STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012611	A. BUILDING: _____ B. WING _____	C 03/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF HOMEWOOD	940 MAPLE AVENUE HOMEWOOD, IL 60430

(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) COMPLETE DATE
S9999	Final Observations S9999 Final Observations Statement of Licensure Violations 300.1210d)6) Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a) general nursing 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 were not met as evidenced by: Based on Observation, Record review and Interview, the facility failed to provide specific safety measures for residents with fall history for 2 of 4 residents (R1and R5), reviewed for falls, of a total sample of 4. As a result of this failure, R1 fell and sustained a fracture of the Right hip and Right leg. Findings Include: Medical Record for R1 noted an 85 year old with Diagnoses to include Dementia, Alzheimer's Disease, Syncope and Collapse. 9/30/2013 Minimum Data Set (MDS) indicates resident requires supervision for ambulation. Fall risk	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

assessment dated 9/30/13 indicated impulsivity and poor safety awareness. R1 requires ambulatory assist with a cane.

Medical record for R1 recorded several falls to include the following dates:3/26/2013 ,4/13/2013, 4/15/2013, 7/18/2013, 8/20/2013, 2x on 9/23/2013, 11/2/2013 and 11/16/2013.
On 11/16/2013 at 8:30AM, nurse's notes read,"Resident fell onto floor when she got out of her locked wheelchair while sitting in the hallway". Notes noted that X-ray was done and the result was, "a well aligned intertrochanteric fracture of the right hip/ femur".

Care Plan review indicates no new and or revised interventions were documented as implemented after each fall.

On 3/6/2015 at 1:00PM,E5(MDS Coordinator) said R1 was encouraged to take rest period and sometimes E5 will make her sit but as soon as you leave(R1) she will get up and walk. E5 said R1 walked all the time around the facility before the last fall in November 2013.

On 3/6/2015 at 2:30PM, E2(Director of Nursing, DON) said the facility was restraint free and could not answer about safety measures implemented for R1. No specific safety measures for ambulation was documented in medical record.

On 3/10/2015 at 2:15PM, E1(Administrator) said there is no restorative nurse employed at facility.

Medical Record noted R5 with Diagnoses include Alzheimer's Disease and Psychosis. Record for R5 documented unwitnessed fall and observed next to bed on floor on the following dates: 9/11/2014 at 6:38AM, 1/08/2015 at

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S9999	Continued From page 2 2:15PM, and and 1/10/2015 at 2:20PM. Minimum Data Set (MDS) of 11/30/2014 scored 00 out of 15 on the BIMS test. R5 was nonambulatory and required extensive assistance for all Activities of Daily Living. Care plan documented the following interventions among others,"Encourage and increase activity awareness when awake and bed in lowest position. On 3/10/2015 at 10:00AM, R5 was observed in bed in high position and with the door closed. No staff was in attendance. E3 (Certified Nursing Assistant, CNA) was summoned to room and immediately said,"Oh I am sorry, it is my fault. I forgot to put the bed down. R5 is a high risk for falls and the bed should not be in the high position". Fall Policy noted ,"the approaches for fall interventions are clear, specific, and individualized for the patient needs". Also,"On the basis of the information obtained and analysis performed in the assessment and planning phases, the next step is to implement an organized approach for the management of the patient's falls or fall risk factors". (B)	S9999		