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 09/06/2011

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

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F 000	INITIAL COMMENTS Complaint Investigations: 1191677/IL53137- F226; F516 1192537/IL54162 - F323	F 000		
F 226 SS=G	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement its abuse protocol for 3 of 4 residents (R1, R2, R3) reviewed for abuse in a sample of 8 residents. This failure resulted in R2 receiving multiple skin tears. Findings include: 1. During a tour of the facility ' s 2nd floor unit with E4, (Assistant Director of Nursing) ADON on 8/5/11 at 10:45am, R1 was observed in bed with visible bruises on her left arm, left leg and what appeared to be a fading bruise of the right peri-orbital area. E4 stated that R1 requires extensive assist from staff for all ADL ' s (activities of daily living) and that the peri-orbital bruising is " always like that. " E4 went on to say that R1 has experienced a recent decline in condition. A Patient Transfer Form dated 7/19/11 shows R1 was re-admitted to the facility on that date. An	F 226		10/6/11

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

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F 226	Continued From page 1 undated Nursing Admission Evaluation shows no applicable skin related risk factors, however, skin assessment diagram reveals multiple areas of skin alterations including a bruise of left upper arm. Nursing notes dated 7/20/11, 7-3 shift, describes " an old bruise to her R (right) medial upper arm and lump noted " , with no reference to left upper arm bruise. There were no further documentation regarding bruising in the nurses notes dated 7/21/11 through 8/5/11. The facility utilizes Skin Worksheets which are completed by the certified nurses aids (CNA ' s) during residents ' showers and or baths. R1 ' s Skin Worksheets dated 7/16/11 through 8/3/11 (five sheets) shows " old bruise " on right upper arm (7/30/11) and " bruises " to right upper arm (8/3/11). There was no documentation found regarding the left arm, right leg and right peri-orbital bruise observed by surveyor. 2. During a tour of the facility ' s 2nd floor unit with E4, Assistant Director of Nursing (ADON) on 8/5/11 at approximately 10:50am, R2 was observed in her room, sitting in a wheelchair. R2 ' s arms were not visible due to a sleeve-like garment on both arms. E4 stated that R2 has very fragile skin and wears geri-sleeves on all four extremities. R2 was observed with an open wound on the left arm which E4 describes as an old skin tear. There were multiple areas of bruising on R2 ' s right arm. E4 stated that the geri-sleeve help to prevent skin tears as R2 ' s skin tears even during transfer to bed. There were multiple areas of bruising and skin tears observed on R2 ' s bilateral lower extremities. On 8/5/11 at approximately 1:50pm, Z2, Family Member, was visiting with R2 and told surveyor	F 226		

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F 226	Continued From page 2 he (Z2) was not aware of any bruising or skin tears on R2 ' s body. Z2 went on to say that he would discuss this with R2 ' s assigned power of attorney. Z2 asked R2 if staff is rough with her during care. R2 responded " they need to be rough with me. I ' m too lazy. " Surveyor addressed this comment made by R2 with E1, Administrator, on 8/5/11 at 4:30pm. There was no response from E1. This concern was again addressed with E1 on 9/6/11 at 2:30pm. E3, Director of Nursing, presented surveyor with written documentation on 9/6/11 at 3:30pm, of an interview she conducted with R2 which states R2 denies mistreatment from staff. There was no evidence that an investigation was conducted. R2 ' s care plan dated 4/15/11 shows diagnoses of Dementia, Legal Blindness, Depression and Muscle Weakness. R2 requires 2 person mechanical lift for transfer. Facility ' s Incident Report log for the period of February to August 2011, shows no incident reports being completed nor investigation done regarding R2 ' s skin condition. Nursing notes dated 7/1/11 through 8/5/11 shows 4 incidences of skin tear, 7/13/11, 7/15/11, 7/23/11, 8/4/11. There was no evidence provided to support these occurrences being investigated. R2 ' s Skin Worksheet dated 7/2/11 through 8/3/11 (6 sheets) does not reflect the presence of these incidences. 3. R3 ' s Minimum Data Set (MDS) dated 8/3/11 shows a 97 year old resident with a diagnosis of Anxiety with impaired cognition and disorganized	F 226		

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F 226	Continued From page 3	F 226		

thought process. An incident report dated 5/17/11 states R3 was " noted with bruising to both metacarpal hands also small skin tear noted between lt. (left) 4th and 5th finger. " The incident report was missing all staff signatures and contained incomplete data regarding care provided to R3 following the discovery of the injuries.

The report faxed to the State agency on 5/18/11 states " Confused resident alleged ' staff beat me up. ' Investigation initiated. Staff suspended. " A follow up report to the State agency dated 5/20/11 states " Investigation complete. Abuse cannot be substantiated. "
Z1, Family Member, told surveyor during a telephone interview on 8/5/11 at 9:00am, that an unidentified certified nurse ' s aide (CNA) reported to her (Z1) that 2 CNA ' s grabbed R3 ' s hand too tightly during care, causing bruising of both hands.

The facility Investigation Report dated 5/17/11 shows E5, Certified Nurses Aid (CNA), and E6, CNA were the individuals caring for R3 when the alleged abuse occurred.
During an interview with E5 on 8/31/11 at 3:40pm, E5 stated that she was a new employee at the time, assigned to take care of R3 with the assistance of E6 to perform a 2 person assist transfer. R3 became very combative (biting, spitting, scratching) during transfer from bed to wheelchair on 5/17/11 because she, R3, did not want to get out of bed. E5 stated that R3 bruises easily and that no bruising occurred as a result of this transfer.

E6, CNA, told surveyor during a separate

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F 226	Continued From page 4	F 226		

interview on 9/1/11, that R3 has a history of accusing staff of being abusive and exhibiting verbal and physical behaviors to staff and residents. According to E6, R3 cries a lot, throws food and knives at other residents during meal times in the dining room. E6 also stated that all the CNA ' s are scared to work with R3 as a result of this behavior. These behaviors, according to E6, are evident on a daily basis; all employees are aware of it but nothing has been done about it.

R3 ' s Care Plan dated 5/6/10 includes interventions to address behaviors of hitting, swearing, attempting to bite staff, falsely accusing staff, pinching, banging eating utensils on the table during meals. These behaviors continue and there is no evidence that these interventions have been revised. Surveyor requested documentation that these behaviors have been addressed by social services. There was none presented and none found in the clinical record. MDS dated 5/16/11 and 8/3/11 states R3 exhibits no behaviors.

Facility ' s Abuse Policy dated 4/21/06 addresses " catastrophic reactions " which it defines as ' reactions or mood changes of the patient in response to what may seem to be minimal stimuli, e.g., bathing, dressing, toileting, etc. and can be characterized by weeping, blushing, anger, agitation or stubbornness. " The Policy states that such reactions should be addressed to prevent negative patient outcomes.

During an interview with E1, Administrator, on 9/1/11 at approximately 11:30am, Surveyor asked E1 how are residents who exhibit undesirable

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F 226	Continued From page 5 behaviors monitored and protected from potential behavior-related abuse. E1 stated that it is the nurse managers ' responsibility to monitor the provision of direct care. Residents are also frequently asked about their care. E1 went on to say that family members are encouraged to report any concerns to staff. E1 agreed that, for ' difficult ' residents, an approach that may be effective would be to assign the same staff to these residents to foster good relationship between staff and resident. E1 stated that the occurrence of skin tears in the facility is likely due to residents picking at their own skin and the facility applies geri-sleeve to those residents. E1 stated that all occurrences of bruise of unknown origin are investigated under the abuse protocol. E1 also stated that all personnel receive training on abuse prohibition. Facility abuse protocol was reviewed and states that all injuries of unknown origin, reports of abuse, neglect or mistreatment will be investigated and reported to the state agency as required.	F 226		
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	F 323		10/6/11

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by:
Based on observation, record review and interview, the facility failed to follow fall prevention precautions for 2 of 4 residents, R1 and R6, reviewed for falls in a sample of 8 residents.

Findings include:
1. R1 ' s Readmission Screens dated 7/5/11, 7/19/11 states R1 has a history of falls. Care plan dated 6/20/07 states R5 is at risk for falls due to debilitation, impaired cognition and use of psychotropic medications. Intervention for use of chair and bed alarm was initiated on 3/7/11.
On 9/1/11 at approximately 2:45pm, R1 was observed up in a wheelchair, asleep. E3 (Director of Nursing) was present and was able to arouse R1 with minimal difficulty. There was a device on the floor beneath R1 ' s bed and there was no alarm device attached to R1 ' s chair. E3 confirmed that the device was an alarm device and stated that it should not be on the floor. E3 made no attempt to remove device from the floor and attach to the wheel chair.

2. R 6 was observed in his room, in a wheelchair on 9/1/11 at approximately 2:50 pm. E4 was present. R6 told surveyor that he receives physical therapy for strengthening of his legs and that he had sustained a fall at home prior to admission. R6 went on to say that he is not supposed to go to the bathroom alone, and should request assistance. There was no alarm device on R6 ' s wheel chair. E4 stated she was not aware of R6 ' s fall risk.
R6 ' s CAA worksheet dated 7/21/11 states R6 triggered for falls on the Minimum Data Set (MDS) due to debilitation and history of Dementia and impaired balance during transfer.

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F 323	Continued From page 7 Interventions to prevent falls include the use of bed and chair alarm.	F 323		
F 516 SS=D	483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to safeguard the clinical record of 1 sampled resident, R3, in a sample of 7 residents. Findings include: 1. R3 ' s Minimum Data Set (MDS) dated 8/3/11 shows a 97 year old resident with a diagnosis of Anxiety. Z1, Family Member, told surveyor during a phone interview on 8/5/11 at 9 am, that she received a letter from the facility which stated that R3 ' s clinical records, including personal information, were misplaced and cannot be found. E1, Administrator, told surveyor on 8/5/11 at 3:30 pm, that R3 ' s entire clinical record was	F 516		10/6/11

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F 516	Continued From page 8 misplaced and cannot be found since June 8th or June 9th, 2011. E1 went on to say that an in depth search of the facility was conducted and staff were interviewed and the record was not found. On 9/6/11 at 3:30 pm, E1 again said that the records were never found. Review of R3 ' s current clinical records shows R3 was admitted to the facility on 1/29/10. There are no records found for care provided prior to 6/9/11.	F 516		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210b) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care	F9999		

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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 resident care plan. 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.
Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

Based on observation, interview and record review, the facility failed to implement its abuse protocol for 3 of 4 residents (R1, R2, R3) reviewed for abuse in a sample of 8 residents. This failure resulted in R2 receiving multiple skin tears.

Findings include:

1. During a tour of the facility ' s 2nd floor unit with E4, (Assistant Director of Nursing) ADON on 8/5/11 at 10:45am, R1 was observed in bed with visible bruises on her left arm, left leg and what appeared to be a fading bruise of the right peri-orbital area. E4 stated that R1 requires extensive assist from staff for all ADL ' s (activities of daily living) and that the peri-orbital bruising is " always like that. " E4 went on to say that R1 has experienced a recent decline in condition.

A Patient Transfer Form dated 7/19/11 shows R1 was re-admitted to the facility on that date. An undated Nursing Admission Evaluation shows no

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applicable skin related risk factors, however, skin assessment diagram reveals multiple areas of skin alterations including a bruise of left upper arm.
Nursing notes dated 7/20/11, 7-3 shift, describes " an old bruise to her R (right) medial upper arm and lump noted " , with no reference to left upper arm bruise. There were no further documentation regarding bruising in the nurses notes dated 7/21/11 through 8/5/11. The facility utilizes Skin Worksheets which are completed by the certified nurses aids (CNA ' s) during residents ' showers and or baths. R1 ' s Skin Worksheets dated 7/16/11 through 8/3/11 (five sheets) shows " old bruise " on right upper arm (7/30/11) and " bruises " to right upper arm (8/3/11).
There was no documentation found regarding the left arm, right leg and right peri-orbital bruise observed by surveyor.

2. During a tour of the facility ' s 2nd floor unit with E4, Assistant Director of Nursing (ADON) on 8/5/11 at approximately 10:50am, R2 was observed in her room, sitting in a wheelchair. R2 ' s arms were not visible due to a sleeve-like garment on both arms. E4 stated that R2 has very fragile skin and wears geri-sleeves on all four extremities. R2 was observed with an open wound on the left arm which E4 describes as an old skin tear. There were multiple areas of bruising on R2 ' s right arm. E4 stated that the geri-sleeve help to prevent skin tears as R2 ' s skin tears even during transfer to bed. There were multiple areas of bruising and skin tears observed on R2 ' s bilateral lower extremities.
On 8/5/11 at approximately 1:50pm, Z2, Family Member, was visiting with R2 and told surveyor he (Z2) was not aware of any bruising or skin

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tears on R2 ' s body. Z2 went on to say that he would discuss this with R2 ' s assigned power of attorney. Z2 asked R2 if staff is rough with her during care. R2 responded " they need to be rough with me. I ' m too lazy. "

Surveyor addressed this comment made by R2 with E1, Administrator, on 8/5/11 at 4:30pm. There was no response from E1. This concern was again addressed with E1 on 9/6/11 at 2:30pm. E3, Director of Nursing, presented surveyor with written documentation on 9/6/11 at 3:30pm, of an interview she conducted with R2 which states R2 denies mistreatment from staff. There was no evidence that an investigation was conducted.

R2 ' s care plan dated 4/15/11 shows diagnoses of Dementia, Legal Blindness, Depression and Muscle Weakness. R2 requires 2 person mechanical lift for transfer.
Facility ' s Incident Report log for the period of February to August 2011, shows no incident reports being completed nor investigation done regarding R2 ' s skin condition.

Nursing notes dated 7/1/11 through 8/5/11 shows 4 incidences of skin tear, 7/13/11, 7/15/11, 7/23/11, 8/4/11. There was no evidence provided to support these occurrences being investigated. R2 ' s Skin Worksheet dated 7/2/11 through 8/3/11 (6 sheets) does not reflect the presence of these incidences.

3. R3 ' s assessment dated 8/3/11 shows a 97 year old resident with a diagnosis of Anxiety with impaired cognition and disorganized thought process. An incident report dated 5/17/11 states

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R3 was " noted with bruising to both metacarpal hands also small skin tear noted between lt. (left) 4th and 5th finger. " The incident report was missing all staff signatures and contained incomplete data regarding care provided to R3 following the discovery of the injuries.

The report faxed to the State agency on 5/18/11 states " Confused resident alleged ' staff beat me up. ' Investigation initiated. Staff suspended. " A follow up report to the State agency dated 5/20/11 states " Investigation complete. Abuse cannot be substantiated. "
Z1, Family Member, told surveyor during a telephone interview on 8/5/11 at 9:00am, that an unidentified certified nurse ' s aide (CNA) reported to her (Z1) that 2 CNA ' s grabbed R3 ' s hand too tightly during care, causing bruising of both hands.

The facility Investigation Report dated 5/17/11 shows E5, Certified Nurses Aide (CNA), and E6, CNA were the individuals caring for R3 when the alleged abuse occurred.
During an interview with E5 on 8/31/11 at 3:40pm, E5 stated that she was a new employee at the time, assigned to take care of R3 with the assistance of E6 to perform a 2 person assist transfer. R3 became very combative (biting, spitting, scratching) during transfer from bed to wheelchair on 5/17/11 because she, R3, did not want to get out of bed. E5 stated that R3 bruises easily and that no bruising occurred as a result of this transfer.

E6, CNA, told surveyor during a separate interview on 9/1/11, that R3 has a history of accusing staff of being abusive and exhibiting

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 09/06/2011

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
F9999	Continued From page 13	F9999		

verbal and physical behaviors to staff and residents. According to E6, R3 cries a lot, throws food and knives at other residents during meal times in the dining room. E6 also stated that all the CNA ' s are scared to work with R3 as a result of this behavior. These behaviors, according to E6, are evident on a daily basis; all employees are aware of it but nothing has been done about it.

R3 ' s Care Plan dated 5/6/10 includes interventions to address behaviors of hitting, swearing, attempting to bite staff, falsely accusing staff, pinching, banging eating utensils on the table during meals. These behaviors continue and there is no evidence that these interventions have been revised. Surveyor requested documentation that these behaviors have been addressed by social services. There was none presented and none found in the clinical record. MDS dated 5/16/11 and 8/3/11 states R3 exhibits no behaviors.

Facility ' s Abuse Policy dated 4/21/06 addresses " catastrophic reactions " which it defines as ' reactions or mood changes of the patient in response to what may seem to be minimal stimuli, e.g., bathing, dressing, toileting, etc. and can be characterized by weeping, blushing, anger, agitation or stubbornness. " The Policy states that such reactions should be addressed to prevent negative patient outcomes.

During an interview with E1, Administrator, on 9/1/11 at approximately 11:30am, Surveyor asked E1 how are residents who exhibit undesirable behaviors monitored and protected from potential behavior-related abuse. E1 stated that it

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F9999	Continued From page 14 is the nurse managers ' responsibility to monitor the provision of direct care. Residents are also frequently asked about their care. E1 went on to say that family members are encouraged to report any concerns to staff. E1 agreed that, for ' difficult ' residents, an approach that may be effective would be to assign the same staff to these residents to foster good relationship between staff and resident. E1 stated that the occurrence of skin tears in the facility is likely due to residents picking at their own skin and the facility applies geri-sleeve to those residents. E1 stated that all occurrences of bruise of unknown origin are investigated under the abuse protocol. E1 also stated that all personnel receive training on abuse prohibition. Facility abuse protocol was reviewed and states that all injuries of unknown origin, reports of abuse, neglect or mistreatment will be investigated and reported to the state agency as required. (B)	F9999		