STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002521	A. BUILDING: _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOBSON PLAZA	120 DODGE AVENUE EVANSTON, IL 60202

(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 Annual Certification and Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 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 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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. These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to provide fall supervision for two residents that sustained unwitnessed falls and required emergent transfer to a local hospital resulting in fractures. This failure affected two of 18 residents (R7 and R51) reviewed for falls and resulted in R7 obtaining a left wrist fracture and in R51 obtaining a fracture of the right leg. Findings include: R7 is an 80-year old male admitted to the facility 07/04/2020 with diagnoses that include, Dementia, Alzheimer's and history of falls. R7 is severely cognitively impaired with a BIMS score of 00 and requires dependent two-person physical assistance with transfers and extensive two-person physical assistance with ambulation. On 1/17/22, R7 sustained a fall while in the day room with no injury. The fall incident report form indicates that at 2pm, R7's chair alarm was heard	S9999		

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S9999	Continued From page 2 going off by staff. Resident was seen getting up from the chair, however there was no staff close enough to assist R7 with the fall. On 3/6/22, R7 had a fall that resulted in closed fracture of the left radius. According to the incident report, R7 was in bed and activated the bed alarm by getting out of bed. Staff saw the resident on the floor and sent R7 to the hospital for evaluation. On 07/21/22 at 10:55 AM, R7 was observed in the day room, alert and confused, standing next to a wheelchair which had a chair alarm activated. R7 exhibited an unsteady gait with tremors. R7 required the assistance of two aids to be assisted to a dining room chair. 07/21/22 10:58 AM, V16 (Restorative CNA) said, R7 requires constant supervision because he is a high fall risk. He has had some falls before where he was hurt. I was assigned to watch over the day room, but I was at the nurse's station washing my hands and when I heard the chair alarm go off. I rushed over to him. He had already gotten up and was standing on the side of the wheelchair holding onto the table. He could have easily fallen if we didn't get to him in time. R7's care plan and fall policy reviewed. The fall assessment dated 3/31/22 had an assessment number of 50. Assessment sheet revised 10/2016 states "Implement Fall precautions for a total score of 15 or greater." Quarterly effectiveness of the fall care plan interventions, reviewed for fall incidents occurring 1/17/22 and 3/5/22, with had no new interventions.	S9999		

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S9999	Continued From page 3 R51's face sheet documents she is an 89-year-old female with a diagnoses history of Dementia, Osteoarthritis, Age Related Osteoporosis, Difficulty walking, and Repeated Falls, who was originally admitted to the facility 05/17/2022. R51's fall assessment dated May 2022, documents a score of 55; implement fall precautions for a total score of 15 or greater. R51's Minimum Data Set dated 05/26/2022, documents she has a Basic Interview for Memory Score of 8, requires one person assistance for transfers, and requires extensive one person assistance with toileting. R51's current urinary incontinence care plan initiated 05/26/2022, documents she is frequently incontinent of bowel and bladder with interventions including: assist to toilet at regular intervals, such as every two hours and as needed ; R51's current fall care plan initiated 05/26/2022, documents she has a potential for falls related to diagnoses of dementia, osteoporosis, and degenerative joint disease, with interventions including: give R51 verbal reminders to ask for assistance with ambulation and transfers as needed, provide toileting assistance as needed. R51's current physician order sheet documents fall precautions. Incident Investigation Report dated 07/20/2022, documents: R51 who ambulates with rolling walker, stood from toilet, lost her balance, kneeling in front of her walker, x-ray results arrived this morning indicating an acute fracture; ambulatory resident R51 used her rolling walker to self toilet, pulled the call light and was	S9999		

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S9999	Continued From page 4 observed by staff kneeling on the floor of the toilet with her walker in front of her, when asked what happened she stated she lost balance when she stood and kneeled to the floor. 07/21/2022 9:10 AM, V26 (Physician) stated R51 couldn't explain what happened during her fall. V26 stated R51 has a poor memory. V26 stated R51 was treated for a fracture after her fall and was observed by him in the emergency room. V26 stated R51 was seen by the nurse practitioner yesterday and reported she fell while in the bathroom. 07/19/22 at 2:10pm, when asked R51 what happened, she stated she stood up, lost her balance, and fell on the floor. 07/21/2022 at 10:59 AM, V16 (Certified Nursing Assistant/CNA) stated incontinence care is documented once per shift. 07/21/2022 at 11:00 AM, V5 (Registered Nurse/RN) stated she was the responding nurse for the fall incident. V5 said around 1:30pm on 07/19/22, I remember seeing her in the day room as I was passing medication. V5 believes R51 got up unwitnessed and walked to the bathroom sometime after seeing her at 1:30pm. V5 stated she believed R51 to have fallen by herself in the bathroom and pulled the call light post fall. V5 said she responded to the call light in the bathroom and saw her already lying on the floor at around?. V5 stated R51 is able to toilet herself and her walker was in front of her when she fell. V5 said there was an activity aide in the day room that was responsible for monitoring the residents at this time. V5 verbalized that it is her expectation that the activity aide would let her know if the residents need anything, such as	S9999		

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S9999	Continued From page 5 going to the bathroom. If the activity aide needs to leave the area, they should be letting her know; I am unsure of where the activity aide was at the time of the fall. V5 (RN) states R51 needs supervision to go to the bathroom. V5 said I expect my aides to supervise and assist her when going to the bathroom. Most residents that use walkers do not have good balance in the first place. At 11:15 AM, V16 (CNA) stated that she was the Activity Aide at the time of the fall incident. V16 said that R51 walks with a walker and independently walks around the facility unsupervised all the time. V16 witnessed R51 stand up, leave the dayroom with her walker, and head towards her room prior to the fall. At 11:30 AM, V8 (Director of Nursing/DON) said R51 has fall precautions in place, meaning that she is at a high risk for falls. V8 stated that R51 has a diagnosis of dementia and will ambulate back and forth to her room during the day with a walker. V8 said her expectation for residents that are at a fall risk would be to oversee or supervise when the resident is ambulating and assist when in need of help. The day room should not be left unattended, there are residents that are high risk for falls located in the day room. R51's progress note dated 07/20/2022, documents she fell in bathroom to her knees yesterday. R51's physician progress note dated 07/21/2022, documents she fell to her knee when getting off the toilet, x-rays showed a fracture of the right leg, she was sent to the emergency room and posterior mold was applied.	S9999		

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S9999	Continued From page 6 R51's July 2022, bowel and bladder record, does not document incontinence care from 07/01/22 - 07/19/22. The facility's fall policy received 07/21/2022 states: "Fall Prevention Activities for ALL Residents Upon Admission - For residents who have been identified at risk for falls, the interdisciplinary plan of care shall include initial interventions, including supervision, and or assistive devices." (A)	S9999		