STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145893	A. BUILDING _____ B. WING _____	C 10/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF PALOS HEIGHTS WEST	**11860 SOUTHWEST HIGHWAY PALOS HEIGHTS, IL 60463**

(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 1695897/IL89192 - F157, F323 cited.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		

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 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to notify a family member of a significant change in resident's condition for one of three residents (R1) reviewed for change in condition. Findings include: Review of R1's medical record, Progress Note 9.13.16 at 9:58 AM, notes in part: "post meal staff noted that patient was drowsy in the chair. Vital signs revealed blood pressure of 84/50 mmhg and POX (pulse oximeter) of 84%. Pt (patient) was taken to room and put in bed for safety and (MD) was paged per answering service at this time." Progress Note of 9.13.16 at 11:00 AM notes in part: "Pt in bed, no instructions received per (MD). Progress Note of 9.14.16 at 9:48 AM notes in part: "Resident in bed with HOB^ (head of bed elevated). O2 (oxygen) administered at 2L/min via NC (2 liters per minute via nasal cannula)." No documentation is noted that R1's family member was notified of this change in condition and need for supplemental oxygen. Review of Social Service Progress Note, 9.14.16 at 3:26 PM, notes in part: "SSW (Social Service Worker) working with nursing and son throughout the afternoon; pt now needing O2 for d/c (discharge) home." E9 (Social Service Assistant, 10.25.16 at 10:56 AM) said in part: R1's family came to facility on 9.14.16 expecting to take R1 home that day, however family member had not been notified	F 157		

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F 157	Continued From page 2 that R1 required supplemental oxygen or why and E9 was attempting to make arrangements for home oxygen therapy for R1. Review of facility's "Change in Condition: When to report to the MD/NP/PA" policy and procedure states in part: (Under Immediate Notification) Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and a marked change (i.e. more severe) in relation to usual symptoms and signs." E1 (Administrator) on 10.25.16 at 4:45 PM said the above policy should be utilized by staff to notify a resident's family member when there is a change in a resident's condition.	F 157		
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 interview and record review the facility failed to monitor the effectiveness of interventions and modify interventions for one resident (R1) and failed to supervise one resident (R2) in a sample of three residents reviewed for falls. These failures resulted in R1 sustaining a left hip fracture and blunt head injury after falling and R2 falling from toilet. R1 died three days later as a	F 323		

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F 323	Continued From page 3 result of this fall. Findings include: Review of R1's medical record (Medical Diagnosis) notes R1 with diagnoses including but not limited to: Urinary Tract Infection (UTI), Anxiety Disorder, Dementia with Behavioral Disturbance, History of Falling, Difficulty in Walking, Muscle Weakness, Fracture of Unspecified Lumbar Vertebra, Diabetes Mellitus, Essential Hypertension and Chronic Kidney Disease. R1's most recent MDS (Minimum Data Set) of 8.24.16 notes R1's BIMS score (Brief Interview for Mental Status) as "2" or severely impaired. R1's previous BIMS (8.14.16) was "4" or severely impaired. Review of facility's Incident/Accident Reports and R1's medical record (Progress Notes) notes R1 had multiple falls without injury (8.10.16, 8.17.16, 8.25.16, 9.1.16, 9.12.16, 9.13.16) and one fall with injury (9.16.16, left hip fracture). -8.10.16: Found sitting on knee on floor. Resident stated family member pushed (R1). No one was in the room with resident. -8.17.16: Readmitted from hospital. At 2:15 PM resident was found sitting on floor with back towards bed, gown was laying on floor next to R1. Family member came to visit and informed staff R1's confusion had increased while at the hospital and R1 kept attempting to get up as well. -8.25.16: Confused, re-directed multiple times to sit in wheelchair. Taken to room to watch television and drink fluids after returning from therapy. Staff heard resident calling out for help and found resident on floor near bed.	F 323		

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F 323	Continued From page 4 -9.1.16: Staff heard resident calling for help and found resident laying on the floor at the south end of R1's bed, laying on left side in front of wheelchair. Resident last seen three minutes prior to fall sitting outside R1's room, was alert but confused. -9.12.16: After breakfast, R1 got up from wheelchair and fell to floor. Resident was agitated. -9.13.16: Found on floor laying on back. -9.16.16: Fell from wheelchair while in hallway by nurse's medication cart while nurse was in another room passing medications to another resident. Staff got resident out of bed earlier and placed in wheelchair because R1 was restless and attempting to get out of bed. R1 was transferred to hospital for low blood pressure (78/54) and low SpO2 (88%). Resident was admitted with diagnoses of left hip fracture and blunt head injury. Additional review of R1's medical record notes R1 was found on the floor on 8.22.16, however no incident report was found. R1's fall care plan was reviewed. The careplan was initiated on 8.10.16 after R1's initial fall. Interventions included: "Reinforce need to call for assistance." R1's cognitive status (as noted above) was severely impaired. No interventions were initiated after R1's falls of 8.17.16, 8.25.16 or 9.1.16. E2 (Director of Nursing, 10.25.16 at 1:37 PM) said in part, the expectation is that care plans should be updated after each fall. R1's death certificate lists R1's immediate cause of death as blunt force injuries of left hip due to	F 323		

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F 323	Continued From page 5 fall. Review of R2's medical record (Medical Diagnosis) notes R2 with diagnoses including but not limited to: Anxiety Disorder, Difficulty Walking, Arthropathy, Dementia with Behaviors Muscle Weakness and Symbolic Dysfunction. R2's most recent MDS (Minimum Data Set) of 8.8.16 notes R2's BIMS score (Brief Interview for Mental Status) as "7" or severely impaired. R1's transfer score is"3/3" (extensive assistance/two+ persons physical assist). Review of facility's incident/accident reports notes R2 fell without injury on 9.8.16. E7's (LPN-Licensed Practical Nurse) statement, obtained by E2 (DON-Director of Nursing), notes in part E7 assisted R2 to the toilet; when finished, instructed R2 to wait while E7 got help. When E7 returned, R2 was on the floor. The facility's conclusion states: "Resident requires 2 person assist which is in (R2's) Kardex. Resident tried to get up from the toilet & fell to floor. Facility to ensure resident is not lift by herself while on the toilet." Review of R2's Fall(s) document (9.8.16) notes in part the following: B. Physical Performance Limitations 1. Difficulty maintaining sitting balance 3. Difficulty maintaining standing position 4. Impaired balance during transitions. D. Diseases & Conditions 22. Muscle weakness 31. Impulsivity or poor safety awareness 37. Other dementia	F 323		

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F 323	Continued From page 6 38. Anxiety disorder Review of progress note related to the incident (9.8.16 at 9:44 PM written by E7) states in part: "Resident attempt to go to bathroom in 202A. Resident taken to (R2's) room. Stated (R2) needed to go to bathroom right away. Assisted to bathroom, pt. (patient) stood, placed on toilet, resident urinated, wiped clean by myself. (A)ttempted to put back in wheelchair, stated "I feel like I'm gonna have a bowel movement;" resident tried to get up by pulling on the wire, unable to carry all (R2's) weight, I asked (R2) to stay on the toilet seat while I quickly asked for help, pt.stated understanding and said "yes;" when I returned to the bathroom, pt. was already seen on the floor." E7 (10.25.16 at 11:33 AM) said in part, E7 got ready to get R2 off of toilet, R2 pulled on E7's arm to get up; E7 got R2 back on toilet seat and told R2 to stay there while E7 went to get CNA (Certified Nursing Assistant). The CNA went into the room and found R2 on the floor. The CNA told E7 that patient is a two person assist and stated, "Did you know that?" "I didn't know the resident good. I was in orientation. It was my first or second day on the unit."	F 323		