STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145443	A. BUILDING ______ B. WING ______	02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING HILLS MANOR	3615 16TH STREET ZION, IL 60099

(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 323	Continued From page 6 E10 was informed regarding this observation after getting out of the bathroom. While E10 was pulling the medication cart, the medication cart drawers started to slide out. E10 was asked if there were confused and ambulatory residents that resides in this hall. E10 stated "yes" On 02/02/12 at 11:30 AM, E5 ADON (Assistant Director of Nursing) said that there are confused and ambulatory residents in this 300 hall.	F 323		
F9999	FINAL OBSERVATIONS Licensure Violations: 300.1210b)5) 300.1210c) 300.1210d)3)6) 300.1220b)3) 300.3240a) 300.1210 General Requirements for Nursing and Personal Care b) The facility shall 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 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	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145443	A. BUILDING ______ B. WING ______	02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING HILLS MANOR	3615 16TH STREET ZION, IL 60099

(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 7 care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), 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. Section 300.1220 Supervision of Nursing	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145443	A. BUILDING ______ B. WING ______	02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING HILLS MANOR	3615 16TH STREET ZION, IL 60099

(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 8	F9999		

Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

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

These Requirements are not met as evidenced by:

A. Based on observation, record review and interview the facility failed to provide resident specific interventions, reevaluate the effectiveness of interventions and provide adequate supervision to prevent reoccurring falls. This is for 3 of 11 residents sampled for falls in a total sample of 22. (R3, R16 and R12)
This failure resulted in R16 sustaining a fracture of the left shoulder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145443	A. BUILDING ______ B. WING ______	02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING HILLS MANOR	**3615 16TH STREET** **ZION, IL 60099**

(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 9	F9999		

Findings include;

1. On 2/1/12 R16 was in the main dining room at 11:00 AM after an activity ended. R16 was well groomed and agreed to talk to me. R16 stated that she broke her shoulder but does not remember how she broke it.

R16's record contains an "Incident/Accident Report" dated 2/27/11 that denotes she was found on the floor with a skin tear to her left hand fourth finger.
R16's record contains "Incident/Accident Report" dated 2/27/11 that denotes, "Resident found sitting on the floor on West Activity...Transferred resident with staff to her wheelchair."
R16's record contains an "Incident/Accident Report" dated 4/16/11 that denotes, "found resident on floor of activity room facing west windows with her back against the front of her wheelchair, legs straight out in front of resident...Resident stated she slid down to the floor from her wheelchair..."
R16' record contains an "Incident/Accident Report" dated 7/18/11 that denotes, "Found resident on floor beside bathroom door."
R16's record contains an "Incident/Accident Report" dated 8/5/11 that denotes, "Resident was found on the floor sitting on her bottom grabbing onto the arm of the wheelchair trying to get up..."
R16's record contained an "Incident/Accident Report" dated 9/21/11 that denotes, "Resident found seated on Mat legs out stretched back resting against the wall...Resident stated that she was trying to go to the bathroom."
R16's record contains an "Incident/Accident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145443	A. BUILDING ______ B. WING ______	02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING HILLS MANOR	**3615 16TH STREET** **ZION, IL 60099**

(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 10 Report"dated 12/16/11 that denotes, "Told by Nurse Walter that resident is on floor. Noted resident on floor in the 300 hall vestibule laying on the left side...complained of left shoulder and arm pain..." The investigation denotes an interview with E11, a resident helper, who states, "I was watching in the west activity room from 7 PM to * PM. It was around 7:50 PM, I was sitting in the middle area of the room, the only residents left were ...(three resident names). One resident was trying to leave through the 100 hall alcove door. I got up and grabbed her pushing her back to the table. When I looked noticed that R16 was trying to leave through the 100 hall alcove door. She was already passed the door when I got to her...Before I could even touch her she suddenly stood up, falling over hitting her left arm against the wall..." R16's record contains nursing documentation that denotes on 12/16/11 R16 was sent to the emergency room because of pain in her arm and leg after a fall. R16's record contains a discharge instruction sheet that states she had a fractured left clavicle. R16's record contains a Minimum Data Set assessment dated 11/21/11 that states she is a one person moderate assist with transfers. R16's care plan lacked resident specific interventions after each fall. For example; After the 9/21/11 fall the facility repeated an initial intervention, "Remind resident to use call light, Ensure call light is in reach." The facility failed to address R16's need for supervision until after the 12/16/11 fall with fracture when the care plan states, "Don't leave resident unattended while up in wheelchair."	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145443	A. BUILDING ______ B. WING ______	02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING HILLS MANOR	3615 16TH STREET ZION, IL 60099

(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 11	F9999		

Continued From page 11

In an interview with two certified nurse assistants E12 and E13, they both stated that R16 requires supervision when up in the wheelchair and that R16 can be impulsive in her behavior.
2) R3 is 88 year old and was admitted to the facility on 9/10/2007 with diagnosis including dementia , COPD (chronic obstructive pulmonary disease) , seizure, osteoporosis and syncope. Review of MDS 12/6/2011 identified R3 requiring moderate to extensive assistance with transfers, mobility and ambulation. Review of the "Fall Risk Assessment" dated 8/8/2011, 6/7/2011, 9/2/2011 and 12/6/2011 showed that R3 is a high risk for fall.

Observation on 1/30/12 at 11:45 A.M. showed R3 was in her wheelchair in the dining room. R3's upper body was leaning forward and has poor trunk control. R3 has a shoulder strap/harness that was released.

A review of the facility's incident reports, R3 fell in the facility 16 times from 4/8/09 through 12/17/2011.

-4/8/09 = " fell on her way to doctor's appointment, son pushing wheelchair and she (R3) fell forward"
- 5/16/09 = found kneeling on the floor
- 6/1/09= found on the floor
- 9/1/09= found on the floor
- 2/27/2010= sustained hematoma at back of head, sent to emergency for evaluation
- 7/21/2010= found lying on the floor
- 1/8/2011 = found kneeling on floor
- 4/4/2011= found kneeling on floor
- 4/7/2011= found sitting on floor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145443	A. BUILDING ______ B. WING ______	02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING HILLS MANOR	3615 16TH STREET ZION, IL 60099

(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 12 - 6/20/2011= rolled from bed to floor mattress - 7/11/2011= rolled from bed to floor mattress - 7/16/2011= rolled from bed to floor mattress - 7/17/2011= rolled from bed to floor mattress -10/8/2011= found on floor 10/8/2011 =R3 took shoulder strap/harness off and transfer self unassisted and fell 12/17/2011= found kneeling on floor Review of R3's current care plan did not include up-dated and revised specific interventions after each fall nor were the falls analyzed to find the root cause in an attempt to prevent further falls. During an interview on 2/2/12 at 1:30 P.M., E8 (restorative nurse) and E5 (Assistant Director of Nursing) stated that " we did not consider rolling from bed to floor was a fall incident, therefore care plan was not updated for interventions." E8 also stated that R3's interventions for fall preventions are as follows: shoulder strap/harness implemented on 9/17/2007; bed and chair clip alarm on 9/17/07 and restorative program on 3/20/2010. E8 further stated that there were no revision for specific approaches in order to prevent R3 for further falls. 3. R12's face sheet in the medical record, documents that R12 is a 74 year old female, with diagnoses including Osteoporosis. The most recent fall risk assessment dated 11/15/11 has R12 as being at high risk for falls. R12's Minimum Data Set (MDS) dated 11/16/11 denotes her functional status for transfers as requiring 2 persons to physically transfer from the toilet. An incident investigation report initiated 12/13/11.states that on 12/13/11, at 9:00 am while	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145443	A. BUILDING ______ B. WING ______	02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING HILLS MANOR	3615 16TH STREET ZION, IL 60099

(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 being transferred off of the toilet, R12 was lowered to the floor by E9, a Certified Nurse's Assistant (CNA). R9's statement in the incident report documents that R12 stood up unassisted from the toilet; her feet started slipping so she, E9, lowered R12 to the floor. On 2/1/11 at 10:30am, in a visiting room in the facility, E9 stated that she was new to the unit where R12 lived and not familiar with R12's transfer needs. E9 elaborated that she was told by another staff member to take R12 to the washroom. When asked how many people does it take to transfer R12, she staid two. When asked how many staff were involved in transfer E9 said she transferred R12 by herself. At 11:00 am on 2/01/12, E2 (DON) was asked how staff are made aware of resident's needs. She answered that resident care cards are located in the shower rooms in the wing where a resident lives. When further asked about the result of the incident investigation, she said that E9 was given a written warning as a result of this incident. B. Based on observation and interview the facility failed to maintain environment that is free of accidents hazard by leaving medications unsupervised in the hallway. Finding include: During medication pass observation on 01/31/12 at 8:50 AM, E10 (Nurse) went to room 303 to give medication to R24. E10 left the medication cart in the hallway with a bottle of Acidophilus with pectin on top of medication cart with out E10 visual control. E10 was informed regarding this observation. E10 stated "you were there". Bottle	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145443	A. BUILDING ______ B. WING ______	02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING HILLS MANOR	**3615 16TH STREET ZION, IL 60099**

(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 14 label says " Keep out of reach of children." Confused residents were observed wandering on the hallway. During the same medication pass observation on 01/31/12 at 9:28 AM E10 gave medications to R23 in room 301 B. After giving the medications to R23, E10 went to room 300 bathroom to wash her hands. E10 left the medication cart in the hallway near room 301 unlocked and unattended. Medication cart was not in E10's visual control. E10 was informed regarding this observation after getting out of the bathroom. While E10 was pulling the medication cart, the medication cart drawers started to slide out. E10 was asked if there were confused and ambulatory residents that resides in this hall. E10 stated "yes" On 02/02/12 at 11:30 AM, E5 ADON (Assistant Director of Nursing) said that there are confused and ambulatory residents in this 300 hall. (B)	F9999		