STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145510	A. BUILDING _____ B. WING _____	C 03/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMPERIAL GROVE PAVILION, THE	**1366 WEST FULLERTON AVENUE CHICAGO, IL 60614**

(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 4 10/30/12, R3's care plan indicated that after the 10/30/12 fall, the mobility alarm (which did not work to alert staff and prevent further falls) should still be used thereafter. The continued use of hip hugger was also recommended, although this device does not prevent further falls, but just prevents hard impact on the resident's hips if her hips hit the floor. Additionally, the reeducation to use the call light was also added as intervention, although R3 is cognitively impaired, does not use the call light, and had fallen from her wheelchair not from her bed where the call light is normally placed. On 11/1/13 R3 developed bruising and pain ion the right shoulder. R3's 11/1/12 right shoulder X-ray showed fractured clavicle.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)2)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the	F9999		

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F9999	Continued From page 5 resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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 care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 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: 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 Services b) The DON shall supervise and oversee the nursing services of the facility, including:	F9999		

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F9999	Continued From page 6 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 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 were not met as evidence by: Based on interview and record review, the facility failed to ensure that a working device to prevent further falls was put in place to prevent falls with injury for 1 resident (R3) out of 4 reviewed for falls. The facility also failed to investigate this fall adequately to determine what caused the fall and put in place appropriate interventions. As a result, on 10/30/12, R3 sustained a fractured right	F9999		

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F9999	Continued From page 7 clavicle after a fall incident. Findings include : R3 has diagnoses of Cerebrovascular Accident, Dementia, Seizures, Left Femoral Fracture, and Progressive Aphasia. As early as 2/18/10, R3's MDS/ Minimum Date Set assessment coded R3 as with memory problem and has moderate impairment of Cognitive skils for Daily Decision Making. R3's incident report on 10/30/12 indicated that at 6:40 PM, R3 was observed sitting on the floor in her room. R3 was unable to recall what happened. R3 was assisted back to her wheelchair and physical assessment indicated that no visible injury was observed. Review of R3's record showed that on 2/6/10, R3 slid out from her wheelchair and sustained a left femoral neck fracture. R3's 10/30/12 fall risk assessment showed that R3 scored 50. Fall risk assessment tool indicated that for score 15 and above, a fall precaution should be implemented. Facility's Summary of Investigation of the 10/30/12 incident stated that no environmental, behavioral, or human factor led to R3's fall. The investigation cited that decrease in muscle strength and decrease in safety awareness might be the factors that had contributed to the 10/30/12 fall. This investigation also indicated that as a corrective action, the facility should continue use of mobility alarm and hip hugger as fall	F9999		

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F9999	Continued From page 8	F9999		

preventive devices. R3 was also re-educated to the use of call light, encouraged to call for assistance prior to transferring. This facility investigation however did not mention if R3's chair mobility alarm was triggered or not during the fall. This mobility alarm was a fall risk intervention in R3's care plan to prevent falls when R3 is up on her wheelchair.

During 3/26/13 phone interview at 12:56 PM, E3 (certified nurse aide / CNA) said that on 10/30/12, she went to R3's room to look for R3 after she noticed that R3 is not in the dining room during meal time. R3 said that R3's room was dark, and she could only see R3's wheelchair at first. E3 said that when she went inside R3's room, E3 saw R3 laying on the floor on her side. E3 said that she also called E4 (nurse) and another CNA. E3 said she did not hear R3's mobility alarm triggered when she found R3 on the floor.

On 3/26/13 at 3:13 PM, E4 said that on 10/30/12 she was called by E3. When she went to R3's room, R3 was sitting on the floor mumbling. E4 said that she also did not hear R3's chair alarm when she went inside R3's room. E4 said that she thought E3 turned it off. E4 continued that previously, she remembered R3 triggering her chair alarm when she moves while in her wheelchair.

Similarly on 3/26/13 at 3:55 PM, E5 (3-11 CNA) said that she also did not hear R3's chair alarm when she entered R3's room after being told R3 was on the floor. E5 said that she was not the first staff to respond to R3's fall on 10/30/12. E5 also said that she saw R3 in the dining room before E5 took her break that evening. E5 said that

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F9999	Continued From page 9	F9999		

during that time, R3 was sitting in her wheelchair with the chair mobility alarm pad on. E5 said that when she came to work at 3 PM, R3 was already in her wheelchair with the chair alarm. E5 said that R3 is able to propel her wheelchair, and probably wheeled herself to her room when E5 took her break. E5 also said that R3 is "busy" and fidgety while on her wheelchair and had triggered her wheelchair alarm in the past. E5 added that R3 would try to get up from her wheelchair, but is normally unsuccessful to fully stand by herself.

On 3/28/13 at 10:32 AM, E6 (Asst. Director of Nursing) said that she investigated R3's 10/30/12 fall incident. R3's Investigation Form on 10/30/12 showed that E6 indicated that R3's chair alarm was in place and working on 10/30/12. E6 however admitted that she did not ask E3 if she heard the alarm trigger, when E3 first saw R3 on the floor. E6 said that she just asked the staff if R3's chair alarm was on, but did not ask if it was working and thus was triggered when she got off the wheelchair and landed on the floor. As a result, there was no investigation to determine why R3's chair alarm did not make a sound on 10/30/12 to alert staff that R3 was trying to get up from her wheelchair. There also was no explanation why no one checked if the alarm was working at the start of the shift, to ensure that it rings when R3's buttocks gets off the alarm pad. Similarly staff did not make sure that R3 stayed in the dining room where she could be visually monitored by staff, as she is a fall risk resident. E6 said that there is no ON/OFF button on the facility's mobility alarm. It is a pad attached to a machine by a cord. E6 said that if the battery is low, it will beep continuously until the battery is changed. The only time it won't trigger, is if the

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F9999	Continued From page 10 cord is disconnected from the pad or it malfunctioned. Even though there is no determination why R3's chair alarm did not trigger when she fell on 10/30/12, R3's care plan indicated that after the 10/30/12 fall, the mobility alarm (which did not work to alert staff and prevent further falls) should still be used thereafter. The continued use of hip hugger was also recommended, although this device does not prevent further falls, but just prevents hard impact on the resident's hips if her hips hit the floor. Additionally, the reeducation to use the call light was also added as intervention, although R3 is cognitively impaired, does not use the call light, and had fallen from her wheelchair not from her bed where the call light is normally placed. On 11/1/13 R3 developed bruising and pain ion the right shoulder. R3's 11/1/12 right shoulder X-ray showed fractured clavicle. "B"	F9999		