STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007843	A. BUILDING: _____ B. WING _____	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALOS HEIGHTS REHABILITATION	13259 SOUTH CENTRAL AVENUE CRESTWOOD, IL 60418

(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 2290680/IL142852 Facility Reported Investigation (FRI) to Incident of 01.18.2022/IL142856	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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. 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 evidenced by: Based on observations, interviews, and record reviews, this facility failed to ensure 2 staff members performed bed mobility while providing direct care to a dependent resident requiring who was assessed to require two staff for ADLs (activities of daily living) care. This affected 1 of 4 residents reviewed for supervison during ADL care. This failure resulted in R1 falling from the bed while being bathed by facility staff and sustaining a 4cm (centimeters) laceration to left side of forehead requiring 8 sutures. Findings include: On 2/8/22 at 10:30am, R1 was observed making slight movements with both hands and lifting forearms off bed minimally. R1 did not make any attempts to reposition self in bed. R1 was not observed moving legs. On 2/9/22, this surveyor made continuous observations of R1 from	S9999		

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S9999	Continued From page 2 9:00am-9:30am. R1 was observed making slight movements with both hands and lifting forearms off bed minimally. R1 was not observed moving legs. R1 was observed to be alert and oriented x 1. R1 was unable to follow simple commands and did not make any attempts to reposition self in bed. On 2/9/22, this surveyor made continuous observations of R1 from 9:30am-9:50am during R1's bed bath. There were two staff members assisting with R1's care. When turned R1 did not make any attempt to extend arms away from body grab/hold on to side rail. R1 did not attempt to assist staff with turning. Both of R1's hands remained closed throughout this observation. Resident was observed moaning when turned side to side. On 2/9/2022 at 11:00am, V2 DON (director of nursing) stated, V6 CNA (certified nurse aide) providing care for R1 on 1/18/22 at the time of the fall is an agency CNA. V2 stated, V6 has not worked at this facility since R1's fall. On 2/9/22 at 11:15am, V5 (unit manager) stated, V5 was present in this facility on 1/18/22 when R1 fell out of bed. V5 stated, V5 was informed by R1's nurse, and V7 (nurse) of the incident. V5 stated,R1 was already placed back in bed when she went to R1's room. V5 stated, R1 is not alert/oriented, R1 is unable to make needs known. V5 stated,V5 has not witnessed R1 attempt to turn self in bed. V5 stated, R1 will sometimes cross legs at ankles, but R1 does not make any significant position changes. Review of R1's medical record, dated 1/18/2022 at 11:59am, V7 (nurse) noted R1 was observed in R1's room on the floor laying on her right side on	S9999		

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S9999	Continued From page 3	S9999		

the floor. R1 was changed at the time of the fall. Physical assessment was completed. Vital signs: blood pressure 147/91, heart rate 80 beats/minute, respirations 18/minute, temperature 97.9 degrees Fahrenheit, and oxygen saturation level 95% on oxygen. R1 is alert and oriented x 1-2. Neurological assessment is completed and is negative. R1 confirms pain level 5 out of 10. New skin alteration on the forehead, is bleeding and with open laceration. Laceration was cleaned and covered with gauze. R1 was transferred out of facility to the hospital. Notified R1's attending physician regarding the fall. Spoke with R1's family member about the fall. R1 returned to facility via ambulance from the hospital at approximately at 1:30pm.

Review of R1's hospital record, dated 1/18/2022, notes R1 presented to the emergency room after falling out of bed. R1 is alert and oriented x 1 per R1's normal. Physical examination noted a 4cm (centimeters) laceration to forehead requiring 8 sutures to close.

Review of this facility's fall incident investigation, dated 1/19/2022, notes V6 CNA statement of the event: V6 was giving R1 a bed bath. R1 had a bowel movement which required V6 to change gloves. As V6 went behind the drawn curtain, R1 rolled out of bed.

Review of R1's fall risk assessment, dated 1/18/2022, notes R1 is at risk for falls.

Review of R1's MDS (minimum data set), dated 4/19/21, notes R1's cognitive status for daily decision making is moderately impaired. R1 requires extensive assistance of two staff members with bed mobility. R1 is totally

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S9999	Continued From page 4 dependent on one staff member for bathing. Review of R1's MDS, dated 7/20/21 and 10/20/21, note R1's cognitive status for daily decision making is moderately impaired. R1 requires extensive assistance of two staff members with bed mobility. R1 is totally dependent on two staff members for bathing. Review of R1's ADL (activities of daily living) flowsheet, dated 10/14/21-10/20/21, notes R1 is totally dependent on staff for bed mobility. R1 is totally dependent on two staff members for bathing. Review of R1's MDS, dated 1/117/22, notes R1's speech is unclear; R1 rarely/never is understood; and rarely/never understands others. R1 requires extensive assistance with bed mobility and is totally dependent for bathing. Review of R1's restorative look back documentation, dated 1/15-1/17/22, notes R1 is totally dependent on staff for ADLs. Review of R1's hospice note, dated 1/19/2022, notes R1 is oriented to person only. R1 is bedfast and completely immobile. Hospice notified by nurse on 1/18/22 that R1 fell out of bed during bed bath requiring sutures. Review of R1's care plan, notes R1 requires extensive assistance with turning/repositioning in bed. R1 will be turned/repositioned with the assistance of two people. It also notes R1 is rarely/never understood in ability to express ideas and wants. R1 rarely/never understands others. Review of this facility's CNA training/education notes make sure before bathing the resident,	S9999		

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S9999	Continued From page 5 gather all supplies. Supplies needed for bathing include, but not limited to, gloves. If the resident is bedridden, have a second staff member on the opposite side when repositioning from side to side. Always get the assistance of another staff member when bathing, repositioning, or performing any task on a resident that is bedridden. " B "	S9999		