STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015499	A. BUILDING _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEK AMERICAN REHAB CARE CTR	220 N FIRST STREET WHEELING, IL 60090

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S 000	Initial Comments FRI of 7/7/2023/IL162112	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b 300.1210c) 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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care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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 interview and record review the facility failed to ensure a resident at risk for falls with a history of falls was supervised in the bathroom. This failure resulted in R1 falling from the toilet and sustaining a right hip fracture requiring surgical intervention. This applies to 1 of 3 residents (R1) reviewed for falls in the sample of 6.

The findings include:

R1's face sheet shows she is a 91 year old female and has diagnoses including: history of falls, unsteadiness on her feet, pain in right hip and a nondisplaced intertrochanteric right femur fracture.
R1's 6/2/23 facility assessment shows she has a moderate cognitive impairment and requires staff assistance with toileting and transfers.

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R1's active fall risk care plan initiated on 12/29/2020 shows she is at high risk for falls and has had falls on the following dates: 12/14/18, 12/17/19, 1/20/20, 4/11/20, 4/29/20, 7/3/20, 2/14/21, 8/15/21, 10/18/21, 11/20/21, 12/25/21, 5/5/22, 11/16/22, 1/8/23, 5/14/23 and 7/7/23. The same care plan shows R1 has a history of attempting to self transfer and she is on the facility's fall prevention program. Fall interventions identified in the care plan include call light in reach at all times, prompt response to her call light, toileting every 2 hours and as needed, supervise when in her wheelchair, and the use of a bed/chair alarm for monitoring. R1's care plan identifies her as primarily Greek speaking.

R1's 6/2/23 fall risk assessment shows she is at high risk for falls due to impaired mobility and limitations.

R1's facility reported incident (not dated) completed by V27 (Assistant Director of Nursing/ADON) shows on 7/7/23 R1 who requires a 1 person staff assist, had a fall from the toilet seat while in the bathroom resulting in a right hip fracture.

A nursing incident note completed by V7 (Licensed Practical Nurse/LPN) on 7/7/23 at 2:30 AM states, "Around 2 AM in the morning CNA (Certified Nursing Assistant) transferred resident to restroom per facility protocol. Resident educated to use call light once done, call light placed within reach. Nursing staff heard the resident calling for help. Nursing staff immediately entered resident's restroom. Resident observed laying down on her right side with face leaning towards the floor. Bathroom's call light noted on off position. Resident noted with redness,

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bruising, and swelling to right cheek and to her brow bone." 911 was called and she was sent to the emergency room.
A nursing progress note completed by V7 on 7/7/23 at 8:19 AM, shows R1 was admitted to the hospital and diagnosed with a right hip fracture and will be transferred to another facility for surgical repair.

X-Ray results from a local community hospital dated 7/7/23 shows that R1 has a displaced, foreshorted right intertrochanteric femur fracture also described in the report as a "right hip fracture."

On 8/25/23 at 8:50 AM, R1 was interviewed (using a Greek speaking interpreter- V25 Social Worker). R1 said she had a fall in the bathroom when the CNA left her in the room alone and went out of the room. R1 said she slid off from the toilet onto the floor and threw a bootie she was wearing on her feet out into the room to try to get staff attention. R1 said she is "97 years old" and sometimes forgets to about the call light.

On 8/25/23 at 8:40 AM, V5 (LPN) said before her recent fall, R1 was a 1 person assist to the toilet. She said R1 tries to get up on her own and does not always use her call light. When she is in the bathroom staff should stay in the room with her.

On 8/25/23 at 9:01 AM, V4 (LPN/Restorative Nurse) said R1 was a fall risk prior to her recent fall. She described R1 as having periods of forgetfulness and said generally CNA's stay in the bathroom with residents who are at risk for falls and she would not have left R1 in the bathroom alone.

On 8/25/23 at 9:18 AM, V6 (CNA) said the staff

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should never ever leave a resident who is a fall risk alone in the bathroom. They should always stay with them or just outside the bathroom door where they can still see the residents if they request privacy.

On 8/25/23 at 10:45 AM, V7 (LPN) said around 2 AM on 7/7/23 she heard a resident yelling for help and went to R1's room where she found her on the bathroom floor. No staff were in the room with R1 when she entered. She said in this instance, the CNA who had put R1 on the toilet left her there to go answer another resident's call light and R1 fell from the toilet. V7 said the CNA who left R1 was educated on never leaving residents at risk for falls alone in the bathrooms.

On 8/25/23 at 11:00 AM, V2 (Director of Nursing) said this particular incident with R1's fall was an issue because the CNA left her alone in the bathroom. She said the CNA (V8) should have gotten another staff person to stay with R1 if she needed to leave the room but she did not do that. V2 said V8, in addition to other staff, were educated and in-serviced about not leaving residents alone in the bathroom.

On 8/25/23 at 12:25 PM, V8 (CNA) said she had been in the bathroom with R1 for like 15 minutes when she heard another resident calling out, so she left the call light by R1 and left her alone in the bathroom. V8 said she did not go to let anyone know that R1 was in the bathroom alone.

On 8/25/23 at 12:34 PM, V3 (R1's Primary Care Physician) He would think R1's hip fracture is consistent with her fall and if the facility has procedures in place to supervise residents at risk for falls then they should follow it.

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S9999	Continued From page 5 The facility provided Fall Prevention Program policy last revised on 2/4/22 says the facility should identify residents at high risk for falls and maintain as safe of an environment as possible and ongoing supervision will be provided by staff. (A)	S9999		