STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145699	A. BUILDING _____ B. WING _____	09/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERMAN WEST COURT	1950 LARKIN AVENUE ELGIN, IL 60123

(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	F 000		
F 315 SS=D	ANNUAL CERTIFICATION SURVEY 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to conduct a comprehensive assessment for the use of an indwelling urinary catheter. This is for one of two residents (R6) who have indwelling urinary catheters in the sample of 14. Findings include: R6's admission record indicated she was admitted to the facility on 8/22/12 after she was hospitalized for sepsis from cellulitis. R6's hospital transfer record indicated she had an indwelling urinary catheter on admission. The facility did not conduct assessment for the continued use of indwelling urinary catheter. It was noted in R6's 8/22/12 bowel and bladder assessment she is continent of bladder with the use of indwelling catheter.	F 315		

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.

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F 315	Continued From page 1 E2 the Director of Nurses stated the R6's indwelling catheter was removed on 9/12/12 as a trial E2 also stated the catheter was leaking. On 9/13/12 at 11:00 am R6 who is able to engage in conversation stated she has sensation to void, but can't make to the bath room, because she is weak. R6 indicated the catheter was removed yesterday (9/12/12) and it feels better and she can call the staff to take her to bath room.	F 315		
F 323 SS=D	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, record review and interview the facility failed to ensure staff supervised (R4) to prevent her from falling, and failed to review and update the fall care plan for (R11) who had two falls . This is for two of three residents (R4 and R11) who are at risk for falls in the sample of 14. Findings include: On 9/11/12 at 11:30 am, R4 was in her room seated in her wheel chair with her left hand and left leg in a splint. R4 had massive bruising around her left periorbital area. R4 was able to	F 323		

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F 323	Continued From page 2	F 323		

state how she bruised her left eye. R4 stated she found herself with her face down on the floor and did not know how it happened. E4 stated, "he left me on toilet for privacy reasons" She also stated sure she would like to have privacy, but I just had a stroke and was not stable. E4 assumed R4 wanted privacy. R4 is a new status post Cardio Vascular Accident (CVA) with left sided weakness of upper and lower extremity and with poor trunk control.
R4 stated the incident occurred on 9/9/12 in the evening. The incident report dated 9/9/12 indicates E2, the director of nursing interviewed R4 and E4 (CNA). R4 said she asked E4 to give her privacy after he placed her on the toilet. E4 left her on the toilet saying to call him after she was done. R4 stated she slid off and bumped her left eyebrow.

R4's 8/29/12 Physical Therapy assessment noted she has diagnosis of right CVA with left hemiplegia, she also has severe left neglect, decreased mobility, transfers, balance, endurance; needs maximum assistance of two persons for sit and pivot, transfer, mobility in bed and chair. R4 is a new status post Cardio Vascular Accident (CVA) with left sided weakness of upper and lower extremity and with poor trunk control.

On 9/14/12 at 10:30 am, E3 Physical Therapist (PT) stated R4 was not safe to be left alone on the toilet on 9/9/12 when she fell. R4 has poor control, she is impulsive.

R4's 8/28/12 fall risk care plan updated on 9/9/12.

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F 323	Continued From page 3 This care plan did not include instructions for staff to use two staff when transferring resident. R11 is an 86 year old female with multiple medical diagnoses including weakness, cataracts, arthritis, breast cancer with metastasis to the hip and spine and colon cancer. Fall risk assessment tool for R11 dated 8/18/12 scores R11 as a 15, indicating R11 is at risk for falls. Incident Report for R11 dated 8/29/12 reflects staff heard R11 calling for help and staff found R11 sitting on the floor on the left side of the bed with her back leaning against the wheel chair. R11 sustained a skin tear to her left forearm, which was steri-stripped. The investigative report dated 8/30/12 reflects R11 had been sitting in her wheel chair next to the bed prior to the fall. The incident report reflects R11 is alert but confused. R11's care plan dated 8/18/12 does not reflect a fall on 8/29/12. Although there are numerous interventions for fall prevention checked off, there is no date for the interventions and no indication that R11's plan of care was reviewed after the 8/29/12 fall and updated with interventions specific to her 8/29/12 fall, in order to prevent a recurrence. On 9/13/12 at 2:00 PM, E2 (DON) reviewed R11's care plan and agreed her care plan had not been updated after the 8/29/12 fall. She stated it was up to the nurse working at the time of the incident to update the care plan.	F 323		

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F 323	Continued From page 4 The incident Report for R11 dated 9/7/12 indicates R11 became weak when getting up from her wheel chair while being assisted by Physical Therapy. Physical therapy helped lower R11 to the floor. R11's care plan dated 8/18/12 does reflect R11 fell on 9/7/12; it states this under the section entitled "problem/need". However, there is no indication that R11's plan of care for falls was reviewed/updated with regards to R11's fall interventions, with no interventions specific to R11's 9/7/12 fall. On 9/14/12 at 10:45 am, E2 presented an updated care plan for R11 which addressed the 8/29/12 and 9/7/12 falls, with updated interventions. For the 8/29/12, care plan reflects anti-slip mat applied and resident instructed to use call light for help. For the 9/7/12 fall, therapy was instructed to keep wheel chair next to bed during a transfer.	F 323		