STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146108	A. BUILDING _____ B. WING _____	C 06/14/2007

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MANOR COURT OF PEORIA	**6900 NORTH STALWORTH PEORIA, IL 61615**

(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 324	Continued From page 28 for falls. 3. 6/01/07: All licensed staff will be provided a copy of the facility policy regarding falls and reminded of their responsibilities regarding documentation and following-up on falls prior to their next scheduled shift. 4. 6/01/07: All falls in the future will be reviewed by facility's Interdisciplinary Team and will be analyzed in the context of the resident's overall condition including his or her fall risk and history of falls. Changes will be made to each resident's care plan as necessary to address the risk of the resident experiencing additional falls.	F 324		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a)5) 300.1210b)3) 300.1210b)6) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 5) All nursing personnel shall assist and encourage residents with ambulation and safe	F9999		

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F9999	Continued From page 29 transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 REGULATIONS are not met as evidenced by: Based on interview and record review, the facility failed to develop and implement a system to collect and analyze data related to the number, types, and frequency of falls to identify trends and patterns. The facility failed to perform a root-cause analysis in order evaluate the circumstances of the falls to prevent further falls. The facility failed to develop and implement interventions to minimize the risk for falls and injuries and failed to monitor the residents to prevent recurring falls with serious injury for 3 of 13 sampled residents identified by the facility at	F9999		

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F9999	Continued From page 30 risk for falls (R1, R2, and R3). Findings include: On 5/31/07, E1, Administrator, provided the facility's policy no: 3.06, Area: Nursing, Subject: Emergencies, "It is the policy of the facility to provide emergency care to a resident in need of it. Staff Responsible: Director of Nurses, Staff Nurse Nurse Aide. 2. Immediate Care of the Resident A. Falls: 1. Check the resident immediately for ability to move extremities; check for bruised area and/or cuts. 2. Check resident's ability to explain what happened; evaluate resident's condition before the fall. 3. Check if or with anyone who witnessed the accident. Determine, if possible, where, how, and when the accident occurred. 4. Check for any apparent dislocation or possible fracture. If any signs of this are noted, stabilize resident until ambulance arrives. 5. Exercise special care in transferring the resident, being careful not to do more damage. Immobilize with splint, if necessary. 6. Call the resident's physician. 7. If head injury has occurred with loss of consciousness, notify physician immediately for orders to transfer to emergency room. 8. If head injury has occurred, notify physician and monitor vital signs and neuro checks at least every four hours for twenty-four hours, or until stable, or as otherwise ordered by physician." This policy does not address investigation, tracking, or monitoring of accident/incidents or how this data will be analyzed to identify trends and patterns to perform root-cause analysis in order to develop and implement corrective actions to address the falls occurring in the facility.	F9999		

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F9999	Continued From page 31 On 5/31/07 at 9:30AM, E1 (Administrator) and E2 (Director of Nurses) stated that there is a monthly Accident/Incident Report log where all falls and incidents are recorded. E2 stated that he reviews the falls and reports the reportable ones to Public Health. E1 stated that they had just implemented a fall committee the day before this investigation was started. E1 stated that he has only been administrator for one month and E2 has been the Director of Nurses for approximately 6 weeks at this facility. E1 stated E1 and E2 have not had a chance to get everything in place yet. E1 stated that they have a Quality Assurance committee that meets quarterly. This committee has not met yet since E1 came to this facility. E1 stated that he and E2 are working on getting a fall committee going in order to analyze data related to falls and to identify trends and patterns so they can prevent future falls. E1 stated that the Minimum Data Set coordinator has been in her position for two weeks. Review of the monthly Accident/Incident Report logs for April and May indicate that in April there were six resident falls: two with injury, all six unwitnessed, three on second shift and three on night shift. May's monthly Accident/Incident Report log indicates that there were sixteen resident falls: six with injury-two fractures, four bruises, and skin tears. Six of these falls were on third shift and four were on second shift. Z1, Medical Director, stated on 6/5/07 that Z1 attends the Quality Assurance committee meetings, but has not met with E1 and E2 yet. Z1 stated that this committee reviews all problems or concerns in order to provide good quality of care to the residents.	F9999		

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F9999	Continued From page 32	F9999		

1. R3's face sheet dated 5/12/07 indicates that R3 is a 97-year-old-male with Diagnoses of Congestive Heart Failure, Hypertension, Coronary Artery Disease, Anemia, and Fracture of the Femur with Open Reduction Internal Fixation. R3 was admitted to the nursing home from the hospital on 5/12/07 after the open reduction internal fixation. The Minimum Data Set (MDS) dated 5/25/07 indicates that R3 is independent in cognitive skills for daily decision-making. On this same MDS, R3 was marked as fell in past 30 days. On the Resident Assessment Protocol, R3 was identified at risk for falls.

The current physician's order sheets starting 5/15/07 states R3 was ordered to receive physical therapy 6 times a week for bed mobility, transfer training, gait safety, therapeutic exercises/activities along with occupational therapy 6 times a week for activities of daily living retraining, functional mobility and endurance. The physicians order sheet of 5/29/07 indicated that an abductor wedge was to be in place at all times.

The physical therapist Initial Examination/Evaluation/Treatment charting indicated that R3's impairment/functional limitations were right hip pain, decline in ability to move in bed, to transfer, or to ambulate. The documentation also states "needs hip precautions."

E6 (Physical Therapy Assistant) was interviewed on 6/4/07 at 2:30 P.M. regarding the treatment ordered for R3. E6 stated that E6 is working with R3 on bed mobility, transfers from wheelchair,

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F9999	Continued From page 33 and strengthening. E6 stated that during therapy, R3 sometimes needs two people to transfer and sometimes E6 can transfer R3 by himself. E6 stated that the physical therapist does not make recommendations to nursing as to how many it takes to transfer the residents unless the nursing staff is having difficulty and ask for help. E6 stated that "hip precautions means: don't cross the legs, don't pivot on the affected side, log roll to turn and position with abductor wedge in place and keep hip in alignment." The current care plan of 5/23/07 states, Problem: "at risk for falls related to Fracture of Right hip, cognitive impairment and history of falls, fall on 5/26/07." The approaches listed were dated 5/23/07 and were: verbal reminders not to ambulate/transfer without assistance, keep call light in reach at all times, frequent room check blue dot program, keep personal items and frequently used items within reach, and low bed with mats at beside. Documentation in the progress note of 5/23/07 states that "the alarm was on and functioning properly." The care plan indicates the approach for a personal alarm to be used at all times was not added to the care plan until 5/30/07. The existence of the Blue Dot Program referred to on this care plan and others could not be verified. Direct care staff interviewed (E5 on 6/1/07 and E8 on 6/5/07) were not aware of this program. No policy/procedure explaining this program was provided. On 5/31/07 at 9:30 AM, E2 (Director of Nurses) stated that the low bed with the mat on the floor and the personal alarm were put in place while R3 resident was in the hospital with his second	F9999		

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F9999	Continued From page 34 hip dislocation of 5/26/07. The right hip fracture or the hip dislocation was not addressed on the care plan or on the Resident Care Assignment Sheet. There were no approaches as to how to care for the hip such as: log rolling resident, abductor wedge in place at all times, remind resident not to cross legs or pivot on affected leg as Physical Therapy assessment indicated. There was no instruction on how many staff are needed to transfer resident from bed to chair on the care plan. Resident Care Assignment Sheet that the CNAs use as a guide to give care indicated that R3 was continent of bowel and bladder, used the bathroom or urinal, needed 2 person assistance, was to be out of bed for meals, had good eyesight, speaks well, uses wheelchair for mobility, needs 1 person assist to transfer, 1 person to assist to turn and position every 2 hours, special equipment elastic stockings and a chair alarm, shower with 1 assist. This care information sheet did not give direction to the CNAs how to transfer and move R3 according to the Physical Therapy assessment "hip precautions." Fall risk assessment of 5/14/07 states R3 was assessed as alert and oriented, requires assistance, fallen 1 or 2 times, visual impairment, confined to chair, balance problem while standing , decreased muscular coordination, use of appliances/devices, balance problem while walking, decline in functional status, unsteady gait and fracture of hip. Facility records contain a form titled Progress	F9999		

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F9999	Continued From page 35 Notes. This form is used by all staff of the facility and anyone else who wishes to document regarding the resident. Physician notes were also observed documented on this form. Facility documentation is computerized. Progress Notes of 5/26/07 at 4:05AM state R3 "was found on floor on left side of bed, laying face down, hitting head causing 3 centimeter (cm) head laceration, also skin tear to the left side of elbow approximately 4 cm and right hand posterior side unable to measure, Resident is a post left hip fracture and complains of pain in that left hip which is turned inward. Personal alarm in place and functioning well at time of fall and bed in lowest position. Sent to hospital Emergency Room." Hospital history and physical dated 5/26/07 indicates that R3 had pain and deformity to his right hip (not left as charted in the nurses note) and was unable to ambulate. R3 was examined and found to have a right hip hemiarthroplasty dislocation. R3 was admitted and for a closed reduction and possible open reduction of the right hip. According to the progress notes on 5/29/07, R3 was transferred back to the nursing home alert to person and place with abductor wedge in place. R3 refused a skin check due to being "in too much pain." The physicians orders and the progress notes of 6/4/07 indicate that R3 was sent again to the hospital emergency room for evaluation of a right hip bulge and pain. Progress notes of 6/4/07 state "CNA to nurses desk, reports (R3's) right hip has a bulge. E7, LPN (Licensed Practical Nurse), assessed right hip is bulging outward, (R3) states the hip is very painful to him.	F9999		

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F9999	Continued From page 36 Transported to the hospital where he was admitted with anemia, urosepsis, and dislocated hip, again." On 6/5/07 at 10:30AM, E2, DON, was interviewed regarding R3's second hip dislocation since his admission on 5/12/07. E2 stated that he doesn't know how it happened. E2 stated that E8 (Certified Nurse Aide/CNA) was getting R3 up for breakfast and noticed the bulge in his right hip and got E7, LPN. E7 assessed R3 and sent him to the hospital. E2 stated that he talked to the nurse about R3's injury and read the nurses notes. The June 2007 Resident Accident and Incident Reports indicated that there have been four falls (3 unwitnessed) since June 1 through June 6. R3's incident of 6/5/07 was not logged on this report. On 6/5/07 E8 ,CNA, was interviewed regarding the dislocation of R3's hip. E8 stated that E8 did not hear any noise from R3's room when she went down the hallway to get him up for breakfast around 6:00AM. E8 stated that R3 was in his low bed with a mat on the floor beside it. The abductor pillow was on the floor at the end of the bed. E8 stated that R3 was lying on his side. E8 said that she asked R3 to roll over to his back and R3 began grunting with pain. E8 stated she did not ask R3 if he had fallen. E8 said that she saw the bulge to R3's hip before she assisted him with transferring to the wheelchair. E8 stated that R3 complained of pain in his right hip, so she sent E9 (third shift CNA) to tell E7, LPN. E8 stated that E7 had them put R3 back to bed so E7 could examine the hip. E7 left to call the doctor. E8 stated that R3 was sent to the hospital	F9999		

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F9999	Continued From page 37 soon after. E8 stated E8 did not think to tell E7 about the bulge to R3's hip before E8 transferred R3. On 6/5/07 at 1100AM, E7, LPN, was interviewed regarding R3's bulge to his right hip. E7 stated that one of the CNA's told her (don't remember which one) that R3's hip was bulging out. E7 stated that R3 was complaining of pain, was all anxious and tense. E7 stated that the 3rd shift CNA told her that R3 did not have any problem through the night--that he had slept. E7 does not remember exactly what time - "it was first thing in the morning, the beginning of the shift." E7 stated that she thinks R3 is a two person assist to transfer. E7 stated that she asked the CNA's to put R3 back to bed in order to assess him. E7 stated that she asked R3 if anything happened to him, and he stated that he did not know. E7 said that then she called the physician. On 6/5/07 at approximately 1:00PM, Z1, Medical Director, was interviewed regarding R3's second hip dislocation on 6/4/07. Z1 stated that E7 called her and stated that she had assessed R3. R3 had a bulge to the right hip and was complaining of pain. Z1 stated that E7 told her that she had administered pain medication around 5:00AM. Medication Administration Record for 6/4/07 indicated that no pain medication was signed out for R3 at 5:00 AM. Z1 stated that neither E7 nor E2 told her that R3 had been transferred to the wheelchair and back to bed with the hip bulging. Z1 stated that R3 is very elderly and his muscles are weak. Z1 stated that the hip should not dislocate by turning in bed, but anything is possible. Z1 was not aware of the abductor wedge being on the floor when R3 turned in bed from side to back.	F9999		

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F9999	Continued From page 38 On 6/5/07 at approximately 1:30PM, E2, DON, was interviewed again about R3's right hip dislocation. E2 stated that no one told him that R3 was transferred to the wheelchair and back with the right hip bulging and complaining of pain. E2 stated, "I guess I didn't ask the right questions." 2. R1's face sheet dated 5/15/07 indicates R1 is an 88-year-old-female with Diagnoses of Diabetes II, Anemia, Congestive Heart Failure, Dementia, Depression, and Atrial Fibulation. R1 was admitted on 11/10/06 from the assisted living part of this facility to the nursing home section. Fall Risk Assessment dated 11/13/06 shows R1 was assessed as having a history of falls--1 or 2 in last 3 months. This same assessment states R1 has a problem with balance while standing and walking and uses a walker. R1 was assessed as having a decline in functional status, is incontinent, and has an unsteady gait. R1 also was assessed as having a decline in cognitive skills and other Dementia. Quarterly Minimum Data Set (MDS) dated 4/30/07 indicates that R1 is moderately impaired cognitively, needs extensive assist for bed mobility and one person physical assist to turn and position. R1 needs limited assistance to walk in the room and one person assistance. Balance while standing is unsteady, balance while sitting is unsteady and R1 has functional limitations to both sides of her neck, arms, hands, legs, and feet. Under the area of accidents, the MDS states R1 fell in the past 31-180 days. R1 ' s record showed the following	F9999		

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F9999	Continued From page 39 documentation regarding falls: Safety Events Falls charting of 12/14/06 indicates R1 had a fall in her room on 12/14/06 with bruising. A Progress Note dated 12/14/06 at 4:23 P.M. documents at "1:15 R1 was yelling from room, was found lying on floor with wheelchair attached to right knee. Wheelchair was closed with resident's right knee being pinched by wheelchair. There was bruising to inner and outer aspect of Right knee." On 2/2/07, R1 had a fall in her room at 9:45 AM. The Progress Notes of this date indicate R1 slid from the bed to the floor while trying to get to bathroom. On 5/12/07 a progress note of this date states R1 was found on the floor on the left side of the bed at 3:30AM. R1 had a hematoma on forehead. A progress note of 5/12/07 at 9:17 AM states R1 was short of breath with audible wheezing. R1 had a large bruise on right side of head/eye from fall. Family was notified and wanted R1 sent to the emergency room. R1's current care plan dated 2/15/07 stated: Problem start date 11/10/06: Resident at risk for falling related to psychotropic drug use and decreased safety awareness secondary to impaired cognition. The approach start date was 11/10/06 with approaches of: give verbal reminders not to ambulate/transfer without assistance, observe frequently and place in supervised area when out of bed, low bed with mats at bedside, Blue dot program. The only new approach other than the ones dated 11/10/06 was dated 1/22/07. This approach stated apply body alarm to resident while up in wheelchair and bed alarm when in bed.	F9999		

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F9999	Continued From page 40 On 6/1/07 at 11:00AM, E5, Certified Nurse Aide/CNA (CNA shift coordinator), was interviewed regarding any special programs for residents at risk for falls, such as blue dot program (one of the approaches listed on the current care plan). E5 stated that they have no special programs here for residents at risk for falls. E5 stated that CNA shift coordinators report off to each other as to what happened on their shift, such as: falls, skin tears. E5 stated that Physical Therapy evaluates the residents or the hospital sends orders as to how much assistance each resident needs. E5 stated that the nurse tells the CNA's and they pass it on to each other. On 6/1/07 at 9:30AM, E8 (CNA) stated that they do not have any special monitoring programs for residents at risk for falls. She knows to watch residents closely while doing cares. On 5/29/07, E2 (DON) was interviewed regarding any new approaches that were added to the care plan after the fall of 5/12/07. E2 stated that he immediately put a low bed, a mat on the floor, and a personal alarm in R1's room after R1 came back from the hospital on 5/15/07. E2 stated on 5/31/07 at 3:30 P.M. regarding his investigation of R1's fall of 5/12/07 that he talked to the nurse on duty, reviewed the charting, and filled out the report to Public Health Department and faxed it. E2 stated that he did not meet with anyone to identify any trends or patterns or develop and implement any corrective actions except for putting a low bed and mat on the floor beside the bed. The care plan, dated 2/7/07 in place at the time of the fall, stated both the mat and low bed were to already be in use. E2 was asked how the CNA's know how to care for the residents and	F9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF PEORIA	**6900 NORTH STALWORTH PEORIA, IL 61615**

(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
F9999	Continued From page 41 which residents are at risk for falls since the fall risk assessments are in the computer. E2 stated that the CN'As have a Resident Care Assignment Sheet to follow when giving cares. E2 stated that they do not have any special monitoring programs for residents at risk for falls. The Care Assignment Sheet for R1 indicated that R1 is: "incontinent of bowel and bladder, toileting bathroom, briefs, one assist, out of bed for all meals, turn and position self, low bed with brakes locked, confused, but alert to self." This care guide does not indicate that R1 is at risk for falls or give direction to observe frequently or place in a supervised area. The approaches identified on the care plan are not on the care assignment sheets that the CNA's use. 3. R2's face sheet indicates that R2 is a 93-year-old-male with diagnoses of Renal failure, Congestive heart failure Hyperosmolality/hypernatremia, Hypertension, and Thrombosis, Venous. R2 was admitted to the nursing home on 11/29/06. Quarterly Minimum Data Set dated 3/1/07 notes that R2 is moderately impaired cognitively, needs limited assistance and 1 person assist to walk in his room, and limited assist and 1 person assist to transfer. The area under accidents is marked to indicate R2 fell in the past 31-180 days. Safety Events charting from 1/11/07 through 5/2/07 indicated the following: "R2 fell 1/11/07 at 12:30PM found on floor next to bed sitting on buttocks with pants down around ankles shoes off." 1/13/07 at 5:50AM, R2 was found in bathroom,	F9999		

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F9999	Continued From page 42 light sounding, lying on his left side in front of toilet, no gown, no shoes, adult diaper on around ankles, head leaning against wall of bathroom, red area to back of head. Body alarm attached to gown and alarm on bedside. 3/30/07, R2 was discovered lying on the floor on the bathroom doorway, noted floor wet, bare feet, hit back of head, bump to right side of back of head. 5/2/07 R2 was found lying on his right side upon entering the room, complained of pain to his left shoulder and left hip, Range of motion painful to upper extremity, no rotation or deformity/shortening noted, did not move resident till Advanced Medical Transport came." Nursing Progress Notes dated 5/2/07 at 12:10AM state R2 was "found lying on the floor on his right side. When asked if he was hurt he stated yes, but would not say where. Upon assessment the left shoulder was very tender and did not want it touched. He could not move Left upper extremity. " Nursing Progress Notes documented again on 5/2/07 at 6:49AM state R2 "returned from hospital. R2 yelling out with transfer from stretcher to bed. After the transfer complete, no further yelling out. Diagnosis is comminuted fracture left proximal humerus. Immobilizer intact to left arm." Progress Notes dated 5/2/07 through 5/4/07 show "R2 was yelling out with uncontrolled pain during cares with movement. Progress note of 5/4/07 states R2 was sent back to the hospital Emergency Room for uncontrolled pain and an Orthopedic consultation. On 5/16/07, R2 returned to the facility after having an open reduction	F9999		

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F9999	Continued From page 43 internal fixation of the left hip." Quarterly Minimum Data Set dated 3/1/07 indicated that R2 "was moderately impaired cognitively, wanders, is socially inappropriate, resists cares, needs limited one person assist to transfer, needs one person assist to move wheelchair, one person assist to dress and bath and has fallen in the past 31-180 days." Resident Assessment Protocol Summary dated 12/22/06 indicates that R2 has a "diagnosis of Delirium and is confused and tends to wander at times. He has exhibited impairment in functioning independently with daily tasks and will assist him. R2 is at risk for falls due to delirium with dementia, complaints of joint pain, unsteady gait, and incontinence." Care plan dated 3/15/07 through 6/13/07 indicates that R2 is a risk for falls related to weakness and unsteady gait and history of fall on 5/2/07. One week after returning from the hospital the approaches dated 5/23/07 were: "give resident verbal reminders not to ambulate/transfer without assistance, keep call light in reach at all times, keep personal items and frequently used items within reach, low bed with bedside mats on floor when in bed and frequent check blue dot program." This care plan does not address R2's fall history with updated specific interventions/approaches to prevent falls. It does not address R2's fracture of the humerus and left hip. Resident Care Assignment Sheet indicates that R2 "is incontinent of bladder and bowel, bathroom with assist of 1, wheelchair with assist of 1, low bed, shower with 1 assist, resists	F9999		

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F9999	Continued From page 44 cares." This Resident Care Assignment Sheet does not give direction as how to transfer R2 with both his fractured hip and fracture humerus. On 6/1/07 at 11:00AM E5 (CNA) and E8 (CNA) stated that the Resident Care Assignment Sheets are what they use to know how to care for the residents. They stated that each CNA shift coordinator reports off to the next shift. Both stated that there is no special monitoring or program for residents who are at risk for falls i.e.: blue dot program that is referred to in the care plan. (A)	F9999		