STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145827	A. BUILDING _____ B. WING _____	C 11/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRITISH HOME, THE	**8700 WEST 31ST STREET BROOKFIELD, IL 60513**

(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 Investigations: 1491406/IL69041-No deficiency 1494985/IL73034-F-323	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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 observation, interview, and record , the facility failed to properly use a gait belt and supervise a resident while assisting with ambulation to prevent a fall for one of four residents (R4) reviewed for falls, in a sample of four. This failure resulted in R4 sustaining an acute non-displaced intertrochanteric fracture. Findings Include: Facility's incident report dated 11/4/14 at 11:00am documented, R4 was in the therapy gym. R4 was exiting the private treatment room with her walker with a gait belt on and the therapist(E9), providing stand by assistance (SBA). R4 fell backward while ambulating. The record further indicate R4 fell onto her left hip, and hit her head on the door. R4 reported pain of 10/10 pain scale while standing, and 3/10 while sitting in the wheelchair per this incident report. The therapist was not in	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 323	Continued From page 1	F 323		

contact with the gait belt when R4 was ambulating.

At 11:05am on 11/12/14 E7 (Licensed Physical Therapist) states, "The physical therapist, and assistants should use a gait belt with all transfers, and ambulation. Their hands should be on the gait belt at all times when the resident is standing. When a therapist is holding the gait belt their hand should be around the belt and closed firmly."

At 9:14am on 11/12/14 E9 (Physical Therapy Assistant)states,"I (E9) was walking out of the private treatment room with R4, she (R4) was using her rollator walker, and she had a gait belt on. I (E9) was giving R4 stand by assistance, meaning I was standing close by her (R4). R4 turned to say hello to E6, and she loss her balance falling backwards. She (R4) tried to grab the walker. I(E9) was along side of her, it was a chair in her path that I tried to push it out of the way prior to the fall with one hand. My left hand was back toward R4 near the gait belt. When she went backwards we (E6 and E9) tried to reach for her (R4) and I (E9) was only able to grab enough of the belt to keep R4 from hitting her head on the floor because she had hit her leg pretty hard on the floor. I (E9) feel like maybe we could have used the regular walker with two wheels, it may have slowed her down."

Facility incident reports, and care plan indicate that R4 had a fall on 10/23/14 and sustained an open area to the occipital region of her head with bleeding. R4's MDS(Minimum Data Set) functional status indicate that R4 required limited assistance of one staff with transfers, and ambulation's.

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F 323	Continued From page 2	F 323		

Fall assessment for R4 dated 9/10, 10/23, and 11/4/14 indicate R4 has transfer difficulties, unsteady gait, and uses an assistive device (wheelchair).

At 9:45am on 11/12/14 Z2(Nurse Practitioner) states, "R4 was here because of a fall she had earlier this year in her apartment. She had a pubic bone fracture and a pelvic hematoma. She was here to get rehabilitation and get stronger. I believe her baseline was walking with a walker in her apartment. I required that R4 had assistance with ambulation. I can't recall anything acute going on with R4. She was making good progress. I can't comment on therapy because I wasn't there. The facility should have their protocols in place to maintain patient safety."

On 11/13/14 at 12:00pm Z1(Attending Physician) states, I saw R4 in the morning on the day of the fall. She was doing good in therapy and was due to go home soon. I heard about the fall from my NP(Nurse Practitioner), that her X-ray was positive for a fracture. I sent her out to the hospital after I got the results. She had no neurological concerns or health conditions that contributed to the fall. She had two falls in the past and that's why she was in therapy to work on preventive measures for falls. She should have had assistance with ambulation because of the prior falls. Her injury at this time is a result of the trauma from falling."

Facility policy dated 10/7/2011 indicate a gait belt is mandatory for all residents handling with the exception of bed mobility and medical contraindications. R4 didn't have any documented contraindications of gait belts being used. E9

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F 323	Continued From page 3 verbalized that she had tried to grab R4's gait belt indicating she didn't maintain hand contact with R4's gait belt.	F 323		