STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004014	A. BUILDING: _____ B. WING _____	C 12/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALHAMBRA REHAB & HEALTHCARE	417 EAST MAIN STREET, BOX 310 ALHAMBRA, IL 62001

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S 000	Initial Comments Compaint Investigation: 2149195/IL141216	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b)5 300.1210c) Section 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 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. These Requirements were not met as evidenced by: Based on observation, interview and record	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

review, the Facility failed to provide supervision and implement effective fall prevention measures for 1 of 3 residents (R1) reviewed for incident/accidents in the sample of 5. This failure resulted in R1 sustaining 3 falls within 4 days, and ultimately sustaining a right hip fracture requiring hospitalization and surgical repair.

Findings include:

R1's Minimum Data Set (MDS) dated 12/14/21 documents that R1 is moderately cognitively impaired and requires extensive assist of one staff to transfer, ambulate, and use the toilet.

The Facility's Incident/Accident Log documents that R1 experienced falls on 9/21/21, 10/10/21, 11/15/21, 11/21/21, 11/22/21, 11/24/21 and 12/3/21.

R1's Care Plan dated 11/16/21 documents, "I will not experience any injuries related to falls." It further documents "bed alarm in place to bed/chair." It continues to document "Start date 11/19/21-non skid tape applied to bathroom floor." It further documents, "Start date 11/29/21-(Non skid mat) to patients wheelchair at all times." R1's Care Plan also lists that on 12/6/21, moving to a room near the nurses station was added as an intervention. Other interventions include assist with transfers and ambuation start date 11/16/21, observe for unsafe actions and intervene start date 11/16/21, verbally remind resident not to ambulate without assistance start date 11/16/21, and gripper socks on when out of bed start date 11/24/21.

The Facility's Incident Investigation dated 11/15/21 documents that R1 fell in his bathroom and stated that he was going to take a shower. It

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further documents that a small sensor pad was placed on patient bed to alert staff when patient is getting out of bed and to remind patient to call for help. It further documents, "Non skid tape applied to bathroom floor to reduce risk of falls."

The Facility's Incident Investigation dated 11/21/21 documents that R1 fell while ambulating in the hallway while bare footed and that gripper socks were applied as an intervention.

The Facility's Incident Investigation dated 11/22/21 documents, "Patient was attempting to take self to shower. Floor was wet from shower running and his lost his balance, falling to buttocks." It further documents labs were to be drawn and that the nurse practitioner conducted a medication review. It documents, "Non skid tape continues in bathroom by toilet and is being placed in shower stall."

The Facility's Incident Investigation dated 11/24/21, documents R1 transferred himself to wheelchair with a pillow in the seat, behind his back. It further documents, "Patient slid out of wheelchair." It continues, "New interventions of (non slid mat) to wheelchair and staff to ensure that no pillows are in wheelchair."

R1's Progress Notes dated 11/28/21 at 2:48 PM documents, "Resident was found by CNA in another residents' bed, was able to be redirected into his own bed by CNA." The Progress Note does not address whether R1's pad alarm was sounding to alert staff since R1 should have a pad alarm in bed/chair according to the Care Plan.

R1's Progress Notes dated 12/3/21 at 4:16 PM, documents, "Resident noted to be on floor

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outside of bathroom door, head leaning on wall with wheelchair behind resident without brakes on. Resident has anti roll back on wheelchair and gripper socks on feet. When interviewing him he stated that he slipped out of wheel chair. Resident able to roll on back. When performing range of motion, resident lifted arms up and screamed in pain and winced. Pillow placed under residents head and covered with a blanket. Staff stayed with resident to maintain body alignment. EMS (Emergency Medical Services) arrived 20 minutes after being called took 3 people to transfer resident to stretcher after neck brace applied. EMS took resident to (local) hospital."

The Facility's Incident Investigation dated 12/3/21 documents that R1 was observed up against his bathroom door frame, complained of pain to neck and back and was transferred to the hospital for a fracture of the right femoral (large leg bone) neck. It continues, "Safety committee meeting held to review recent fall and ensure that interventions are working. At this time patient is non compliant with self-transfers, taking alarm off, and forgetting to call for help."

The Illinois Department of Public Health Final Report dated 12/8/21 documents, "Resident Name: (R1). Date of Incident: 12/3/21. Type of Occurrence: Serious Injury." It continues, "Nurse called to resident room. Patient was observed on floor in bathroom doorway." It continues to document that R1 complained of neck and back pain, neurological checks were initiated and an ambulance was called. It further documents that R1 was transferred from the local hospital to another hospital for fracture of right femoral (large leg bone) neck.

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S9999	Continued From page 4 R1's Progress Notes dated 12/9/21 document that R1 was readmitted to the Facility with a diagnosis of a right hip fracture. R1's Care Plan start date 12/9/21 documents R1 was readmitted status post surgery due to right hip fracture. R1's Progress Notes dated 12/12/21 documents, "Resident self transferred several times through out the day. Resident educated on asking for help to avoid falling." The Progress Note does not address whether R1's pad alarm was sounding to alert staff since R1 should have a pad alarm in bed/chair according to the Care Plan. On 12/13/21 at 3:30 PM, R1's previous room's bathroom and R1's current bathroom floors were observed. There were no non-skid strips in either bathroom/shower area. This intervention was supposed to implemented 11/15/21 according to the 11/15/21 Incident Investigation and again according to the 11/22/21 Incident Investigation. On 12/14/21 at 8:30 AM, R1 was observed awake in bed, eating breakfast. On 12/14/21 at 8:50 AM, There were 2 non skid strips observed in R1's bathroom, near the toilet, that had not been there upon observations made on 12/13/21. There were still no non skid strips located in the shower area. At this time, V18, Maintenance, stated, "They got put down yesterday. Does that still count?" On 12/14/21 at 9:15, V16, Licensed Practical Nurse (LPN), confirmed that R1 had moved rooms and verified the room numbersafter his hospitalization due to a fractured hip.	S9999		

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S9999	Continued From page 5 On 12/14/21 at 9:20 AM, R1 was observed by this surveyor and V1, Administrator. R1 was observed standing up, unattended, near the toilet in the restroom which is located in his room. At this time, V1 stated, "(R1) do you need the girls (CNAs)?" R1 responded, "Yes, badly." R1 was barefoot, and R1's non skid socks were located in his bed. V1 called out to V4, Certified Nursing Assistant (CNA), to come and assist R1 onto the toilet. At this time, R1's pad sensor alarm was positioned in R1's bed, under the sheet, and was not sounding. V1 stated, "(R1) can unplug it and moves it. I bet someone got him up and reset it. I'll find out who got him up." R1's Care Plan does not address R1 unplugging the pad alarm. On 12/14/21 at 9:25 AM, V3, CNA stated, " (R1) was up in his chair wheeling around earlier today but he went back to bed at 6:30 (AM) and has been in bed since." On 12/14/21 at 9:30 AM, V4 looked for R1's non-slip mat in his room, and was unable to locate it stating, "I will have to get him one. I am not seeing any." The Facility's Safety and Supervision of Residents policy dated July 2017, documents, "Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. It further documents, "3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. 4. Implementing interventions to reduce accident risks and hazards shall include the following: D. Ensuring that the interventions are implemented. 5. Monitoring the effectiveness of interventions	S9999		

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S9999	Continued From page 6 shall include the following: A. Ensuring that interventions are implemented correctly and consistently. B. Evaluating the effectiveness of interventions; C. Modifying or replacing interventions as needed; and D. Ensuring the effectiveness of new or revised interventions." On 12/14/21 at 1:30 PM, V17, Regional Clinical Director, stated, "I would expect them to follow the policy by ensuring the interventions are implemented, effective and updated." (B)	S9999		