PRINTED: 02/25/2012 FORM APPROVED OMB NO. 0938-0391

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUI				С
		145893	B. WII	···		09/0	6/2011
	PROVIDER OR SUPPLIER CARE OF PALOS HEI	GHTS WEST			REET ADDRESS, CITY, STATE, ZIP CODE 11860 SOUTHWEST HIGHWAY PALOS HEIGHTS, IL 60463		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	ГS	F	000			
F 226 SS=G	` '	F226; F516 F323 P/IMPLMENT	F	226			10/6/11
	policies and proced mistreatment, negle	evelop and implement written lures that prohibit ect, and abuse of residents on of resident property.					
	by: Based on observative review, the facility for protocol for 3 of 4 reviewed for abuse	NT is not met as evidenced tion, interview and record ailed to implement its abuse esidents (R1, R2, R3) in a sample of 8 residents. It in R2 receiving multiple skin					
	Findings include:						
	E4, (Assistant Direct 8/5/11 at 10:45am, visible bruises on happeared to be a faperi-orbital area. E4 extensive assist fro (activities of daily livbruising is "always that R1 has experied condition.	the facility 's 2nd floor unit with ctor of Nursing) ADON on R1 was observed in bed with er left arm, left leg and what ading bruise of the right 4 stated that R1 requires im staff for all ADL 's ving) and that the peri-orbital is like that. " E4 went on to say enced a recent decline in					
	was re-admitted to	Form dated 7/19/11 shows R1 the facility on that date. An					
LABORATOR'	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		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.

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		PLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		145893	B. WIN	G			C 6/2011
	PROVIDER OR SUPPLIER	GHTS WEST	•	11	EET ADDRESS, CITY, STATE, ZIP CODE 1860 SOUTHWEST HIGHWAY ALOS HEIGHTS, IL 60463		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 226	undated Nursing Adapplicable skin relaassessment diagraskin alterations inclarm. Nursing notes date "an old bruise to he and lump noted ", arm bruise. There were garding bruising 7/21/11 through 8/5 Worksheets which nurses aids (CNA' and or baths. R1's 7/16/11 through 8/5 bruise "on right up bruises " on right up bruises " to right up bruises" to right up bruises " to right up bruises " to right up bruises" to right up bruises " to right up bruises " to right up bruises" to right up bruises " to right up bruises " to righ	dmission Evaluation shows no ted risk factors, however, skin m reveals multiple areas of uding a bruise of left upper d 7/20/11, 7-3 shift, describes er R (right) medial upper arm with no reference to left upper were no further documentation in the nurses notes dated 5/11. The facility utilizes Skin are completed by the certified s) during residents ' showers a Skin Worksheets dated 5/11 (five sheets) shows " old oper arm (7/30/11) and " pper arm (8/3/11). Imentation found regarding the not right peri-orbital bruise	F 2	26			

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		145893	B. WIN				C 6/ 2011
	ROVIDER OR SUPPLIER	GHTS WEST		1	REET ADDRESS, CITY, STATE, ZIP CODE 1860 SOUTHWEST HIGHWAY PALOS HEIGHTS, IL 60463		0/2011
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F 226	he (Z2) was not aw tears on R2 's bod would discuss this attorney. Z2 asked during care. R2 res rough with me. I 'm Surveyor addresse with E1, Administra There was no resp was again address 2:30pm. E3, Direct surveyor with writte 3:30pm, of an inter which states R2 de There was no evide conducted. R2 's care plan day of Dementia, Legal Muscle Weakness mechanical lift for the Facility 's Incident February to August reports being compregarding R2 's skin Worksh (23/11, 8/4/11. The to support these of R2 's Skin Worksh (8/3/11) (6 sheets) distributed these incidences. 3. R3 's Minimum is shows a 97 year old	rare of any bruising or skin y. Z2 went on to say that he with R2 's assigned power of R2 if staff is rough with her sponded "they need to be not too lazy." If this comment made by R2 stor, on 8/5/11 at 4:30pm. Sonse from E1. This concerned with E1 on 9/6/11 at or of Nursing, presented on documentation on 9/6/11 at view she conducted with R2 nies mistreatment from staff. Sence that an investigation was blindness, Depression and R2 requires 2 person ransfer. Report log for the period of 2011, shows no incident bleted nor investigation done	F 2	226			

Facility ID: IL6014534

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		145893	B. WI				C 6/2011
	ROVIDER OR SUPPLIER		•	1	REET ADDRESS, CITY, STATE, ZIP CODE 1860 SOUTHWEST HIGHWAY PALOS HEIGHTS, IL 60463	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 226	thought process. A states R3 was " n metacarpal hands between It. (left) 4 report was missing contained incomply provided to R3 foll injuries. The report faxed the states " Confused me up. ' Investigate " A follow up reports for annot be substant 21, Family Members telephone interview unidentified certifier reported to her (Z) hand too tightly duboth hands. The facility Investigate containing an interview E5 stated that she time, assigned to assistance of E6 that transfer. R3 becar spitting, scratching wheelchair on 5/1 want to get out of easily and that no this transfer.	An incident report dated 5/17/11 oted with bruising to both also small skin tear noted th and 5th finger. " The incident g all staff signatures and lete data regarding care lowing the discovery of the othe State agency on 5/18/11 If resident alleged 'staff beat ution initiated. Staff suspended out to the State agency dated investigation complete. Abuse of the state agency of the state ag	F	955			

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	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLET		TED				
		145893	B. WIN	G			C 6/ 2011
	ROVIDER OR SUPPLIER	GHTS WEST	•	11	EET ADDRESS, CITY, STATE, ZIP CODE 1860 SOUTHWEST HIGHWAY ALOS HEIGHTS, IL 60463		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 226	interview on 9/1/11 accusing staff of be verbal and physical residents. According food and knives at times in the dining the CNA's are scaled from the CNA's are scaled from the CNA's are scaled from the CNA's are evident on are aware of it but it. R3's Care Plan dainterventions to add swearing, attempting staff, pinching, ban table during meals, and there is no evident addressed by social presented and non-MDS dated 5/16/11 no behaviors. Facility's Abuse P' catastrophic reactions or mood response to what meaning the characterized anger, agitation or states that such response to the catastrophic reactions or mood response to what meaning the characterized anger, agitation or states that such response to the catastrophic reactions or mood response to what meaning the characterized anger, agitation or states that such response to what meaning the characterized anger, agitation or states that such response to what meaning the characterized anger, agitation or states that such response to what meaning the characterized anger, agitation or states that such response to what meaning the characterized anger, agitation or states that such response to what meaning the characterized anger, agitation or states that such response to what meaning the characterized anger, agitation or states that such response to what meaning the characterized anger, agitation or states that such response to what meaning the characterized anger, agitation or states that such response to what meaning the characterized and th	that R3 has a history of sing abusive and exhibiting behaviors to staff and g to E6, R3 cries a lot, throws other residents during meal room. E6 also stated that all ared to work with R3 as a result ese behaviors, according to a daily basis; all employees nothing has been done about atted 5/6/10 includes dress behaviors of hitting, ag to bite staff, falsely accusing ging eating utensils on the These behaviors continue dence that these interventions Surveyor requested these behaviors have been all services. There was none er found in the clinical record. and 8/3/11 states R3 exhibits colicy dated 4/21/06 addresses ions "which it defines as 'changes of the patient in the pat	F 2	226			
	9/1/11 at approxima	ately 11:30am, Surveyor asked ts who exhibit undesirable					

Facility ID: IL6014534

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		IPLE CONSTRUCTION IG	(X3) DATE SI COMPLE	
		145893	B. WIN	NG _			C 6/2011
	ROVIDER OR SUPPLIER	GHTS WEST		1	REET ADDRESS, CITY, STATE, ZIP CODE 1860 SOUTHWEST HIGHWAY PALOS HEIGHTS, IL 60463	, <u>56/6</u>	0/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	behaviors monitore potential behavior-ris the nurse manag the provision of direfrequently asked at E1 went on to say the encouraged to reposagreed that, for 'disapproach that may assign the same stagood relationship by stated that the occupacility is likely due own skin and the fact those residents. E1 bruise of unknown of the abuse protocol. personnel receive the Facility abuse protocol. personnel receive that all injuries of unabuse, neglect or minvestigated and reprequired. 483.25(h) FREE OF HAZARDS/SUPER The facility must enenvironment remain as is possible; and	d and protected from elated abuse. E1 stated that it ers ' responsibility to monitor ect care. Residents are also cout their care. that family members are ort any concerns to staff. E1 efficult ' residents, an be effective would be to aff to these residents to foster etween staff and resident. E1 arrence of skin tears in the to residents picking at their incility applies geri-sleeve to stated that all occurrences of origin are investigated under E1 also stated that all raining on abuse prohibition. The col was reviewed and states in the eported to the state agency as eACCIDENT		323			10/6/11
	This REQUIREMEN	NT is not met as evidenced					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SURPLIER/CLIA

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	TED
		145893	B. WIN	IG _			C 6/ 2011
	ROVIDER OR SUPPLIER	GHTS WEST		1	REET ADDRESS, CITY, STATE, ZIP CODE 1860 SOUTHWEST HIGHWAY PALOS HEIGHTS, IL 60463		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	interview, the facilit precautions for 2 of reviewed for falls in Findings include: 1. R1's Readmiss: 7/19/11 states R1 h dated 6/20/07 state debilitation, impaire psychotropic medic chair and bed alarm On 9/1/11 at approxobserved up in a whof Nursing) was pre R1 with minimal diff the floor beneath R alarm device attach confirmed that it sh made no attempt to and stated that it sh made no attempt to and attach to the whole who was a considered for supposed to go to that he had sustain admission. R6 wen supposed to go to the should request assidevice on R6's who the aware of R6's R6's CAA workshot triggered for falls on the supposed to go to falls of the supposed to go to the should request assidevice on R6's who the supposed to go to the should request assidevice on R6's R6's CAA workshot triggered for falls on the supposed to go to falls on the supposed to go to the should request assidevice on R6's R6's CAA workshot triggered for falls on the supposed to go to falls on the supposed for falls on the supposed to go to falls on the supposed for falls on the supposed for falls on the supposed for falls of the supposed for falls on the supposed for falls on the supposed for falls of the supposed for fall supposed for falls of the supposed for fall suppo	cion, record review and y failed to follow fall prevention of 4 residents, R1 and R6, a sample of 8 residents. Ion Screens dated 7/5/11, has a history of falls. Care plants R5 is at risk for falls due to disconstitution and use of attions. Intervention for use of a was initiated on 3/7/11. A winately 2:45pm, R1 was neelchair, asleep. E3 (Director as each and was able to arouse ficulty. There was a device on 1's bed and there was not need to R1's chair. E3 device was an alarm device and the floor. E3 or remove device from the floor heel chair. Id in his room, in a wheelchair imately 2:50 pm. E4 was reveyor that he receives a strengthening of his legs and the da fall at home prior to to to not say that he is not the bathroom alone, and istance. There was no alarm neel chair. E4 stated she was fall risk. Set dated 7/21/11 states R6 in the Minimum Data Set	F3	323			
	and impaired balan	tation and history of Dementia ce during transfer.					

Facility ID: IL6014534

· · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUIL	DING			c	
		145893	B. WIN	G			6/2011	
	ROVIDER OR SUPPLIER	GHTS WEST		1186	FADDRESS, CITY, STATE, ZIP CODE O SOUTHWEST HIGHWAY OS HEIGHTS, IL 60463			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 323 F 516 SS=D	Interventions to prebed and chair alarm 483.75(I)(3), 483.20	event falls include the use of m. O(f)(5) RELEASE RES INFO,	F 3				10/6/11	
55=D	A facility may not re resident-identifiable. The facility may rel resident-identifiable accordance with a agrees not to use of except to the extent to do so. The facility must sa	elease information that is						
	by: Based on interview failed to safeguard sampled resident, Findings include: 1. R3 's Minimum shows a 97 year ol Anxiety. Z1, Family Membe interview on 8/5/11 letter from the facili clinical records, included were misplaced an E1, Administrator, for the facility of t	NT is not met as evidenced v and record review, the facility the clinical record of 1 R3, in a sample of 7 residents. Data Set (MDS) dated 8/3/11 d resident with a diagnosis of r, told surveyor during a phone at 9 am, that she received a lity which stated that R3's sluding personal information, d cannot be found. told surveyor on 8/5/11 at 3:30 re clinical record was						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUI		G	(0
		145893	B. WIN	IG _		09/0	6/2011
	ROVIDER OR SUPPLIER	GHTS WEST		1	REET ADDRESS, CITY, STATE, ZIP CODE 1860 SOUTHWEST HIGHWAY PALOS HEIGHTS, IL 60463		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 516	June 9th, 2011. E1 depth search of the staff were interview found. On 9/6/11 at the records were not review of R3 's cure R3 was admitted to	not be found since June 8th or went on to say that an in a facility was conducted and yed and the record was not to 3:30 pm, E1 again said that	F!	516			
F9999	LICENSURE VIOL 300.610a) 300.1210b) 300.3240a) Section 300.610 Re a) The facility shall procedures, govern the facility which sh Resident Care Poli least the administra the medical advisorepresentatives of the facility. These p with the Act and all These written polic operating the facility least annually by th written, signed and meeting. Section 300.1210 (Nursing and Perso	esident Care Policies have written policies and ning all services provided by hall be formulated by a cy Committee consisting of at eator, the advisory physician or rry committee and nursing and other services in policies shall be in compliance rules promulgated thereunder. ies shall be followed in ry and shall be reviewed at his committee, as evidenced by dated minutes of such a	F99	999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COMPLE	TED
	145893	B. WIN	NG _			C 6/ 2011
	GHTS WEST			11860 SOUTHWEST HIGHWAY	0070	3/2011
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
and services to atta practicable physical well-being of the reseach resident's complan. Adequate and care and personal cresident to meet the care needs of the resection 300.3240 A a) An owner, licensagent of a facility stresident. Based on observati review, the facility faprotocol for 3 of 4 reviewed for abuse This failure resulted tears. Findings include: 1. During a tour of the E4, (Assistant Direct 8/5/11 at 10:45am, visible bruises on heappeared to be a faperi-orbital area. E4 extensive assist fro (activities of daily libbruising is "always that R1 has experied condition. A Patient Transfer II	in or maintain the highest I, mental, and psychological sident, in accordance with hiprehensive resident care I properly supervised nursing care shall be provided to each e total nursing and personal esident. Ibuse and Neglect ee, administrator, employee or hall not abuse or neglect a on, interview and record ailed to implement its abuse esidents (R1, R2, R3) in a sample of 8 residents. If in R2 receiving multiple skin the facility 's 2nd floor unit with ector of Nursing) ADON on R1 was observed in bed with er left arm, left leg and what adding bruise of the right I stated that R1 requires m staff for all ADL 's ving) and that the peri-orbital is like that. " E4 went on to say enced a recent decline in	F99	9999			
undated Nursing Ad	dmission Evaluation shows no					
	ROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa and services to atta practicable physical well-being of the releach resident's complan. Adequate and care and personal cresident to meet the care needs of the reseach of a facility shresident. Based on observation review, the facility shresident. Based on observation review, the facility shresident. Based on observation reviewed for abuse This failure resulted tears. Findings include: 1. During a tour of the E4, (Assistant Direct Reviewed for abuse This failure resulted tears. Findings include: 1. During a tour of the E4, (Assistant Direct Reviewed for abuse This failure resulted tears. Findings include: 1. During a tour of the E4, (Assistant Direct Reviewed for abuse This failure resulted tears. Findings include: 1. During a tour of the E4, (Assistant Direct Reviewed for abuse This failure resulted tears. Findings include: 1. 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CARE OF PALOS HEIGHTS WEST SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 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	ROVIDER OR SUPPLIER CARE OF PALOS HEIGHTS WEST SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 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. 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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	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 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. 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An	ROVIDER OR SUPPLIER CARE OF PALOS HEIGHTS WEST SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 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. Based on observation, interview and record review, the 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	ROVIDER OR SUPPLIER TARE OF PALOS HEIGHTS WEST SUMMARY STATEMENT OF DESICIENCIES (EACH DESCIPENCY) (EACH DESCIPENCY WAST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 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. 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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		145893	B. WIN				C 6/2011
	PROVIDER OR SUPPLIER	GHTS WEST	•	1	REET ADDRESS, CITY, STATE, ZIP CODE 1860 SOUTHWEST HIGHWAY PALOS HEIGHTS, IL 60463		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	assessment diagra skin alterations incl arm. Nursing notes date: " an old bruise to be and lump noted ", arm bruise. There were garding bruising i 7/21/11 through 8/5 Worksheets which nurses aids (CNA' and or baths. R1's 7/16/11 through 8/3 bruise " on right up bruises " to right up bruises " to right up bruises " to right up there was no docu left arm, right leg an observed by survey 2. During a tour of the E4, Assistant Director 8/5/11 at approximate observed in her roots arms were not vis garment on both and very fragile skin and four extremities. R2 wound on the left and old skin tear. There bruising on R2's rigeri-sleeve help to skin tears even dur were multiple areas observed on R2's On 8/5/11 at approximate of the process	ted risk factors, however, skin m reveals multiple areas of uding a bruise of left upper d 7/20/11, 7-3 shift, describes er R (right) medial upper arm with no reference to left upper vere no further documentation in the nurses notes dated 6/11. The facility utilizes Skin are completed by the certified s) during residents 'showers is Skin Worksheets dated 6/11 (five sheets) shows "old oper arm (7/30/11) and "oper arm (8/3/11). mentation found regarding the ind right peri-orbital bruise	F99	999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SURPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		IPLE CONSTRUCTION NG	COMPLE	TED
		145893	B. WIN	۱G _			C 6/ 2011
	ROVIDER OR SUPPLIER	GHTS WEST		1	REET ADDRESS, CITY, STATE, ZIP CODE 11860 SOUTHWEST HIGHWAY PALOS HEIGHTS, IL 60463		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	would discuss this vattorney. Z2 asked during care. R2 res rough with me. I 'm' Surveyor addressed with E1, Administra There was no response again addressed 2:30pm. E3, Directo surveyor with writte 3:30pm, of an interwhich states R2 de There was no evide conducted. R2 's care plan date of Dementia, Legal Muscle Weakness. mechanical lift for the February to August reports being compregarding R2 's skir Nursing notes dated incidences of skir 7/23/11, 8/4/11. The to support these oc R2 's Skin Worksh 8/3/11 (6 sheets) do these incidences. 3. R3 's assessme year old resident with impaired cognition and surveyor with me. I'm' Surveyor addressed with E1 and E2 and E3 and E3 and E4 a	y. Z2 went on to say that he with R2's assigned power of R2 if staff is rough with her ponded "they need to be a too lazy." d this comment made by R2 tor, on 8/5/11 at 4:30pm. Onse from E1. This concerned with E1 on 9/6/11 at or of Nursing, presented in documentation on 9/6/11 at view she conducted with R2 nies mistreatment from staff. Ence that an investigation was seed 4/15/11 shows diagnoses Blindness, Depression and R2 requires 2 person ransfer. Report log for the period of 2011, shows no incident leted nor investigation done	F99	999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145893	B. WI	NG _			ට 6/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE OF PALOS HEIGHTS WEST				1	REET ADDRESS, CITY, STATE, ZIP CODE 1860 SOUTHWEST HIGHWAY PALOS HEIGHTS, IL 60463		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F9999	R3 was " noted with hands also small skath and 5th finger.' missing all staff signincomplete data regfollowing the discovered to states " Confused me up. ' Investigatis" A follow up report 5/20/11 states " Investigatis" A follow up report 5/20/11 states " Investigatis and the substant Z1, Family Member telephone interview unidentified certified reported to her (Z1) hand too tightly durboth hands. The facility Investig shows E5, Certified CNA were the indivict alleged abuse occur During an interview E5 stated that she with time, assigned to take assistance of E6 to transfer. R3 becam spitting, scratching) wheelchair on 5/17/want to get out of be easily and that no be this transfer. E6, CNA, told survey interview on 9/1/11,	h bruising to both metacarpal kin tear noted between It. (left) ' The incident report was natures and contained garding care provided to R3 very of the injuries. the State agency on 5/18/11 resident alleged 'staff beat on initiated. Staff suspended. It to the State agency dated vestigation complete. Abuse liated. " To told surveyor during a ron 8/5/11 at 9:00am, that and nurse 's aide (CNA) that 2 CNA 's grabbed R3's ing care, causing bruising of ation Report dated 5/17/11 Nurses Aide (CNA), and E6, iduals caring for R3 when the	F99	999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING	COMPLE	(X3) DATE SURVEY COMPLETED	
		145893	B. WING	3		C 6/ 2011	
NAME OF PROVIDER OR SUPPLIER MANORCARE OF PALOS HEIGHTS WEST			S	STREET ADDRESS, CITY, STATE, ZIP CODE 11860 SOUTHWEST HIGHWAY PALOS HEIGHTS, IL 60463	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F9999	verbal and physical residents. According food and knives at times in the dining the CNA's are sea of this behavior. The end of this behavior it. R3's Care Plan do interventions to add swearing, attempting staff, pinching, band table during meals and there is no evidence behaviors. Facility's Abuse Power and the end of the end	I behaviors to staff and ag to E6, R3 cries a lot, throws other residents during meal room. E6 also stated that all ared to work with R3 as a result rese behaviors, according to a daily basis; all employees nothing has been done about ated 5/6/10 includes dress behaviors of hitting, and to bite staff, falsely accusing ging eating utensils on the atherest these behaviors continue dence that these interventions. Surveyor requested at these behaviors have been all services. There was none af services. There was none af services. There was none af ound in the clinical record. If and 8/3/11 states R3 exhibits all olicy dated 4/21/06 addresses tions which it defines as changes of the patient in any seem to be minimal g, dressing, toileting, etc. and red by weeping, blushing, stubbornness. The Policy actions should be addressed to	F999	99			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145893	B. WII	۷G			C 6/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE OF PALOS HEIGHTS WEST			•	1	REET ADDRESS, CITY, STATE, ZIP CODE 1860 SOUTHWEST HIGHWAY PALOS HEIGHTS, IL 60463		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F9999	is the nurse manage the provision of direct frequently asked at E1 went on to say the encouraged to reposagreed that, for 'disapproach that may assign the same stage of relationship by stated that the occupacility is likely due own skin and the fact those residents. E1 bruise of unknown the abuse protocol. personnel receive the tail injuries of unabuse, neglect or maked asked that all injuries of unabuse, neglect or maked asked that all injuries of unabuse, neglect or maked asked that all injuries of unabuse, neglect or maked asked that all injuries of unabuse, neglect or maked asked that all injuries of unabuse, neglect or maked asked that all injuries of unabuse, neglect or maked asked that all injuries of unabuse, neglect or maked that all injuries of unabuse.	ers ' responsibility to monitor ect care. Residents are also bout their care. that family members are out any concerns to staff. E1 efficult ' residents, an be effective would be to eaff to these residents to foster etween staff and resident. E1 errence of skin tears in the to residents picking at their excility applies geri-sleeve to stated that all occurrences of origin are investigated under E1 also stated that all raining on abuse prohibition.	F9	999			