STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014633	A. BUILDING: _____ B. WING _____	C 12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INVERNESS HEALTH & REHAB	1800 COLONIAL PARKWAY INVERNESS, IL 60067

(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
S 000	Initial Comments Complaint Investigation: 2198800/IL140711	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 a) 300.1210 b) 4), 5) 300.1210 c) 300.1210 d)3) 300.1210 d)6) 300.1450 Section 300.610 Resident Care Policies 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. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014633	A. BUILDING: _____ B. WING _____	C 12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INVERNESS HEALTH & REHAB	1800 COLONIAL PARKWAY INVERNESS, IL 60067

(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	Continued From page 1 and psychosocial needs that are identified in the 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. 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. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 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'	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014633	A. BUILDING: _____ B. WING _____	C 12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INVERNESS HEALTH & REHAB	1800 COLONIAL PARKWAY INVERNESS, IL 60067

(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	Continued From page 2 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 300.1450 Language Assistance Services A facility shall provide language assistance services in accordance with the Language Assistance Services Act and the Language Assistance Services Code. This REQUIREMENT is not met as evidenced by: Noncompliance resulted in three deficient practice statements. A. Based on observation, interview, and record review, the facility failed to have individualized care plans to meet resident specific needs for falls and failed to implement the interventions set place per the resident's plan of care for three of three (R1, R2, and R3) residents reviewed for care plans. This failure resulted in (R1) sustaining fractures to the tibia and fibula (2 long	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014633	A. BUILDING: _____ B. WING _____	C 12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INVERNESS HEALTH & REHAB	1800 COLONIAL PARKWAY INVERNESS, IL 60067

(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	Continued From page 3 bones of lower leg) as a result of a fall. B. Based on observation, interview, and record review, the facility failed to respond in a timely manner to address a resident's complaints of pain and waited several hours to notify the physician that a STAT (urgent/immediate) order for an x-ray was delayed. This failure applied to one (R1) of three residents reviewed for nursing care services and resulted in R1 being in pain for over nine hours before being sent to local hospital for evaluation and x-ray, where it was then determined that R1 had sustained a fracture of the right tibia and fibula (two long bones of lower leg). C. Based on observation, interview, and record review, the facility failed to monitor and prevent a fall with serious injury for a cognitively impaired resident, failed to educate staff on fall prevention measures, and failed to ensure that staff implemented these measures to mitigate resident fall risk. This affected one (R1) of three residents reviewed for accidents and supervision and resulted in R1 sustaining a fracture of the tibia and fibula (long bones of lower leg). Findings include: R1 R1 is cognitively impaired who primarily speaks the Urdu language and with diagnoses listed in part (but not limited to): diabetes, hypertension, muscle weakness, and osteoarthritis. On 12/7/21 at 10:50am, V2 (Director of Nursing/DON) stated, on 11/26/21 during the morning shift, V5 (certified nurse aide/CNA) assisted R1 from the bed to go to the bathroom	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014633	A. BUILDING: _____ B. WING _____	C 12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INVERNESS HEALTH & REHAB	1800 COLONIAL PARKWAY INVERNESS, IL 60067

(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	Continued From page 4 but did not get any assistance from fellow staff to transfer R1 as required by the resident's transfer assessment. R1 fell to the ground and the incident was never reported to the nurse on duty (V6). The following day on 11/27/21, R1 refused to get out of bed. R1 complained of pain and swelling. R1 was transferred to the hospital late afternoon. R1 was admitted with fracture of the knee, anemia and fractures of the tibia and fibula (two long bones located on the lower leg). MDS (minimum data set) dated 11/6/21 shows R1 requiring extensive assistance in transfer with minimum two-person physical assist. R1's care plan dated 8/18/21 states in part (but not limited to): "(R1) is at risk for falls. The resident has impaired cognition and impaired safety awareness. The resident has balance or walking impairments. The resident experiences weakness. The resident takes medications that may cause dizziness, loss of balance, or impair judgement. Goal: Prevent a serious fall related injury. Interventions: Be sure all light and other personal items are in reach. Keep bed in lowest position; refer to physical or occupational therapy as needed for treatment; remind to request assistance when getting up if needed; Educate, remind and reinforce safety awareness for call for assistance with transfers if resident is cognitively able to understand and retain the information; Report falls to physician and responsible party." R1's care plans do not have any other interventions that focused on R1's strengths nor addressed R1's inability to understand the directions provided as R1 was not English speaking nor able to retain any of the information provided to the resident.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014633	A. BUILDING: _____ B. WING _____	C 12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INVERNESS HEALTH & REHAB	1800 COLONIAL PARKWAY INVERNESS, IL 60067

(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	Continued From page 5 On 12/7/21 at 1:25 PM, R1 was observed in bed with the call light that was above R1's head and not easily reached by the resident. There were no fall mats or any other fall preventative devices or measures in place to prevent future falls or from re-injuring the current fracture. Interview with V2 (director of nurses/DON) on 12/7/21 at 10:50 AM stated, "R1 is the resident that was hospitalized for a fall. R1 came back with a fracture and R1 is wearing a leg immobilizer. The C.N.A. (certified nurse aide V5) didn't report the fall to us and she didn't get help to do the transfer. We only found out the next day when (R1) complained of pain to a nurse that spoke R1's language. We tried to get an x-ray, but the x-ray company couldn't give us a quicker response, so we called the physician assistant to get R1 transferred to the hospital. We found out later R1 got a fracture of the knee I think, or I know it was the right lower leg." Surveyor asked what caused the delay in transfer. V2 stated, "I know that the morning nurse once the resident complained she called the PA (Physician assistant). We normally call the PA who's assigned to (R1). When we reached the PA, she ordered for stat x-ray, but the x-ray company couldn't give us a time they'd come so the PA was called back for orders to send (R1) out to the hospital." Surveyor asked why R1 was transferred late in the day almost 9 and a half hours later and not immediately. V2 stated, "I don't know why I cannot answer that." R1's progress note reads: "V10 (LPN) wrote: 11/27/2021 07:00 AM Health Status Note Text: patient refused to get up and stated, "It's hurt. Noted swelling on right knee and patient unable to move leg". Called Physician	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014633	A. BUILDING: _____ B. WING _____	C 12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INVERNESS HEALTH & REHAB	1800 COLONIAL PARKWAY INVERNESS, IL 60067

(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	Continued From page 6 Assistant and received order for stat X-ray of right hip, right knee, and right tibula-fibula." "V9 (RN) wrote: 11/27/2021 11:02 AM Health Status Note Text: Followed up with X-ray company what time X-ray is coming, unable to give ETA, per staff to call us back once he knows ETA." "V10 (LPN) wrote: 11/27/2021 16:50 (4:30 PM) Health Status Note Text: patient is taken to ER for pain to right leg via ambulance." Interview with R1's nurse on duty, V3 on 12/7/21 at 1:30 PM stated, "I don't speak R1's language. I normally communicate with R1 through motions, but I don't understand R1." Surveyor asked how R1 was able to communicate R1's needs to the staff. V3 stated, "There is someone here later this afternoon I think that speaks R1's language but I'm not sure who that person is." Surveyor asked if there were any other means of communication provided to the resident. V3 stated, "No." Surveyor asked V3 whether R1 was a fall risk. V3 stated, "I'm not sure. I don't know R1 very well and I haven't heard anything about R1 except I think R1 fell recently." Surveyor asked if R1 had a recent fall and what measures would be in place to prevent further falls. V3 stated, "I know that R1 should have R1's call light within reach but I don't know what else." Surveyor asked if fall mats were utilized in the facility. V3 stated, "I think so and R1 probably needs one, so I'll make sure R1 has them when R1 is in bed. " On 12/7/21 at 1:40 PM, surveyor asked V4 (CNA) to ask R1 what R1 was saying. V4 stated, "I have no clue." Surveyor asked how she was able to know what R1 needed. V4 stated, "I guess R1 just points but I don't know what R1 is saying."	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014633	A. BUILDING: _____ B. WING _____	C 12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INVERNESS HEALTH & REHAB	1800 COLONIAL PARKWAY INVERNESS, IL 60067

(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	Continued From page 7 Surveyor asked if V4 was given any information such as fall risk regarding R1. V4 stated, "I wasn't told anything. I'm just agency." On 12/7/21 at 1:50 PM, V7 (unit manager) was asked if there were fall risk residents on the unit she managed. V7 stated, "I'm the unit manager for all 3 units and there are fall risk residents in all of them." Surveyor asked if the nurses and aides working with each resident should know what to do for fall risk residents. V7 stated, "Yes they should." On 12/9/21 at 3:00 PM, V14 (Physician assistant) stated upon interview, "They (the facility) contacted me very early in the morning and said R1 had some pain in the leg so they asked me for an order for Tylenol and x-rays and so I said give R1 Tylenol and ordered stat x-rays. I then got a second call around 3:30 in the afternoon and they asked me for orders for stronger pain medications because the resident was in more pain, so I told them to send R1 out to the ER. I contacted the daughter, and it shows on my texts around 8 am that Saturday (11/27) that the resident was having pain in R1's hip and knee. The nurse said R1 had a possible fall last night and I recall the nurse called me early that morning and daughter tried to figure out how R1 fell but she wasn't told of any fall the night she visited her mom. So again, R1 got Tylenol at 3:30pm and the facility called me again because the nurse told me that the x-rays were not even here yet and that the resident was in more pain. So, I said to just send R1 out to the hospital. R1 spent the entire day I guess waiting for the x-ray but later in the afternoon R1 was in more pain. I don't recall the nurse telling me a pain scale or how much pain but like I said just to send R1 out. The usual protocol for an incident like this would	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014633	A. BUILDING: _____ B. WING _____	C 12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INVERNESS HEALTH & REHAB	1800 COLONIAL PARKWAY INVERNESS, IL 60067

(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	Continued From page 8 be to give pain medications and give x-rays but I was not told until later in the day that the x-rays didn't come. I know weekends take longer for x-ray company to come out, but I followed the normal protocol. Perhaps I could have been called sooner that the x-ray people were not providing stat service." R2 R2 is cognitively impaired with diagnoses listed in part (but not limited to): Diabetes, congestive heart failure, chronic kidney disease and a history of falls. R2's care plan dated 11/2020 reads: "(R2) is at risk for falls related to fall history, incontinence, medication use, risk score per fall screen, weakness. Goal: (R2) will not sustain a fall related injury by utilizing fall precautions through the review date. Interventions: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Report falls to physician and responsible party. Report to physician any untoward side effects associated with the resident's medication use. Use Fall Risk screen to identify risk factors." On 12/7/21 at 1:45 PM, R2 was observed in bed that was elevated up waist high and did not have any fall mats on either side of the elevated bed to sustain any potential fall. The resident was asked if R2 was able to use R2's call light for assistance but appeared moderately confused and disoriented. On 12/8/21 at 2:40 PM R2 was in bed that was lifted to the highest level. There were no fall mats in place and R2's call light was under the sheets	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014633	A. BUILDING: _____ B. WING _____	C 12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INVERNESS HEALTH & REHAB	1800 COLONIAL PARKWAY INVERNESS, IL 60067

(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	Continued From page 9 and above the left side of R2's head. On 12/8/21 at 2:45 PM R2's nurse V13 (Licensed Practical Nurse/LPN) did not identify R2 as at risk for falls. V13 stated, "I don't think R2's at risk. I only have two people on this wing that are fall risk and R2 is not one of them." Surveyor asked who the aide that was assigned to R2 during her shift. V13 stated, "I don't know who that is. It's some agency aide and I haven't seen her." R3 R3 has diagnoses listed in part (but not limited to): Dementia, dysphasia, hypertension, right hip pain, difficulty in walking, and history of falls. R3's care plan dated 10/6/21 reads: "(R3) is at risk for falls related to fall history, gait/balance problems, limited mobility, risk score per fall screen, weakness. Goal: The resident will not sustain a fall related injury by utilizing fall precautions through the review date. Interventions: Anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Bed in low position while in bed. Provide clutter free environment with adequate lighting. PT/OT evaluate and treat as ordered or as needed. Remind resident and reinforce safety awareness for locking wheelchair, reporting when a fall occurs, calling for assist with transfers. Report falls to physician and responsible party. Report to physician any untoward side effects associated with the resident's medication use. Use Fall Risk screen to identify risk factors. On 12/7/21 at 1:45 PM, R3 was observed in bed on an air mattress. The bed was elevated waist high and there were no fall mats or other fall	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014633	A. BUILDING: _____ B. WING _____	C 12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INVERNESS HEALTH & REHAB	1800 COLONIAL PARKWAY INVERNESS, IL 60067

(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	Continued From page 10 preventative measures to keep R3 safe from falling out of bed. Surveyor asked V3 (LPN) about R3. V3 stated, "I don't know R3 well but looking at R3 I think R3 is a fall risk and R3's bed should be lowered and R3 should have mats on each side in case R3 falls. I don't know where the mats are, but I will get some for R3." Surveyor asked if there were any other fall prevention interventions for R3. V3 stated, "I'm sorry I don't know." Surveyor asked if she received any fall training for residents at risk for falls. V3 stated, "Not really. I just finished orientation of this floor and I wasn't given any training on that." On 12/8/21 at 2:50 PM, R3 was again in bed with a bed at the highest level. There were no fall mats or other fall prevention interventions in place to keep R3 from falling out of bed. R3's assigned nurse V13 (LPN) stated, "R3 is not a fall risk. I wasn't told R3 was at risk for falls but R3's bed should be lowered as it is pretty high up." Surveyor asked if she was provided any fall interventions for R3. V13 stated, "No because I didn't even know R3 was a fall risk resident." V9 (Registered Nurse/RN) was also asked about R3. V9 stated, "No R3 is not one of the residents that are high risk (for falls)." Policy dated 3/27/2004 titled "Standards and Guidelines: Falls" states in part (but not limited to): "It will be the standard of this facility to complete an initial assessment, on-going monitoring/evaluation of resident condition and subsequent intervention development in an attempt to prevent falls and injuries related to falls. The staff will evaluate and document falls that occur while the resident is active in the facility. If a resident sustains a fall while a	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014633	A. BUILDING: _____ B. WING _____	C 12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INVERNESS HEALTH & REHAB	1800 COLONIAL PARKWAY INVERNESS, IL 60067

(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	Continued From page 11 resident, staff should attempt to identify possible causes of the fall. Causes refer to factors that are associated with or that directly result in a fall. Often multiple factors in varying degrees contribute to a falling problem. After a fall the interdisciplinary team should review the circumstances surrounding the fall and develop an appropriate intervention(s) and plan of care. Based on evaluation of an existing fall(s) pertinent interventions will be implemented by staff such as resident education if appropriate, staff re-education regarding transfer techniques and safety during activities of daily living care, resident footwear, appropriate lighting, maintaining close proximity of frequently used items, medication reviews, toileting programs, use of hip protects, referral to therapy for strengthening/coordination/balance, addressing medical issues such as hypotension and dizziness, use of fall prevention programs that provide more frequent supervision." "A"	S9999		