STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145450	A. BUILDING _____ B. WING _____	C 11/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN LAKELAND REHAB & HCC	**820 WEST LAWRENCE CHICAGO, IL 60640**

(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 000	INITIAL COMMENTS Complaint Investigation 1686433 /IL89767	F 000		
F 323 SS=G	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 by: Based on interview and record review, the facility failed to implement fall prevention monitoring and interventions to prevent a resident at risk for fall from falling multiple times with in a two day period. This applies to one of four residents (R1) reviewed for falls in a sample of six. As a result, R1 sustained repeated falls, skin tear on the right forearm, bilateral nasal bone fracture and subdural hematoma. Findings include: Admit/Transfer/Discharge logs indicate that R1 was admitted to the facility on 11/03/2016, with the diagnoses in part: Subarachnoid hemorrhage, Repeated falls, Anxiety disorder, History of traumatic brain injury, Alcohol abuse, convulsions, Ataxia.	F 323		

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

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F 323	Continued From page 1 R1's initial fall risk assessment dated 11/03/2016 indicates R1 has unsteady gait, predisposing condition of Seizures, impaired memory or judgment, history of falls in past 1-6 months, on drugs that have a diuretic effect, drugs that affect the thought process, drugs that create a hypotensive effect, R1scored at high risk for falls. Admit/Transfer/Discharge logs and census activity of R1 indicates: R1 was admitted to the facility on 11/03/2016 at 12:19pm. R1's nursing notes indicates, R1 had a fall at 2:00pm, and second fall at 7:30pm which resulted in skin tear of four inches long to the right forearm with minimal amount of bleeding. R1 was transferred to a local community hospital (Hospital#1) on 11/04/2016 at 12:15am, came back to the facility at 4:30am, with negative reports of head injury. R1 had a third fall on 11/04/2016 at 6:55am, and R1 was transferred to local community hospital (Hospital#2) at 4:48pm, radiologic studies revealed subdural hematoma and bilateral nasal bone fractures. Nurses progress notes and post occurrence documentation by E2 (Director of Nursing-DON) indicate that R1 fell on 11/03/2016 at 2:00pm and R1 was observed getting up from the wheelchair to transfer to a regular chair in the dining room. R1 lost his balance and fell on his buttocks before staff could get to him. R1 stated," I was just trying to see if I can get up by myself to that chair." Nurses notes and post occurrence documentation dated 11/03/2016 indicate that R1 fell at 7:30pm, R1 was in his wheelchair, R1 got up, started to walk and fell backwards, hitting his head on the floor. With the fall, R1 had a skin	F 323		

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F 323	Continued From page 2	F 323		

tear of four inches long noted on the right forearm with minimal amount of bleeding. On 11/04/2016 at 12:15am, R1 was transferred to a local hospital (Hospital#1) and was transferred back to the facility at 4:30am.

Post occurrence documentation dated 11/04/2016, 7:05am reads that E3 (Registered Nurse-RN) saw R1 sleeping in bed, after 30 minutes, E3 went to check on R1 and found him on the floor next to his bed with bleeding from nose. R1 stated " He was trying to get his pants. " R1 complained of pain in the nose. Neurological checks for every 15 minutes were initiated. R1 was transferred to local hospital (Hospital#2) at 4:48pm.

R1's care plan reads R1 is at high risk for falls secondary to history of falls, psychotropic use, diagnosis of Diabetes Mellitus, hypertension, and stroke and Traumatic brain injury includes interventions: safety release belt placed on wheelchair, use of personal or pressure sensor alarms when in bed initiated on 11/04/2016. R1 is also care planned for impaired cognitive functioning with interventions of providing orientation/directional cues as needed initiated on 11/03/2016. The interventions were put in place only after the fall occurred, not prior to the fall as preventive measures.

On 11/17/2016 at 3:05pm, E4 (Restorative Director) stated " He (R1) was transferred to fourth floor because he needed more supervision and I did the restorative assessment. He was very confused, agitated, had unsteady gait and was unsafe to walk. He was at high risk for falls with prior history of falls. Our fall protocol is implemented with interventions based on how the

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F 323	Continued From page 3	F 323		

resident fell. If a resident falls from a chair, we put a chair alarm or safety release belt, if the fall is from bed; we put bed alarm in place. For him (R1) after the first fall, we put a safety release belt. After the second fall, I did one on one supervision until he was sent out to the hospital (Hospital#1). After the third fall, we put a bed alarm. After the third fall, the social worker was doing one to one supervision until he was sent out to another local hospital (Hospital#2) " . When asked about whether the 1:1 supervision was implemented after R1 came back to the facility from local hospital (Hospital#1), E4 stated, " No, the nurses were not doing 1:1 supervision, but they were frequently monitoring him. The nurses should have kept him (R1) on 1:1 supervision. "

CT scan (special x-ray) of head on 11/03/2016 at 11:48pm at local hospital (Hospital#1) reads: Slightly hyper dense extra-axial collection about much of the right cerebral hemisphere measuring up to 6 millimeters in width may reflect a sub acute subdural hematoma. A short term follow-up exam is recommended to evaluate stability findings.

On 11/04/2016, the admitting diagnosis at local hospital (Hospital#2) is subdural hematoma.

CT scan of head on 11/04/2016 at local hospital (Hospital#2): Findings: There is a right-sided extra-axial intermediate density collection overlying the entire right cerebral hemisphere. It measures up to 5 millimeters in thickness. Bilateral nasal bone fractures noted.
CT scan of the head on 11/05/2016 at local hospital (Hospital#2): Impression: Slight interval increase in right subdural hematoma. Increased density, indicating a more acute component.

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F 323	Continued From page 4 CT scan of the head on 11/05/2016 at local hospital (Hospital#2): Findings: A right subdural hematoma, measures five to six millimeters in thickness at the level of the inferior frontal lobe. This is stable. On 11/21/16 at 9:53am, Z1 (physician) stated, "He (R1) had poor judgment, history of psychiatric illness, I put him on psychiatric consultation, he (R1) was not a suitable resident for this nursing home, If they were doing 1:1 supervision after the second fall, they should have continued with the same intervention to avoid third fall." On 11/21/16 at 10:20am, E2 (DON) stated " He (R1) had ataxia was very unsafe to walk, even when I was doing my initial fall risk assessment, he was trying to get out of the bed, So, I called for the help of the nurse aide to help him use the washroom. We didn't put him on 1:1 supervision after he came back from the local hospital (Hospital#2), but we were monitoring him every 15 minutes. The facility policy titled " Prevention of Falls " dated 06/13 reads: The facility will assess hazards and risks, develop a plan of care to address hazards and risks, implement appropriate resident interventions, and revise the resident's plan of care in order to minimize the risks for fall incidents and/or injuries to the resident. Develop a plan of care to include goals and interventions which address risk factors. Risk factors may include but are not limited to the following: Contributing diagnoses, co morbidities, history of fall incidents, incontinence, medications, and assistance required with	F 323		

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F 323	Continued From page 5 activities of daily living, gait/transfer/ balance issues, behaviors and /or cognitive status. This policy was not followed.	F 323		