STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005193	A. BUILDING: _____ B. WING _____	C 08/25/2022

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

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S 000	Initial Comments Facility Reported Incident of July 12, 2022\IL149316	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210 b) 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 care and personal care shall be provided to each resident to meet the total nursing and personal	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 are not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide adequate supervision and failed to follow a residents fall intervention for one resident (R1) in a sample of 3. This failure resulted in R1 falling and sustaining an acute nondisplaced fracture of the left lamina of cervical (C)1 extending to the margins of the left transverse foramen and a left frontal laceration requiring four sutures. Findings Include: R1's Face sheet documents that R1 has a diagnosis which include but not limited to a displaced fracture of first cervical vertebra subsequent encounter for fracture with routine healing, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and dysarthria following unspecified cerebrovascular disease. R1's Brief Mental Status Interview (BIMS) dated 07/20/22 documents that R1 is severely impaired with memory problems. R1 was not interview able	S9999		

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S9999	Continued From page 2 for this investigation. Facility's document dated 07/12/22 and titled "Incident/Accident Notification Initial Report" documents, in part: R1 found lying in prone position on the floor next to R1's bed by staff ... Laceration noted to R1's forehead above R1's left eye with some bleeding ... Orders given to send to the emergency room for evaluation. R1 admitted and was taken to local hospital via ambulance then transferred to another local hospital. R1 was admitted to the local hospital for laceration to the forehead requiring sutures and acute nondisplaced fracture of the left lamina and C1 extending to the margins of the left transverse foramen. R1's progress notes authored by V9 (Registered Nurse, RN) dated 07/12/22 at 6:15 am, documents, in part that V6 (Certified Nursing Assistant, CNA) informed V9 that R1 was on the floor next to R1's bed ... R1 landed on R1's forehead ... Pressure dressing applied to R1's forehead. R1 with 1 centimeter (cm) laceration. R1's hospital records dated 07/12/22 documents, in part that R1 was admitted to local hospital at 08:26 am, R1 came from skilled nursing facility with active bleeding from laceration; EMS (Emergency Medical Service) stated CNA (Certified Nursing Assistant) at skilled nursing facility was cleaning R1 and R1 fell off the bed and hit R1's forehead. At 11:00 pm, Cervical Collar (C)- collar put on R1, x-ray shows fracture at C-1. R1 being transferred to another local hospital. On 08/08/22 at 11:39 am, Surveyor observed R1 in bed awake and alert unable to answer questions appropriately with R1's legs hanging off	S9999		

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S9999	Continued From page 3	S9999		

the side of R1's bed, no floor mat in place with a cup of water spilled on the floor next to R1's bed.

On 08/08/22 at 11:54 am, V3 (Staffing Coordinator\Certified Nursing Assistant, CNA) was asked regarding R1's legs hanging off the side of R1's bed, and the cup of water spilled on the floor next to R1's bed. V3 stated, V3 had 2 CNA's that did not show up to work that were assigned to the 4th floor unit and no CNA was assigned to R1's room until 12:00 pm. V3 stated, I (V3) was now assigned to R1's room at 12:00 noon and had not had a chance to round to provide care to R1 for the shift. V3 was asked regarding the cup of spilled water next to R1's bed. V3 stated, "That is water spilled. Someone left it (referring to the water next to R1's bed), and someone can fall if it stays there."

On 08/08/22 at 12:00 pm V5 (Registered Nurse, RN) was interviewed regarding R1's care. V5 stated, "The CNA just came in. We (referring to the 4th floor staff) had 2 CNAs to call off today." V5 was asked regarding R1 hanging off R1's bed. V5 stated, "He (R1) does that." Surveyor asked V5 regarding the spilled water on R1's floor. V5 stated, "If someone walks into to this, they (referring to if someone walked into the spilled water on the floor next to R1's bed) can fall."

On 08/09/22 at 1:23 pm, V2 (DON) was interviewed regarding R1's care. V2 stated, R1 recently fell out of R1's bed, was injured and went to the local hospital. V2 was asked when was the last time staff rounded on R1 on 07/12/22 prior to R1's fall. V2 stated, I (V2) did not know. V2 also stated that residents should be rounded on every hour and a minimum of every 2 hours to prevent falls with injury. V2 was asked the importance of rounding on residents. V2 stated, if a resident

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S9999	Continued From page 4 goes unmonitored from staff that increases that resident's risk of falling. V2 stated that all residents including residents who do not score as a fall risk should have fall interventions in place such as frequent monitoring and rounding at all times to prevent the resident from falling. V2 was questioned regarding a resident who was falling out of the bed being left unsupervised. V2 stated, "That should not happen. If a resident is falling out of the bed the staff should not leave the resident and should call out for help or pull the call light." V2 was asked what could happen if a residents fall care plan intervention is not in place or not followed. V2 stated, the resident could get a very serious injury. 08/09/22 at 2:19 pm, Surveyor attempted to interview V6 (Certified Nursing Assistant, CNA) regarding R1's fall on 07/12/22 and V1 (Administrator) stated, "V6 no longer was employed by the facility." V1 provided a phone number to reach V6. Surveyor attempted to reach V6 and was unable to reach V6 with phone number provided by V1. On 08/09/22 at 2:28 pm, V9 (Registered Nurse, RN) was interviewed regarding R1's fall on 07/12/22. V9 stated, on 07/12/22 V9 was on the 4th floor unit hallway at V9's medication cart. V6 Resident Assistant, (RA) informed V9 that V6 observed R1 hanging off the side of R1's bed and needed to be repositioned in bed. V9 stated, by the time V9 and V6 went back to R1's room to reposition R1 in R1's bed, R1 was lying near the window, face down on the bare floor, with blood coming from R1's forehead. V9 stated, I (V9) was not sure of the exact timeframe in which V9 had saw R1 prior to V6 informing V9 that R1 was hanging off the bed.	S9999		

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S9999	Continued From page 5 On 08/10/22 at 2:39 pm, V8 (Nurse Practitioner, NP) was interviewed regarding R1's care. V8 stated, residents who are known to hang off the side of the bed and climb out of the bed left unsupervised and do not have fall interventions in place are at high risk for falls with injuries such as head injuries, fractures, and dislocations. V8 also stated that residents who are known to climb out of bed or hang from the side of the bed, beds should be in the lowest position and should have a floor mat to catch the patient if the patient falls. R1's Falls care plan dated initiated 04/10/20 documents, in part: "Rounding at a minimum of every 2 hours and prompt or assist for change in position." R1's Fall Risk Assessment dated 04/16/22 documents that R1 has a score of 5 which indicates that R1 is at risk for falls. Facility's document dated 08/2020 and titled "Management of Falls" documents, in part: "Policy: The facility will assess hazards and risk, 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 risk for fall incidents and/or injuries to the resident. Procedure: ... 6. Assess and monitor resident's immediate environment to ensure appropriate management of potential hazards." Facility's undated document titled "Job Description" documents, in part: "Title: Certified Nursing Assistant: 1. Job Summary: Provides residents with daily nursing care in accordance with current federal, state and local standards, guidelines and regulations, facility policies and as may be directed by the Charge Nurse,	S9999		

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S9999	Continued From page 6 Supervisor, Assistant Director of Nursing or Administrator to ensure that the highest degree of quality care is maintained at all times ... Essential Functions: ... F. Make rounds to assure customers are safe and comfortable." (A)	S9999		