STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000137	A. BUILDING: _____ B. WING _____	C 11/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTH & REHAB CENTER	2840 WEST FOSTER AVENUE CHICAGO, IL 60625

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S 000	Initial Comments Complaint Investigation 2287701/IL151603	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)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 care needs of the resident. d) Pursuant to subsection (a), general	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 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 interview, and record review, the facility failed to implement adequate fall prevention and monitoring for one resident (R1) of 3 residents reviewed for falls. This failure resulted in R1 sustaining a fall with bilater femur fracture requiring R1 to be hospitalized. Findings include: R1 is 90 year old individual, admitted to the facility on 1/10/2020. R1's Brief Interview for Mental Status (BIMS), dated 10/18/22, document R1 has BIMS score of 15/15. R1's Activities of Daily Living (ADL) Assistance, dated 11/9/22, documents R1 needs two person assistance and depends on staff for all ADL care. R1's Minimum Data Set (MDS) (7/22/2022) section G documents R1 is a total dependent resident and requires extensive assistance with a two person assist for Activities of daily living (ADL) care. Facility reported Incident report, dated 9/25/2022, documents R1 fell while ADL care was being provided, and R1 sustained a laceration to right	S9999		

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S9999	Continued From page 2 (R) lower leg and R1 was transported to a community hospital nearby. Nursing notes, dated 9/25/2022, at 15:28 PM, document R1 fell off the bed unto the floor and blood was noted coming from a wound R1 sustained on the right leg. R1's medications document R1 was on blood thinners at the time of the fall. R1's hospital records, dated 9/25/2022, documents R1 presented to the hospital with Rt (right) knee laceration after mechanical after fall at the NH (Nursing Home), and x-ray showed R1 had active and healed fractures in both LLs (lower legs) On 11/12/2022 at 12:45 PM, V5 (Director of Nursing-DON) said R1 fell on a weekend as V6 (Certified Nurse's Assistant -CNA) was giving R1 a bath. V5 said V6 wanted to turn R1, and R1 was on one side of the bed, and V6 went to adjust the other side R1's bed, and R1's leg slid over R1's other leg, and R1 slid out of bed and fell out of bed. R1 then hit a bedside table and R1 landed on the floor. V5 said V6 yelled for assistance and V4(Licensed Practical Nurse-LPN) come to assist V4. V5 said V4 called the doctor and also called 911. V5 said, "For residents who are immobile and are a two person assist, the staff are supposed to make sure there are two staff members when changing the resident." V5 said, "What went wrong that day when R1 fell, was that V6 tried to bathe R1 by herself, and it did not go well. It was the carelessness of (V6) that day that contributed to (R1's) fall." V5 said there should be two CNAs assisting R1, because R1 is a big lady, and is dependent, and R1 needs a two person assist for	S9999		

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S9999	Continued From page 3 safety issues. V5 said for residents who are totally dependent for Activities of Daily Living (ADLS), the facility requires these residents to be assisted by two staff members for safety purposes. V5 said, "the point of taking care of residents is to provide a safe environment for our residents." On 11/12/2022 at 1:40 PM, V4 (Licensed Practical Nurse-LPN) said V4 was sitting by the nursing station on 9/25/2022 about 2:30 PM, getting report ready for the next shift, when V6(Certified Nurse's Assistant-CNA) shouted to V4 to go to R1's room. V4 said V4 rushed to R1's room and found R1 on the floor. V4 said V6 said V6 had just finished changing R1's incontinence pads, and V6 wanted to make the rest of R1's bed, when R1 slid down the bed and fell, hitting R1's bed side table. V4 said V4 observed R1 bleeding profusely, then asked the CNA what happened, and the CNA said, "I was just done changing (R1), and I was repositioning (R1) back, and (R1) slipped out of the bed and fell." V4 said R1 is supposed to be attended to by two staff members. V4 said, "I saw blood coming from (R1's) right leg, and it was a new skin tear, and it was bleeding a lot, so I called 911 and attended to (R1's) bleeding as I called the doctor." V4 said V7 (R1's physician) gave orders for R1 to be rushed to the emergency department immediately. V4 said V6 should have had two staff members in the room while changing R1. V4 said the CNAs know to check on the assignment sheet for the care and assistance each resident needs, and R1 is marked for two persons assist since R1 is a dependent resident for Activities of daily living (ADLs). V4 said, "(V6) failed to protect (R1) because only one person was helping (R1) with ADL care, and this led to (R1) falling and getting injured. We failed to protect (R1)."	S9999		

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S9999	Continued From page 4 On 11/12/2022 at 2:06 PM, V6 (CNA) said on 9/25/2022, V6 was completing incontinence care for R1, and after V6 was done, V6 positioned R1 on the side and R1 was holding on to the side rail, and one of R1s leg was on top of the other leg, and as V6 was trying to go to the other side and bring R1 back on the other side of the bed, R1 started to slip and the momentum flipped R1 out of bed. V6 said R1's leg hit a table where R1 keeps R1 phone and communication device, and R1's leg was bleeding. V6 said V6 called out to the nurse to come to R1's room, and both V4 and V6 started to give R1 first aid while waiting for the ambulance to come. V6 said, "I knew (R1) needs a two person assist, but everyone else was busy, so I went to provide care by myself." V6 said, "Had I waited for another staff member to come assist me in changing (R1), this incident of (R1) falling out of bed would probably not have happened. Our goal is to keep residents safe. I did not keep (R1) safe on that day, because of my poor judgment." On 11/12/2022 at 2:31 PM, V7 (R1's physician) said V7 expects patients to be kept safe at the facility. V7 said if R1 was a two person assist for Activities of daily living (ADLs), then there should have been two staff members assisting R1 with ADL care. V7 said the fall R1 experienced could have been prevented if staff had followed the right ADL care protocol and had two staff members assisting R1, and R1 would not have suffered broken bones. V7 said R1's is not a good candidate for surgery per the orthopedic provider at the hospital, and R1's fractures will have to heal without surgery. Facility's Fall Protocol and Guidelines, no date,	S9999		

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S9999	Continued From page 5 documents; "Residents identified as a risk for fall will be placed on the Fall Prevention Program while in the facility." (A)	S9999		