STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007918	A. BUILDING: _____ B. WING _____	C 02/17/2023

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LANDMARK OF RICHTON PARK REHAB & NS(	22660 SOUTH CICERO AVENUE RICHTON PARK, IL 60471

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S 000	Initial Comments Complaint Investigation: 2391153/IL156281	S 000		
S9999	Final Observations Statement of Licensue 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal 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 develop an effective plan that includes supervision, and intervention to reduce or prevent the risk of falling for 1 of 3 residents (R3) reviewed for fall prevention, This failure resulted in R3 having four falls within 8 days which resulted in a Right Acute Subarachnoid Hemorrhage and Right Subdural Hematoma, bruising to the face and a Left Subdural Hematoma. Findings include: R3 had the diagnosis of Hemiplegia and Hemiparesis following Cerebral Infraction affecting the left dominant side, Convulsion,	S9999		

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S9999	Continued From page 2 reduce mobility, history of falling, lack of coordination, weakness and Syphilis. Brief interview for mental status dated 12/3/22 documents a score of twelve which indicates moderate impairment. Section G (functional status) documents: R3 needs extensive assistance with one person physical assist with bed mobility, transfers walking in room/corridor, locomotion on/off unit and toilet use. Balance during transitions and walking: R3 was not steady, only able to stabilize with staff assistance (moving from seated to standing position, walking, turning around and surface to surface transfers) Functional limitation in range of motion: R3 had upper/lower extremity impairment on one side. Fall review dated 1/25/23 documents a score of 14 which indicated as a high risk for falls. Care plan initiated 11/5/21 documents: R3 was a risk for fall related to history of falls, left hemiparesis and alcohol abuse. (2/1/23 fall) On 2/15/23 at 1:00pm, R3 was observed not positioned upright in his broader chair. R3's buttock was observed in the middle of the chair seat, slid down from the back of the chair. On 2/15/23 at 1:05pm, R3 who was assessed to be alert and oriented to person, place and time said, my first fall, I stood up to get a snack, I dropped that fell under my bed. I fell when I bent over and hit the right side of my eye brow on the floor. R3 pointed to his right eye brow. I was discharged to the hospital. On 2/15/23 at 1:38pm, V3 (asst. social service director) said, R3 is alert and oriented to person, place and time now. R3 is coming back to himself today. R3 was so confused when R3 was falling.	S9999		

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S9999	Continued From page 3 On 2/15/23 at 2:13pm, V7 (restorative nurse/mds) said, R3 was found on the floor in his room in a sitting positon beside his bed. R3 reported trying to get some hot sauce from under the bed. R3 had an opening to the right eye brow. R3 was discharged to the hospital. We provided R3 a Reacher. On 2/16/23 at 12:38pm, V7 said, giving a R3 a Reacher when nothing was found on the floor was not an ineffective intervention. On 2/16/23 at 2:32pm, V9 (CNA) said, I was called in to reposition R3 in the chair. I had to pull R3 up in the chair. Nursing note dated 2/1/2023 documents: 5am-during routine rounding, observed R3 sitting on the floor on his buttocks near his bed. R3 was observed small open area noted to right brow. R3 stated, "I was trying to pick my hot sauce from off the floor". R3 had on non-slip sock and lock wheelchair was beside the bed. 911 called.	S9999		
	Incident dated 2/1/23 documents: R3 (A0X3) was found on the floor, beside the bed in a seated position with a small open area to the right brow. Predisposing physiological factors- gait imbalance. R3 stated, he was trying to pick up my hot sauce from the floor. There wasn't any food or hot sauce on the floor in R3's room. Upon further assessment wheelchair observed unlocked. Hospital paperwork dated 2/1/23 documents: R3 came in from a fall at the nursing home found to have a right acute subarachnoid hemorrhage and a right subdural hematoma. R3 overestimates/forget limitation. Final reportable dated 2/6/23 documents: R3 was			

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S9999	Continued From page 4 transferred to the hospital, CT scan revealed subarachnoid hemorrhage. R3 stated that he was trying to pick up some hot sauce when he got out of bed without calling for assistance. It was determined that R3 was attempting to ambulate without assistance while bending down. Reacher provided to R3 with teaching on use with a safe and accurate return demonstration. (2/5/23 fall) On 2/15/23 at 1:05pm, R3 said, my second fall was due to me attempting to walk to my dresser to get a snack. On 2/16/23 at 12:43pm, V7 said, education and reminders to lock the wheelchair and sit down slowly are not effective interventions for R3 who was only oriented and alert to self. Nursing note dated 2/5/2023 documents: R3 was in the hallway like 50 feet from writer (V16 nurse). Writer (V16) observed R3 attempting to stand up out of his chair, writer (V16) tried running to catch R3 before fall with no success. R3 chair was unlocked. R3 fell on his buttock. R3 has an unstable gait. On 2/15/23 at 2:13pm - V7 (restorative nurse/mds) said, R3 had a fall on 2/5/23. R3 stood up from his wheel chair, to put his coat that R3 was sitting on, on the back of his wheelchair. When R3 attempted to sit back down, the wheelchair moved. R3 was educated and reminded to lock wheelchair and sit down slowly, physical therapy to evaluate for transfer and gait, to ensure wheelchair is clutter free. On 2/15/23 at 3:30pm, V12 (CNA) said, R3 has two falls on 2/5/23. R3 had a fall before, I started my shift. I was informed by V16 (nurse). Ten	S9999		

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S9999	Continued From page 5 minutes into my shift, I heard a boom-flesh/skin hitting the floor. I entered R3's room. R3 keep stating, "I have to use the bathroom." R3 had a urinal on the side of R3's wheelchair. R3 was confused. I guess R3 felt the need to stand up to void. I helped R3 to the bathroom. On 2/16/23 at 12:43 pm, V7 said, it is possible to educate a resident (R3) who was only alert to self. R3 was very confused. As team, we should of came up with something else for R3 and needed to review the full picture of R3 to determine interventions. Incident dated 2/5/23 documents: Mental status: R3 was alert to person. Predisposing physiological factor: gait imbalance. Predisposing situation factors: admitted with in the last 72 hours, ambulating without assist and recent room change. (2/6/23 fall) On 2/15/23 at 1:05pm. R3 said, I don't recall this fall. Nursing note dated 2/6/2023 documents: R3 was observed on floor mat near bedside in left side lying position. R3 was unable to give description of what happened. Floor mats in place. All safety precautions in place. Resident to be sent to hospital for CT scan. Incident dated 2/6/23 document: R3 was oriented to person. Injuries observed at the time is the incident: bruise to face. Care plan created on 2/6/23 documents: low bed, medication review, labs, and urinalysis. Hospital paperwork dated 2/6/23 documents: CT scan (2/7/23) documents: Right subdural	S9999		

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S9999	Continued From page 6 hematoma has not changed significantly is approximately 8mm thick, mildly enlarged when compared to 2/1/23. Left subdural hematoma is also new since 2/1/23. (2/8/23 fall) On 2/15/23 at 1:05pm. R3 said, I don't recall this fall On 2/15/23 at 2:13pm, V7 (restorative nurse/mds) said, R3 had a fall in the dining room. R3 slid from wheelchair onto his buttock. Care planed intervention for R3 to take a nap after lunch was not an effective intervention. R3 should have cushion, if R3 was in the wheelchair. On 2/15/23 at 3:48pm, V14 (physical therapy) said, R3 was not at baseline, could not sit up or stand. R3 was a high fall risk who could maintain his balance. R3 was not considered for a lap buddy, seat belt or wedge cushion. R3 was given a broad-chair.	S9999		
	On 2/16/23 at 1:00pm, V18 (activity aide) said, it was around 4:00pm in dining room. I was the only staff in the dining room. Activities had started at 1:00pm ended at 300pm. R3 was sleeping during the activity time and after the activity. R3 was in bigger chair like a geri-chair. R3 was sitting up in chair. One Resident yelled, he (R3) is moving. R3 was observed half way up out of the chair on the right side. I went to go get R3 but R3 was on the floor. I was about three tables away. R3 had raised his body up over the side and R3 hit the floor. I was collecting items from the residents at the tables prior to R3's fall. V18 said, she yelled for someone. R3 was just looking at me. R3 was alert but did not respond, not at his baseline. R3 unable to say what happened. R3 will sometimes			

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S9999	Continued From page 7 sleep while in the dining room. Usually the fall risk residents need to be monitored in the dining room. When asked how long residents can sleep in the dining room, V18 said, fall risk resident have to be monitored and usually will not go back to the room. Nursing note dated 2/8/2023 documents: At approximately 4:30pm, writer (V17 nurse) was called to the dining room by staff. R3 was observed trying to get up from his chair. Staff attempted to intervene but was unable to catch R3. R3 was observed on the floor on his butt. R3 stated 'I slid from my chair. Incident dated 2/8/23 documents: R3 was oriented to person. Wheelchair bound. Witnessed statement documents: V18 (CNA) said, I was in the dining room during activities, R3 suddenly woke up from his sleep and began trying to get up. I immediately attempted to intervene but was unable to reach R3. R3 fell to the floor. It was determined R3 was observed on the floor lying on left side. R3 was unable to state what happen. Care plan intervention dated 2/8/23 documents: offer R3 to take a nap after lunch. Incident/Accident/Fall policy not dated did not apply. (A)	S9999		