

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000236	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/08/2014
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NAME OF PROVIDER OR SUPPLIER MANORCARE OF OAK LAWN EAST	STREET ADDRESS, CITY, STATE, ZIP CODE 9401 SOUTH KOSTNER AVENUE OAK LAWN, IL 60453
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(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) COMPLETE DATE
S9999	<p>Final Observations</p> <p>STATEMENT OF LICENSURE VIOLATIONS</p> <p>300.610a) 300.1210b) 300.1210d)6) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p>	S9999		

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

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S9999	<p>Continued From page 1</p> <p>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:</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>THESE REQUIREMENTS ARE NOT MET AS EVIDENCED BY:</p> <p>Based on observation, interview, and record review, the facility failed to follow their policy for turning residents during incontinence care to prevent falls for 2 of 3 residents (R1, R3) reviewed for falls in the sample of 3. This failure resulted in R1 rolling out of bed, hitting her head on the windowsill, and falling to the floor. R1 sustained a laceration to the head requiring 3 staples and trauma to the head causing bleeding on the brain.</p> <p>FINDINGS INCLUDE:</p> <p>On 5/6/14 at 8:15am, R1 was sitting up in a chair in the hospital room. R1 has 3 staples to the left side of her head, 2-3 centimeters above the left</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>ear and dark purple bruising to the following areas: center of the forehead, and the left neck, shoulder, upper arm, breast, side, abdomen, hip, buttocks, and back of the thigh. R1's right shoulder is swollen and misshapen with an obvious deformity. R1 stated that in the morning of 5/2/14, a nurse aide was changing her incontinent brief. As R1 was turned to the left side, the aide was on the right side. The aide pulled the brief out from under her, causing R1 to roll off the left side of the bed, hit her head on the windowsill, and fall to the floor. Only one aide changed her that morning.</p> <p>On 5/6/14 at 2:45pm, R3 was in bed receiving skin care by E11(Nurse Aide). E11 pushed and turned R3 toward the left side, while remaining on the right side of the bed, the opposite side. R3's head and left shoulder rolled off the bed and R3 grabbed with her right hand to brace herself on the windowsill. R3 was able to brace herself and allowed E11 to continue cleaning her.</p> <p>Hospital records document the following: 5/2/14 Neurosurgeon Consult R1 sustained a traumatic subarachnoid hemorrhage; Physician Note 5/2/14 "significant bruising and swelling to the left shoulder; Emergency Room Documentation 5/2/14 laceration 3 centimeters in length to the left side of scalp, closed with 3 staples; diagnoses of scalp laceration and subarachnoid hemorrhage; Computer Tomography Scan 5/2/14 small volume left parietal subarachnoid hemorrhage and adjacent subcutaneous hematoma.</p> <p>On 5/7/14 at 10:10am, E7(Nurse Aide) stated she was the only one in the room changing R1 on 5/2/14. At that time, while on the left side of the</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>bed, E7 turned R1 toward the right, cleaned her, and rolled the wet incontinent brief and linen under R1. E7 instructed R1 to turn back to the center of the bed, but R1 was closer to the left side of the bed. E7 went back around the bed to the right side and asked R1 to turn to the left. R1 turned slightly, E7 placed her hand on R1's hip area, and pulled the brief and linen out from under R1. R1 fell off the left side of the bed.</p> <p>On 5/7/14 at 10:40am, by phone interview, Z1(Physician) stated that R1 is alert and oriented. Z1 spoke with R1 about what happened. Z1 stated R1 is oriented and reliable, her version of the fall is very detailed and consistent. Z1 stated R1 sustained a laceration to the left side of her head which required staples, a very large collection of blood to the left shoulder which required a blood transfusion, and a small area of bleeding on the brain from trauma. Z1 stated the facility should have followed their policy to prevent R1's fall.</p> <p>On 5/7/14 at 12:05pm, E1(Director of Nursing) stated if there is only one caregiver, the resident is turned toward the caregiver, not away from them.</p> <p>Incontinence Care Policy - Assist to side lying position by turning towards caregiver, unless more than one caregiver present.</p> <p>(A)</p>	S9999		
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Manor Care of Oak Lawn East
9401 S. Kostner Avenue
Oak Lawn, IL 60453

This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Illinois Department of Public Health. Preparations and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.

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The facility will continue to 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.

Corrective action taken for residents found to have been affected by deficient practice

R1 no longer resides in the facility

R3 has been assessed for appropriate level of assistance with bed mobility support and observed through ongoing monitoring bed mobility performed per facility guidelines

How the center will identify other residents having the potential to be affected by the same deficient practice.

Residents who require assistance with incontinence care while in bed

What changes will be put into place to ensure that the problem will be corrected and will not recur.

Educate nursing staff on facility guidelines regarding proper turning with incontinence care.

ADNS or designee will conduct random weekly observations of staff providing incontinence care per facility policy x 4 weeks.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.

Identified concerns shall be reviewed by the facility's QAA Committee.
Recommendations for further corrective action will be discussed and implemented as needed

Date when corrective action will be complete:

6/4/2014