STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014765	A. BUILDING: _____ B. WING _____	C 01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN NORTH SHORE REHAB & HCC	5050 WEST TOUHY AVENUE SKOKIE, IL 60077

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S 000	Initial Comments Facility Reported Incident of December 21, 2022 IL154847	S 000		
S9999	Final Observations Statement of Licenure Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)6) 300.1220 b)3) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

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.

Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
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. The plan shall be reviewed at least every three months.

These requirements are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide adequate assistance to R1 during a transfer from the

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S9999	Continued From page 2 wheelchair to the bed, and failed to document and report the incident during the transfer in a timely manner. These failures caused R1 to sustain a fracture of the right hip requiring hospitalization and surgery. This deficiency affects one (R1) of three residents reviewed for Resident safety/Accident prevention in a total sample of 4. Findings include: R1 iwas admitted on 11/30/22, with diagnosis listed in part, but not limited to: Displaced intertrochanteric fracture of right femur subsequent encounter for closed fracture with routine healing, Orthopedic aftercare following surgical amputation, Acute osteomyelitis right ankle and foot, Surgical aftercare following surgery on the circulatory system, Peripheral Vascular Disease, Generalized muscle weakness, Gait and mobility abnormality, history of falling, Metabolic encephalopathy. R1's Care plan indicated: R1 has limited transfer skills due to toe amputation. R1 has impaired ADLs in the following areas: hygiene and grooming, dressing, and sitting balance. R1 has limited trunk strength and mobility affecting posture/postural control and function, especially regarding sitting balance, repositioning in wheelchair and bed. She has ADL self-care performance deficit due to recent hospitalization, weakness, post amputation of right 2nd toe. She is at risk for falls due to unsteady gait, weakness, use of psychotropic, recently hip fracture and hospitalization due to altered mental status. R1's MDS (Minimum Date set) admission assessment, dated 12/6/22, Section G, Functional Status, indicated: ADL (Activity of	S9999		

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S9999	Continued From page 3 Daily Living) assistance: A. Bed mobility- how the resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture. Self-performance: Extensive assistance (resident involved in activity, staff provide weight bearing support). Support: 2 + person physical assist. B. Transfer- how resident moves between surfaces including to or from bed chair, wheelchair, standing position. Self- performance: Extensive assistance. Support: 2+ person physical assist. Incident report of bruise and right hip pain, dated 12/20/22 at 6:00am, completed by V15, LPN (Licensed Practical Nurse), indicated: R1 complained of right hip pain with pain scale of 5, PRN (as needed) Tylenol given with relief, noted with bruise, when asked what happened, R1 verbalized "I bumped my hip somewhere while transferring from wheelchair to bed last night. I feel pain when I'm moving it but if I don't move it, I'm okay." Staff provided an ice pack and it helped. Nurse Practioner and family notified. Radiology report, dated 12/20/22 8:38pm, impression: impacted basicervical fracture with varus deformity. Incident/accident notification Final report 12/23/22 (initial report sent on 12/21/22) submitted to IDPH documented R1 is 100 years old and admitted to facility on 11/30/22, with diagnosis above for PT/OT. R1 is alert and oriented x 2-3. R1 had as incident while transferring from wheelchair to her bed, and right hip pain noted immediately after. X-ray ordered at facility. Results showed "what appears to be an impacted basicervical fracture of right femoral neck with some varus deformity". Attending physician ordered for resident to be sent out to hospital for further evaluation.	S9999		

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S9999	Continued From page 4 Investigation initiated. Facility Response/Follow up: Per interview with R1, she was transferring with V14, CNA, from wheelchair to bed, when she lost her balance, and believes she hit something, but unable to identify. R1's room was inspected, and situation was re-enacted. It is possible R1 could have come in contact with half side rails as R1 uses them to adjust self in bed. Per interview with staff, therapy and therapy recommendation, R1 is able to pivot transfer with 1 person assist. Per interview with V14, CNA, stated she assisted R1 from wheelchair to bed when she suddenly lost her balance. Attending physician ordered for resident to be sent out for further evaluation at that time, however, R1 and family requested that she transfer the following morning. Pain medication provided and per staff and R1, she slept comfortable through the night. R1 admitted to hospital for hip fracture and surgical intervention. Facility has been in contact with R1's family and R1 will return to facility to continue short term rehabilitation. Review R1's therapy records with V13, Therapy Director, indicates: Physical Therapy Evaluation and plan of treatment, certification period :12/1/22 to 1/29/23 indicated: Referred to PT due to new onset of decrease strength, decrease in functional mobility, decrease in transfers, reduced balance, reduces ability to safely ambulate, reduced functional activity tolerance and increased need for assistance from others. Medical precautions: Right toe amputation WBAT RLE in forefoot offloading post op shoe. Behaviors: Attentive, oriented, cooperative, and able to make needs known. Underlying impairments: Standing balance: static balance- poor maximum	S9999		

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S9999	Continued From page 5 assist and upper extremity support to maintain standing balance and reach ipsilaterally, unable to weight shift. Dynamic standing- unable (total dependence) Functional assessment: Bed mobility- Maximum Assistance Transfer- Maximum Assistance Gait- level surfaces- Total dependence without attempt to initiate Wheelchair mobility- Total dependence without attempt to initiate Objectives: R1 will safely perform functional transfer with maximum assist and 75% verbal cues and 75% tactile cues for weight shift over center of gravity, for push up from arms of chair and for safety while turning in order to decrease level of assistance from caregivers, safely return to house hold activity and return to prior level of functional abilities. R1's Therapy treatment encounter notes, dated 12/19/22, indicated: Therapeutic activities: Sliding board transfer training to increase functional task performance, training in weight shifting for SB position under patient buttock with minimal assist. Verbal instructions and tactile cues for hands/feet position moderate assist and extra time scooting along the board: to initiate sliding board transfer, sequencing and hands position on the board. Physical Medicine Rehabilitation notes follow up, dated 12/19/22, indicated: Chief complaint: mobility and ADL dysfunction secondary to other acute osteomyelitis, right ankle and foot, encounter for orthopedic aftercare following surgical amputation now with left thumb, index and middle finger numbness and electrical pain. Assessment: Transfers- Maximum assist with sliding board.	S9999		

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S9999	Continued From page 6 Hospital record, dated 12/21/22, indicated: Chief complaint- Fracture due to fall and underlying osteoporosis. 100-year-old female presented to emergency department status post fall. She fell 2 days ago when trying to transfer back to bed from chair. Hospital Discharged summary, dated 12/26/22, indicated: status post right hip fracture. On 12/22/22, she underwent right hip ORIF (Open Reduction Internal Fixation). On 1/24/23 at 10:35am, R1 was observed for contact isolation due to shingles. R1 was lying in bed with O2 (oxygen) via NC (nasal cannula) at 0.5 LPM (liters per minute). R1 is alert and oriented, but forgetful. R1 is not a good historian. R1 remembers of banging her hip during transfer causing her pain and hospitalization due to fracture, but cannot give details of the incident. On 1/24/22 at 2:38pm, V13, Therapy Director, said R1 is evaluated and has certification for therapy from 12/1/22 to 1/29/23. V13 said R1 needs 2 persons assist for transfer. V13 said they communicated to nursing staff regarding assistance needed for transfers. V13 said they recommended sliding board for transfers due to her unsteady when standing due to rheumatoid changes to the joints. V13 said for safety transfer, they recommended sling board with 2 persons assist. V13 they informed the nursing staff regarding R1's safety transfers. On 1/24/23 at 3:30pm, reviewed R1's medical record regarding FRI (Facility reported incident) dated 12/21/22 with V1, Administrator and V3, ADON (Assistant Director of Nursing). Informed V1 that FRI reported did not indicate the date the incident occurred. It was identified at first, right hip pain and bruise of unknown origin on	S9999		

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S9999	Continued From page 7 12/20/22, then during investigation, it was found out R1 had an incident of hitting her right hip on side rails when V14, CNA (Certified Nursing Assistant), transferred her from wheelchair to bed on 12/19/22. No incident report or documentation in R1's progress notes was done. On 1/14/23 at 3:40pm, V3, ADON, said any incident report will be discussed by IDT (interdisciplinary team) for root cause analysis, and care plan will be updated based on root cause analysis to prevent future re-occurrence of the incident. V3 said V2, DON (Director of Nursing), updates the care plan and risk management. Informed V3 and V6, Nurse Consultant, R1's care plan was not updated in relation to the incident. No new intervention was formulated to prevent re-occurrence of the incident. V3 and V6 reviewed R1's care plan, and said there are no updates in the care plan pertaining to the facility reported incident. On 1/24/23 at 3:48pm, V14, CNA, said that V14 transferred R1 by herself on 12/19/22 around 7pm, from wheelchair to bed, and R1 lost her balance. V14 said R1 probably hit her hip to the side rail and landed on the bed. R1's both legs were hanging off the bed. She asked V16, LPN, for assistance to put her on bed. R1 complained of pain on her right leg. She said the nurse is aware of the incident. R1 complained of pain, and V16 gave her pain medication. V14 said she applied ice pack to R1's leg. V14 said she did not use gait belt when transferring R1 to bed. She is not aware R1 needs 2 person assistance, and she is not aware R1 needs sliding board for transfer. On 1/25/23 at 11:24am, V2 said V1, Administrator, did the investigation of the incident.	S9999		

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S9999	Continued From page 8 V2 said V16, LPN, should have documented and reported the incident that happened on 12/19/22 when R1 lost her balance and hit the side rail during transfer with V14, CNA, especially since R1 complained of pain. Incident report was made on 12/20/22, when R1 complained of pain, and a bruise was noted on the right hip at 6am to V15, LPN. V2 said R1's X-ray of the right hip was ordered at 10am, but there is no documentation what time it was taken. The Xray result with fracture hip was received at 8:30pm. V2 said the Xray tech should come within 4 hours from the time it was ordered. R1 was sent out to the hospital on 12/21/22 per family request, because it was already late, and family would like to be with R1 when she goes to the hospital.. On 1/25/23 at 12:54pm, V16, LPN, said on 12/19/22, V14, CNA, called him for assistance in R1's room. He found R1 lying in bed with legs off the bed. He helped V14 straighten R1 in bed, and boosted her up. R1 complained of right hip pain. R1 said she hit her right hip to the wheelchair during transfer. He did not see any redness or bruising at that time. He gave her PRN pain medication, and V14 applied ice pack to her hip. He said he did not document or make an incident report, because he was busy with another resident. He forgot to endorse it to the next shift because he got busy. He said he should have documented in the progress notes the incident tha happened during transfer and should have made an incident report. R1's admission MDS assessment, dated 12/6/22, indicated R1 needs extensive assistance with 2 + person assist for transfer. R1's therapy notes indicated R1 needs sliding transfer board for safety. At the time of incident report, R1 was transferred by V14, CNA, by herself, with gait	S9999		

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S9999	Continued From page 9 belt, and not using transfer board. R1's care plan was not updated when she returned from the hospital after surgery due to fracture, to prevent re-occurrence of the incident. V14 was not aware R1 needs 2 persons assist and need sling board for transfer. V2 said the therapist should communicate with nursing staff regarding R1's safety transfer. V2 said a gait belt should be used during transfer. Facility's policy on Incident/accident reports indicates: Policy: The incident/accident report is completed for all unexplained bruises or abrasions, all accidents or incidents where there is injury or the potential to result in injury allegations of theft and abuse registered by residents, visitors or other and resident-to-resident altercations. Procedure: An accident refers to any unexpected or unintentional incident, which may result in injury or illness to a resident. This does not include adverse outcomes that are a direct consequence or treatment or care that is provided in accordance with current standards of practice. 4. All unusual occurrences. 9. An incident/ accident report is to be completed and shall include A. Date and time of incident/accident B. Description and possible cause of incident, physical assessment, injuries noted, vital signs, treatment rendered and notification of appropriate parties. 10. The facilities shall maintain a file of each incident and accident affecting a resident that is not the expected outcome of the resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the process notes or nurse's notes of that resident. 15. Facility must ensure that the resident	S9999		

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S9999	Continued From page 10 environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accident. Facility's policy on transfer techniques indicates: Purpose: To safely transfer the resident from bed to chair to from one location to another. 7. Place gait belt around the resident's waist unless contraindicated. Facility's policy on Gait belt/transfer belt indicates: Policy: To assist with a transfer or ambulation. A gait belt will be used with weight-bearing residents who require hands on assistance. Facility's policy on Management of falls indicates: Policy: The facility will assess hazards and risks, develop a plan of care to address hazards and risks, implement appropriate resident interventions and revise the resident plans of care in order to minimize the risks for fall incidents and or injuries to the resident. (A)	S9999		