

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/17/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145350	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/12/2009
NAME OF PROVIDER OR SUPPLIER MANORCARE OF ROLLING MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 4225 KIRCHOFF ROAD ROLLING MEADOWS, IL 60008		
(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 000	INITIAL COMMENTS Complaint investigation 0993428/IL42973. No extended survey was conducted.	F 000			
F 323 SS=G	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility has failed to provide adequate monitoring and supervision to R1 who was identified as a risk for falls due to a compromised medical condition. The facility also has failed to ensure that specific interventions to address R1's fall prevention was in placed. This failure resulted to R1's unassisted transfer that resulted to a fall incident on 7/22/09. R1 sustained a head contusion and scalp laceration and was sent to the hospital via emergency transport. Findings includes: R1 was a 100 year old with diagnoses that includes syncope with fall, brain tumor, anemia secondary to hematoma, hypertension, CRF (chronic renal failure), osteoporosis and osteoarthritis of knees.	F 323			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/17/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145350	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/12/2009
NAME OF PROVIDER OR SUPPLIER MANORCARE OF ROLLING MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 4225 KIRCHOFF ROAD ROLLING MEADOWS, IL 60008		
(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	<p>Continued From page 1</p> <p>R1 was admitted to the facility from the hospital on 6/11/09. Record showed that R1 was at the hospital from 6/6/09 to 6/11/09. Hospital record indicated that R1 had a fall incident while in the bathroom in her home on 6/5/09. Record indicated that R1 had hit her head from the fall incident of 6/5/09, and this had precipitated R1 to be hospitalized. As hospital record indicated, R1's fall incident was related to a syncopal episode. During this hospitalization, R1 was also diagnosed with a brain tumor with a significant mass effect. Record indicated that due to the brain tumor, R1 was on a seizure prophylaxis.</p> <p>When admitted to the facility, R1 was assessed as a risk for fall due to weakness, impaired balance and mobility, history of fall, brain tumor with seizure prophylaxis. R1 was also identified as hard of hearing, blind in the left eye and was forgetful .</p> <p>Physical therapy evaluation dated 6/12/09 showed that R1 required maximum assistance with 2 persons physical assists for transferring from sit to stand, to bed, wheelchair and toilet. Further review of the physical therapy evaluation indicated that R1 had a shuffling and unsteady gait, and was considered as a fall precaution.</p> <p>Review of MDS (minimum data set) dated 7/2/09 showed that R1 was assessed and scored 3/3 (extensive assistance with 2+ persons physical assist) for toilet and transfer needs.</p> <p>Review of fall incident report dated 7/22/09 showed that R1 was found lying on the bathroom floor in room 179 at 1:00 P.M. It was indicated in the report that R1 was sent to the hospital via</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/17/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145350	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/12/2009
NAME OF PROVIDER OR SUPPLIER MANORCARE OF ROLLING MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 4225 KIRCHOFF ROAD ROLLING MEADOWS, IL 60008		
(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	<p>Continued From page 2</p> <p>emergency transport for fall evaluation on 7/22/09 at 1:25 P.M. R1 sustained an "avulsion with flap on the left scalp" from the fall. R1 later returned back to the nursing facility at 6:15 P.M. on 7/22/09. Nurse's documentation dated 7/22/09 at 5:45 P.M. indicated that R1's avulsion on the left scalp cannot be sutured, therefore a gel foam was placed and was secured with a wound dressing.</p> <p>On 8/11/09 at 2:15 P.M. , E2 (Director of Nursing) stated that R1 had a fall incident on 7/22/09 at 1:00 P.M. in room 179. Per E2, R1 was left alone while on the toilet seat and this was when R1 must have transferred self without assistance that lead to the fall incident. As E2 added, R1 should have not been left alone in the toilet since R1 was a high risk for fall due to a compromised medical condition.</p> <p>On 8/12/09 at 9:50 A.M., E3(CNA) stated that R1 was forgetful and needed extensive assistance for transfers. E3 also stated that on 7/22/09 at around 1:00 P.M. after lunch, E3 assisted R1 to the toilet. E3 further stated that she had left R1 alone while R1 was seated on the toilet seat. E3 further stated that she went back to the dining room to assist other residents when she had heard that R1 was found on the bathroom floor.</p> <p>On 8/12/09 at 1:45 P.M., E5(CNA-certified nurse assistant) stated that she found R1 lying on the bathroom floor in room 179 on 7/22/09 at around 1:00 P.M. E3 indicated that R1 was alert when found on the floor. E5 also stated that there was some blood noted on the floor next to R1's left side face.</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/17/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145350	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/12/2009
NAME OF PROVIDER OR SUPPLIER MANORCARE OF ROLLING MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 4225 KIRCHOFF ROAD ROLLING MEADOWS, IL 60008		
(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	<p>Continued From page 3</p> <p>On 8/12/09 at 10:40 A.M., E4(nurse) stated that R1 was found lying on the bathroom floor on 7/22/09 at around 1:00 P.M. E5 stated that R1 sustained a laceration on the left side of forehead with noted moderate amount of bleeding. E4 further stated that R1 was sent to the nearby hospital for fall evaluation.</p> <p>Record showed that few days after the fall incident occurred on 7/22/09, R1 was noted to have lethargy and was less responsive. R1 later expired on 7/26/09.</p> <p>On 8/12/09 at 12:25 P.M., Z1(attending physician) stated that R1 did not sustained an intracranial bleeding from the fall of 7/22/09. Z1 also indicated that the cause of death was the brain tumor . As Z1 further stated, R1's fall of 7/22/09 have contributed to R1's changed in mentation, lethargy and less responsiveness, however, R1's medical diagnosis of brain tumor with significant mass affect would also affect mentation and also was considered a possible source for R1's changed in mentation. As Z1 indicated, when R1 was diagnosed at the hospital (6/6/09 hospitalization) with a brain tumor, R1 was given 4-6 weeks of survival rate.</p> <p>Considering R1's medical history with syncopal fall, forgetfulness, weakness and brain tumor with significant mass affect with seizure prophylaxis, R1's care plan showed no specific and individualized plan of care in placed to ensure that there was an appropriate assistance and monitoring to address fall prevention.</p>	F 323			