's room, she was on the floor. E9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145999	A. BUILDING ______ B. WING ______	C 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROSSE POINTE MANOR	**6601 WEST TOUHY AVENUE NILES, IL 60714**

(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 13	F9999		

stated that R1 gets up and walks by herself a lot. E9 stated that on 2/1/13, she was making shift rounds and R1 was calling for help. E9 said that when she entered the room, R1 was on the floor; "the problem is she removes all the alarms and walks."

On 3/7/13 at 10:47am, E10, (LPN) stated that on 11/20/12, the staff found R1 lying on the floor right behind the door. E10 stated "It was hard to get into the room because she was right behind the door." E10 added that R1 had blood behind her head and was complaining of pain in her left hip. E10 stated "she walked by herself quite a bit, but we did help her occasionally. She walked alone at first, but after this incident we said we have to help her, she was on a lot of narcotics." E10 stated "once in a while she would be sitting watching TV, and 20 minutes later she would be sleep with her mouth open."

On 3/7/13 at 12:48pm via phone conversation, E8 (Registered Nurse/RN) stated that on 2/1/13, she found R1 on the floor yelling and complaining of hip pain. E8 added that the "staff is supposed to stand by and assist R1 when ambulating because she uses a walker and is a fall risk." "She knows how to remove the alarms."

On 3/7/13 at 2:47pm via phone conversation Z3 (Psychiatrist) stated R1 was suffering from depression and always wanted to stay in her room a lot, but it was not safe for her.

On 3/7/13 at 3:00pm, E2 (Director of Nursing) stated "she needs supervision outside of the room, not inside." Then E5 (Director of Quality Assurance) said "R1 stated in her dreams she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145999	A. BUILDING ______ B. WING ______	C 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROSSE POINTE MANOR	**6601 WEST TOUHY AVENUE** **NILES, IL 60714**

(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 14 was trying to go to the bathroom." On 3/11/13 at 10:45am via phone conversation, Z2 (Medical Doctor) stated that he explained to R1 that all of the medications could cause "balance problems." Z2 stated it was difficult to balance R1's level of comfort and pain relief. Z2 did not state the medications had been reviewed and re-evaluated. On 3/11/13 at 12:55pm, Z1 (Medical Doctor) stated that R1's pain medications were necessary. However, Z1 stated that the facility informed him that R1 had some falls related to her medications. Z1 did not state whether any medication changes had been implemented. The facility was asked to provide documentation of R1's restorative programs from May/2012 - Feb/2013. Although staff and the facility's incident reports indicated that R1 fell while attempting to go to the bathroom on at least 3 occasions, R1 was not on a toileting program. R1's care plan for the fall she sustained on 7/21/12 documents that she was on a walking program. R1's restorative assessment dated 11/14/12 documents: "Restorative programs will be discontinued." R1's care plan interventions for the falls on 11/20/12 and 2/6/13 documents restorative re-assess for functional status. There were no restorative assessments located in R1's medical record for these dates. On 3/7/13 at 1:18pm, E4 stated that R1 was not on a restorative program since they were discontinued on 11/14/12. R1's fall risk assessment dated 11/14/12	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145999	A. BUILDING ______ B. WING ______	C 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROSSE POINTE MANOR	**6601 WEST TOUHY AVENUE NILES, IL 60714**

(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 15	F9999		

documents that R1 is at risk for falls. There was no fall risk assessment located in R1's medical record after she sustained the fall on 11/20/12. After R1 sustained a fall on 2/1/13, the fall risk assessment was completed on 2/4/13 (3 days after the fall). On 3/7/13 at 2:22pm, E3 (MDS/ Care Plan Coordinator/LPN) stated that the fall risk assessment dated 11/14/12 applies to the fall R1 sustained on 11/20/12 (six days after the fall).

On 3/7/13 at 1:18pm, E4 (Assistant Administrator/LPN) stated that the facility's policy is to complete a fall assessment for each resident on admission, quarterly and after each incident and for adding care plan interventions. E4 stated that R1 requires minimal assistance with ambulation. E4 stated that when R1 fell on 7/14/12, she wanted to go to the toilet and she rolled off the bed. "R1 is on a lot of pain medications which contributed to her fall. " E4 stated that the facility gave R1 a bed alarm but she refused. E4 was then asked, what interventions were added after R1 refused the alarm? E4 stated the facility offered R1 a laser sensor alarm, but she refused that as well. E4 stated "I have a background in pharmacy and with all this medication, she would be euphoric. In my opinion this is causing these accidents".

R1's radiology report from the local hospital dated 6/17/11 documents the following impression: Right inferior pubic remus fracture and possible fracture of the right superior pubic remus laterally.

R1's physical exam from the local hospital dated 11/20/12 documents: Head is with contusion and with laceration. R1's imaging results from the local hospital dated 11/20/12 documents: head

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145999	A. BUILDING ______ B. WING ______	C 03/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROSSE POINTE MANOR	**6601 WEST TOUHY AVENUE NILES, IL 60714**

(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 16	F9999		

laceration - staple X 1.

R1's radiology report from the local hospital dated 2/2/13 documents the following impression:
-Acute left pubic rami fractures. - Subacute fracture of the left superior pubic remus.

R1's CT (Computed Tomography) from the local hospital dated 2/2/13 documents:
Clinical indication- Parenchymal contusion; subdural hematoma
Impression- there is evidence for a trace amount of acute extra-axial hematoma in the left temporal region.

The facility's policy regarding incidents- Reportable and Non-Reportable documents:
All resident falls will be assessed and the resident ' s existing plan of care will be evaluated for needed changes. The resident's Fall risk Assessment shall be reviewed and revised as needed. The resident's plan of care shall be updated if additional care interventions are necessary.

B