STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145434	A. BUILDING ______ B. WING ______	07/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARIDGE HEALTHCARE CENTER	**700 JENKISSON** **LAKE BLUFF, IL 60044**

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F 323	Continued From page 14 On 7/18/13 at 2:00 pm during the environmental tour, the toilet hand rails plastic arm rests for the residents from R19 through R24 were cracked and sharp plastic edges were exposed. The toilet hand rail metal legs were two inches above the ground level. The cracked plastic arm rest on toilet hand rails has the potential to cause skin tears and or lacerations. The second floor dining room wall corner metal frame is exposed with sharp edges ten inches long. The exposure was at four feet above the ground level. Any one walking along the corner could get hurt from metal sharpness. E4 (Maintenance Director) stated he has to patch it. Resident's chairs movement must have scraped the metal frame.	F 323		
F9999	FINAL OBSERVATIONS Licensure Violations 300.1210b) 300.1210d)6) 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.	F9999		

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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 300.1220 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)

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THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY:

Based on observation, record review and interview the facility failed to thoroughly evaluate fall risk factors, develop a fall plan of care with specific and individualized interventions and have nurse call cord accessible and monitor a resident (R2) to prevent from falling when she was ambulating unassisted by staff. The facility also failed to ensure the toilet hand rail arm rests are not broken and free from potential for skin tear hazard.

As a result R2 fell multiple times (2/19/13, 6/5/13 and 7/3/13). When R2 fell on 6/5/13, she sustained fracture of her right hip.

This is for one of four residents in the sample of 18 residents evaluated for falls and six residents (R19 through R24) from out side of the sample whose toilet hand rail arm rests were broken with sharp edges exposed.

Findings include:

On 7/17/13 at 10:30 am R2 called / yelled with sounds that was in foreign language (Korean). The yelling was audible from the hallway where R2's room was. Upon entering R2's room, her nurse call cord was observed at the foot of the bed between side wall and her bed. The cord was too short for R2 to reach and call for help. R2 responded by pointing to her right hip with a grimace on her face. E10 (Nurse) came to interpret Korean for R2's expressions. R2 complained of pain to her right hip. E10 stated she would give R2 her pain medication.

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F9999	Continued From page 17 The facility documented the following falls for R2: (1) On 2/19/13 R2 was found lying face down with walker on top of her, not talking, speaks Korean, sustained 5 cm wide circle bump to forehead. There is no evaluation to show how R2 fell. The facility did not modify interventions to prevent future falls. The facility did not develop a fall care plan for R2 until 5/2/13. E2 (Director of Nurses) stated there may be a fall care plan in the thinned record, but did not present any fall care plan for review other than the one of 5/2/13. (2) On 6/5/13 at 9:50 pm R2 was found lying on the floor on her right side complaining of low back pain and right leg pain. On 6/6/13 at 8:50 pm the facility became aware of R2's X-Ray result, which showed she sustained fracture to her right hip and femur. The facility did not conduct a comprehensive evaluation to show why and how R2 fell. The intervention added to the plan of care was to use bed alarm during the night. (3) On 7/3/13 at 9:00 pm R2 was found on floor lying on her back, according to her room-mate she was trying to help her get on the wheel chair and R2 slid from the chair. There was no intervention to show how the facility will prevent such future occurrence. R2's fall risk evaluations ((3/7/13, 6/5/13 and 6/10/13) indicated she is at high risk for falls. The risk factors indicated in the evaluation are: Change in Mental Status, History of Falls, Age and Medications. The facility did not further evaluate these risk factors to develop fall prevention care plan with specific and individualized interventions.	F9999		

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The facility undated fall protocol showed the comprehensive falls assessment must be done on every resident on admission and on readmission and after each fall. The facility did not follow their fall prevention protocol for R2's falls.

R2's 5/2/13 fall prevention care plan interventions are not specific to the risk factors identified in the fall risk evaluation. The examples of non-specific interventions are: (a) Instruct resident to ask for assistance prior to attempting to transfer to walk. It is not clear how the facility will ensure R2 who has memory impairment will follow the instruction. On 7/18/13 at 2:05 pm R2 exhibited memory problems (could not recall incidents of falling, day or time of the day). (b) Place the call light within easy reach and encourage to use it prior to attempting to transfer or walk. R2's Nurse call cord was not accessible on 7/17/13 at 10:30 am and 7/18/13 at 11:30 am. On 7/18/13 at 12:15 pm E3 (Nurse) verified the Nurse call cord was at the foot of R2's bed. (c) make sure environment is free from hazard such as poorly arranged furniture. On 7/18/13 at 1:45 pm E2 stated R2 had cluttered furniture at the time of R2's fall on 6/5/13 and her extra furniture was sent to her home. This intervention was not noted in R2's plan of care. (d) Implement fall precaution procedures per protocol. The facility also did not follow their fall protocol by not conducting comprehensive evaluation of R2's fall and by not developing and implementing individualized and specific interventions to prevent and monitor R2 from falling.

On 7/19/13 at 1:45 pm Z1 (Physician) stated R2 is non-compliant in seeking assistance. She (R2) thinks she can get up and walk and she also does

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not use the walker. Z1 also stated what you do under these circumstances, is to provide close supervision if not one to one monitoring.

There was no documentation to show if R2 and her family were educated about the risks of unassisted ambulation. There is also no documentation to show if the facility educated staff about the extent of monitoring especially when R2 is non-compliant and speaks foreign language.

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(B)