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| | IL6005227 | A. BUILDING: _____ B. WING _____ | C 07/28/2023 |

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| S 000 | Initial Comments<br><br>Complaint Investigations:<br><br>2385232/IL161318<br>2385251/IL161340<br><br>Facility Reported Incident of 6/21/23/IL161507 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610a)<br>300.1210b)<br>300.1210c)<br>300.1210d)6)<br>300.1220b)3)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological | S9999 | Attachment A<br>Statement of Licensure Violations | |

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| S9999 | Continued From page 1<br>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.<br><br>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.<br><br>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:<br><br>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.<br><br>300.1220 Supervision of Nursing Services<br><br>b) The DON shall supervise and oversee the nursing services of the facility, including:<br><br>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. | S9999 | | |

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| S9999 | Continued From page 2 | S9999 | | |

These requirements were not met as evidenced by:

Based on observation, interview, and record review the facility failed to 1.) provide appropriate staff assistance to transfer one resident (R2) of three residents reviewed for falls. This failure resulted in R2 sustaining a right ankle fracture and a fracture of right distal tibia. 2.) The facility failed to follow fall care plan interventions and provide appropriate assistance for a resident (R1) with multiple history of falls; and failed to properly transfer a resident (R1) back to bed after a fall. These failures resulted in R1 sustaining a hip fracture.

Findings include:

1. R2 was admitted to the facility on 05/07/21 with diagnosis including but not limited to hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, acute embolism, and thrombosis of unspecified deep veins of lower extremity, bilateral, lack of coordination, paralytic gait, unspecified abnormalities of gait and mobility, history of falling, and generalized muscle weakness.

R2's care plan dated 04/01/22 documents in part R2 is at risk for falls as evidenced by history of Cerebrovascular Accident with hemiplegia/hemiparesis, generalized weakness, incontinence of bladder and bowel, paralytic gait, and anxiety with intervention to utilize two person assist transfers with (total body mechanical lift) and provide support to legs as needed during transfer.

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| S9999 | Continued From page 3<br><br>R2's care plan dated 06/21/22 documents in part R2 has been assessed for transfer self-performance and support and needs and requires mechanical lift assistance with two staff members to operate a (total body mechanical lift) to complete the transfer and intervention includes R2 will be transferred with a two person transfer when using a (total body mechanical lift).<br><br>Fall Risk Review dated 02/14/23 documents R2's score at 15, Fall Risk Review dated 04/02/23 documents R2's score at 13. Fall Risk Review form documents that a score of 10 or above represents high risk.<br><br>Restorative Nursing Review Assessment dated 02/20/23 document in part R2 requires total dependence with transfer with two+ persons physical assist using (total body mechanical lift).<br><br>R2's fall report dated 06/21/23 completed by V26 (Agency LPN) documents, V26 called to room by staff and observed resident on the floor, assessed resident, has no open wounds or bruising noted, vitals within normal limits and staff assisted resident to bed, called the doctor for x-ray order. Witnesses listed as V25 (Certified Nursing Assistant) who provide the following statement, "(R2) was scheduled for a shower and was transferring him (R2) from the bed to the shower chair. He (R2) became unsteady and was lowered to the floor." V16 (Housekeeper) document the following statement, "I was moving on to clean the next room and I heard a loud noise, I opened the door and observed resident (R2) on the floor."<br><br>R2's nurse progress notes dated 06/21/23 by V26 (Agency Licensed Practical Nurse) documents in part, "Writer called to room by staff and observed | S9999 | | |

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| S9999 | Continued From page 4 | S9999 | | |

resident on the floor connected to the (total body mechanical) lift machine. Resident assessed by writer and accompanying staff. Resident has no open wounds or bruising noted resident vitals are within normal limits. Writer called the doctor for x-ray orders. Writer gave resident pain medication. Resident says his pain is at a ten."

R2's nurse progress note dated 06/22/23 by V30 (Registered Nurse) documents in part, V30 received call from portable diagnostic company regarding abnormal x-ray results. V28 (R2's Nurse Practitioner) notified with order to send resident to hospital.

R2's Radiology report dated 06/22/23 completed at the facility documents in part acute nondisplaced transverse fracture of the distal right tibia. Acute fracture of the lateral malleolus was slight interior and lateral displacement of the distal fracture fragment.

R2's hospital records of CT (Computed Tomography) Lower Extremity on 06/22/23 documents in part impression mildly displaced lateral malleolus fracture, and nondisplaced and/or minimally displaced distal tibial fractures.

R2's MDS (Minimum Data Set) dated 07/03/23 indicates R2 has intact cognition and requires extensive assistance with two+ persons physical assist for bed mobility, transfer, dressing, toilet use, and personal hygiene.

On 07/25/23 at 11:27 AM, R2 was lying in bed with right leg in cast. R2 stated, V25 (CNA) came into R2's room on the day R2 fell with the total body mechanical lift and said V25 was going to give R2 a shower. R2 stated V25 was alone, there were no other staff in the room. R2 stated

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|---|---|---|---|---|
| S9999 | Continued From page 5 | S9999 | | |

usually when the staff bring the lift into R2's room they come in with two CNAs. R2 stated that R2 asked V25, "Aren't you supposed to have another person with you when you do this?" R2 stated V25 responded, "No, I know what I'm going." R2 stated, V25 got R2 up into the Hoyer machine but V25 kept turning the top where the straps hook and R2 could tell it was twisted. R2 stated V25 was alone, there was no other staff in the room during this time and V25 was operating the total body mechanical lift on her own. R2 stated the next thing R2 realized is R2 was falling onto the floor and the rest of the total body mechanical lift just collapsed right on top of R2. R2 stated, "I hit the floor hard." R2 stated V25 just stood there like a deer in headlights.

On 07/26/23 at 8:18 AM, V1 (Interim Director of Nursing) stated a resident being transferred using a total body mechanical lift requires two staff members to be present during the transfer. V1 stated two staff are always required for safety to prevent the resident from falling. V1 stated R2 requires a total body mechanical lift with two people assist for all transfers. V1 stated on 06/21/23, R2 was being transferred from the bed to the shower chair using the total body mechanical lift and that V25 (CNA) was the only staff member in the room with R2. V1 stated there should have been two staff members in the room when V25 was transferring R2. V1 stated if two staff members were in the room there is a possibility the resident could have been eased to the floor and prevented the injury.

On 07/26/23 at 8:46, V16 (Housekeeper) stated V16 was in the next room next to R2's doing V16's daily cleaning routine when V16 heard a big heavy thump sound from R2's room. R2 stated R2 went right away to R2 room, opened R2's

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|---|---|---|---|---|
| S9999 | Continued From page 6 | S9999 | | |

door and saw R2 lying on the floor. V16 stated there was only R2 and R2's CNA (V25) in R2's room. V16 stated there was no other staff in the room and that V25 was standing over R2 who was lying on the floor.

On 07/26/23 at 1:45 PM, V8 (Restorative Director) stated R2 needs to be transferred via total mechanical lift with two staff members. V8 stated V8 was working on the unit the day of R2's fall but did not witness the fall. V8 stated V8 interviewed V25 that day as part of the post fall investigation and stated V25 told V8 that V25 was by herself in the room with R2 during the time of the fall. V8 stated V25 was transferring R2 so V25 could give R2 a shower. V8 stated V8 worked the floor that day and V25 did not come to V8 or any of the other CNAs to ask for help to transfer R2.

On 07/26/23 at 2:50 PM, V28 (R3's Nurse Practitioner) stated R2 has contractures, is immobile and bed bound. V28 stated R2 is dependent on total body mechanical lift for transfers and there should always be two staff members when R2 is transferred. V28 was notified by the facility on 06/21/23 that R2 had sustained a fall and x-rays were ordered. V28 stated on 06/22/23 R2 was sent to the hospital due to x-ray results which showed acute right ankle distal fracture of tibia and fibula. V28 stated having only one staff present when R2 was being transferred in the mechanical lift could have contributed to R2 falling and that there should have been two staff present.

On 07/27/23 at 9:45 AM, V7 (CNA) stated V7 was working on the unit the day of R2's fall. V7 stated V25 did not ask V7 to help when transferring R2.

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| S9999 | Continued From page 7<br><br>On 07/27/23 at 9:56 AM, V31 (CNA) stated via phone interview that V31 was working on the unit the day of R2's fall. V31 stated V25 did not ask V31 to assist V25 with transferring R2 on that day.<br><br>On 07/27/23 at 10:08 AM, V44 (CNA) stated via phone interview that V44 was working on the unit the day of R2's fall. V44 stated V25 did not ask V44 to help transfer R3 that day.<br><br>On 07/27/23 at 12:11 PM, V25 (CNA) stated via phone interview, "This is not a good time for me. I don't want to talk about that incident. I already wrote a statement with respect to the fall. I don't want to talk to you."<br><br>Attempts to contact V26 (Agency LPN) via phone at the following dates/times: 07/26/23, 8:59 AM, 07/26/23, 12:02 PM, 07/27/23, 12:13 PM were unsuccessful. V26's voicemail box not set up to leave messages.<br><br>On 07/27/23 at 12:16 PM, V1 stated V1 took V25's statement because V1 was in the building when R2's fall happened. V1 stated V25 told V1 that V25 was the only staff in the room at that time of R2's fall. V1 stated V1 has texted V26 three times to request V26 to call the facility to talk to surveyor and can see that V26 read the text messages but V26 never responded.<br><br>Facility policy and procedure titled, Mechanical Lift Transfer (Full Size/Hoyer Type Lift) dated 10/10/11 documents in part the purpose is to assure that all residents that are assessed to require extensive assistance high (with minimal to no ability to bear weight of bilateral lower extremities and/or total assistance in transfer are transferred safely with no injury to resident or | S9999 | | |

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| S9999 | Continued From page 8<br>care handler and the operating of the lift requires a minimum of two trained operators.<br><br>—<br><br>2. R1's Fall incident report dated 6/17/23 at 5:14 PM shows R1 was observed on the floor leaning to R1's left side, with R1's wheelchair behind R1. Prior to the incident R1 was sitting in the hallway in R1's wheelchair. R1's Fall incident report dated 5/27/23 shows at approximately 10:00 PM, R1 was observed on the floor on a sitting position and leaning to the right side (location not indicated). Prior to incident R1 was sitting in the hallway in R1's wheelchair after refusing to go to bed.<br><br>R1's clinical records show R1 had a multiple history of unwitnessed falls on 4/1/23 and 4/10/23.<br><br>R1's Minimum Data Set (MDS) dated 6/2/23 shows R1 had severe cognitive impairment and required extensive two staff assistance for transfer and locomotion off unit. R1's MDS dated 3/3/23 shows R1 had severe cognitive impairment, required extensive two staff assistance for transfer, and required extensive one person assist for locomotion on and off unit. One of R1's fall care plan interventions initiated on 5/27/23 reads, "When out of bed have resident supervised in common area, engage as able. Offer resident color activities." R1's comprehensive care plan also shows R1 has a self-care deficit with interventions initiated on 3/22/22 to provide extensive assistance with one person support for locomotion on unit with wheelchair. | S9999 | | |

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| S9999 | Continued From page 9<br><br>On 7/25/23 at 3:50PM, a phone interview conducted with V18 (Agency Licensed Practical Nurse) regarding R1's 5/27/23 fall. V18 stated V18 was the nurse in charge for R1. V18 stated nobody saw how R1 fell, and it was around 8:00 PM to 10:00 PM. V18 stated before the fall, R1 was sitting in the wheelchair in the hallway because R1 refused to go to bed. V18 stated V18 was passing medication and did not witness how R1 fell. V18 stated V18 was made aware that R1 fell, V18 went in the room and found R1 sitting on the floor.<br><br>On 7/27/23 at 10:23 AM, a phone interview conducted with V20 (Nurse) regarding R1's fall on 5/27/23. V20 stated, "Actually, I was not the nurse, but I was coming from the elevator, and I heard someone screaming for help. The nurse was passing meds in the hallway. I went in the room and I found [R1] on the floor. [R1] was sitting on the floor by the wheelchair." V20 stated V20 is not sure how R1 got inside other resident's room. V20 stated R1 knew how to get around in R1's wheelchair. V20 stated V19 was assigned to R1 and was doing patient care with another resident and also did not witness how R1 fell. V20 stated R1 had no injuries and did not complain of pain.<br><br>On 7/27/23 at 12:09 PM, during phone interview conducted with V19 stated, V19 does not remember R1's fall on 5/27/23.<br><br>R1's Fall incident report dated 6/22/23 at 12:15 PM documented by V15 (Agency Licensed Practical Nurse) shows R1 had an unwitnessed fall in R1's room, was found lying on the floor attempting to walk while holding onto the bedside table. R1's hospital records dated 6/23/23 shows R1 sustained a left hip fracture. | S9999 | | |

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| S9999 | Continued From page 10<br><br>On 7/25/23 at 12:06 PM, V8 (Restorative Director) stated on 6/22/23 around a little after noon, V8 heard a loud noise and immediately went in R1's room with V41 (Former Assistant Director of Nursing). V8 stated R1 was found in the bathroom sitting on the floor with R1's head against the wall by the grip bar and the bedside table was flipped over on top of R1's waist. V8 stated R1 kept saying R1 had pain on R1's head. V8 stated V8 and V41 moved the bedside table, brought the wheelchair in the bathroom, lifted R1's arms and legs and sat R1 on the chair to put R1 back to bed. V8 stated R1 kept holding R1's head. V8 stated V15 (Agency Licensed Practical Nurse) assessed R1 and called the doctor<br><br>On 7/26/23 at 7:09 AM, a phone interview with V19 (Certified Nursing Assistant/CNA). V19 stated R1 had fallen several times and at the time of R1's fall on 6/17/23, V19 was on the 3rd floor nurses' station doing something in the computer. V19 stated that R1 was in the hallway in front of R1's room. V19 stated that no one saw R1 when R1 fell. V19 stated V19 was not watching R1 because V19's back was turned away from R1. V19 stated R1 was not assigned to any one-on-one staff supervision. V19 stated R1 had gotten up off the chair, V19 heard the noise, and found R1 on the floor by the door of the nurses' station. V19 stated V19 yelled for help, and everybody came to assist R1.<br><br>On 7/26/23 at 10:13 AM, a phone interview conducted with V7 (Certified Nursing Assistant) for R1's 6/17 fall. V7 stated it was before dinner R1 was sitting in the hallway. V7 was in another room with a different resident. V7 stated that 15-20 minutes before R1 fell, V7 locked R1's wheelchair and placed R1 in the hallway a few | S9999 | | |

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| S9999 | Continued From page 11<br>feet from R1's room. V7 stated V7 heard a noise, and someone yelled that someone fell. V7 stated V7 came out the room and saw R1 on the floor by the nurses' station. V7 stated when R1 was in the hallway R1 would just sit there.<br><br>On 7/27/23 at 9:30 AM, V17 (Licensed Practical Nurse) stated when R1 fell on 6/17/23, V17 was doing medication pass in another resident's room. V17 stated V17 heard V19 said something that R1 was on the floor. V17 stated V17 did not see how R1 fell. V17 stated R1 did not sustain any injuries. V17 stated V17 walked past R1 approximately 10 minutes before R1 fell, and R1 was sitting in the wheelchair in the hallway by the nurses' station. V17 stated R1 was calm at that time. V17 stated V17 is not sure who was watching R1 when R1 was in the hallway. V17 stated, "With [R1] age we have to watch [R1]."<br><br>At 1:55 PM, V1 (Interim Director of Nursing) stated, "If a resident has fallen on the floor after the nurse has does an assessment the resident would be transferred from the floor to the bed or from the floor to the wheelchair using a [Mechanical] lift with 2 staff members regardless if the resident requires using a [Mechanical] lift or not before the fall. If their limbs are out of alinement or if the resident is complaining of neck pain, the nurses would not move the resident from the floor and would call 911."<br><br>The facility's policy titled; "Fall Prevention Protocol" dated 8/03/17 reads in part:<br>Risk Assessment<br>III. Fall Prevention<br>B. Implement individualized approaches/interventions based upon resident risk<br>V. Care plan | S9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6005227 | A. BUILDING: _____ B. WING _____ | C 07/28/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKEVIEW REHAB & NURSING CENTER | 735 WEST DIVERSEY CHICAGO, IL 60614 |

| (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 12<br>A. Interdisciplinary care plan is implemented for residents at risk and may include<br>1. Interventions to prevent falls<br>The facility's policy titled; "Post Fall Management Protocol" dated 8/03/17 reads in part:<br>I. Post fall physical assessment<br>A. If fracture or head injury is suspected, DO NOT MOVE resident and advise resident not to move affected area; complete assessment.<br>(A) | S9999 | | |