Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015457	A. BUILDING: ______ B. WING ______	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE FOREST PLACE	1100 PEMBRIDGE DRIVE LAKE FOREST, IL 60045

(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
S 000	Initial Comments Annual Certification Survey	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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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1 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 fall risk interventions were in place for a resident (R27) at risk for falls with a history of falls. This failure contributed to R27 falling and sustaining a impacted and comminuted left femur fracture and a dislocated left knee. This applies to 1 of 13 residents reviewed for safety in the sample of 13. The findings include: R27's face sheet shows she has diagnoses including: history of falling, unsteadiness on feet, need for assistance with personal care, dizziness and reduced mobility. R27's 10/24/23 fall risk assessment shows she is at high risk for falls.	S9999		

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S9999	Continued From page 2 R27's active care plan effective 6/1/2022 shows that she is alert and oriented x 2-3 but forgetful, at risk for falls, has an unsteady gait and needs limited to total assist of 1-2 staff with her activities of daily living. A intervention effective 6/1/2022 shows R27's bed should be in the lowest and locked position. R27's fall risk care plan shows she had a fall from bed on 10/24/22 and an updated intervention was added for a floor mattress on the left side of her bed. R27's 1/28/23 nursing progress notes completed by V9 (Registered Nurse/RN) at 7:50 PM states, "CNA {V6} noted resident {R27} laying on her back with the pillow under her head. Unable to recall what happened she was verbally responsive but confused. Complained of left leg pain and back pain. Resident left facility in a stretcher at 7:55 PM." A nursing progress noted dated 1/29/23 at 1:23 AM, shows R27 was admitted to the hospital. R27's hospital records from a local community hospital show that she was admitted on 1/28/2023 and discharged back to the facility on 2/2/2023. The hospital records state the following, " Patient is a 94 y.o. female with past medical history of hypertension, neuropathy, presenting from {the facility} after a fall. Patient's daughter was present throughout the encounter. Reports that she received a call from {the facility} advising that the patient had been found on the floor next to her bed. Notes she has fallen before and usually mattresses are placed on the floor as bed rails are not allowed. However there was no mattress on the floor when incident occurred. Patient had been served dinner while laying in bed. Was found 30 minutes after that on the floor." The same hospital records show R27 sustained a	S9999		

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S9999	Continued From page 3 fracture of the left distal femur. A radiology note dated 1/29/23 shows R27 has a "There is a impacted and comminuted fracture (a bone broken in at least 2 places as a result of trauma -Web MD) of the distal left femur and intercondylar region with moderate displacement and angulation. There is anterior subluxation of the lateral femoral condyle (dislocated knee) in relation to the tibial plateau. There is soft tissue swelling of the left knee region and small hemarthosis (bleeding in the knee)." R27 was discharged from the hospital back to the facility on 2/2/23 with orders for no weight bearing and a leg immobilizer. A IDPH Long Term Care Facility Incident and Accident Report investigation was provided by the facility. The investigation shows that R27 was found on the floor on the left side of her bed at 6:30 PM, on 1/28/23. A Post Fall Occurrence Follow-up provided with the investigation shows that factors contributing to the fall included confusion and impaired cognition. Factors of how the fall could be prevented include "Mats on floor to minimize injury." On 3/7/23 at 8:43 AM, R27 was in bed eating her breakfast. Her bed was up against the wall on the right side of the room and raised up approximately 1/4 of the way. The overbed table legs were underneath her bed and her tray was on the table. A large blue thick fall mat was folded up and moved out creating an approximate 2 inch gap between the base of the bed and the mat. R27's left leg was elevated underneath the covers and the outline of her immobilizer was visible through the covers. R27 said, "I don't remember all of what happened that day I was more confused I guess you could say, but I had a fall from bed, hit the floor and broke my leg."	S9999		

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On 3/7/23 at 1:43 PM, V3 (Assistant Director of Nursing) said, "I think what happened with R27's fall was that they have to raise up her bed to get the overbed table to go underneath it and have to pull the fall mat away from the bed because the table cannot sit on it. A fall mat would have minimized the impact from the fall onto the floor. R27 broke her leg and dislocated her knee when she fell."

On 3/7/23 at 2:15 PM, V4 (CNA) said, "I was not here when R27 fell. But I know that when she is eating we have to raise the bed up and move the fall mat away. We do not usually stay in the room with her when she is eating. The purpose of the fall mat is to prevent her from hitting the floor if she has a fall."

On 3/8/23 at 8:56 AM, V5 (Registered Nurse) said, "prior to R27's last fall her bed was in the middle of the room and she was supposed to have a big fall mat down on the left side of her bed. We do have to move the mattress away when she eats and raise her bed to be able to get the bedside table underneath the bed."

On 3/8/23 at 9:28 AM, V6 CNA said, "The day that R27 fell she was confused and agitated and the lab had been in to draw blood. I took R27 her dinner tray and I did not stay with her, I would just go check in on her every 30 minutes or so. On one of the checks I found R27 on the floor on the left side of her bed. We do have to raise her bed to get the overbed table underneath and pull her fall mat away. R27's bed at the time of the fall was in the center of the room. There was 1 fall mat for the left side of her bed that was pulled away and was not right next to her bed."

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S9999	Continued From page 5 On 3/8/23 at 10:37 AM, V8 (R27's physician) said, " This type of an injury a femur fracture and a dislocated knee is consistent with a fall yes. I would think had the large fall mat had been down it would have minimized the extent of the injury from the fall. I think the fall interventions do need to be followed." The facility provided policy titled Assessment, Documentation, and Care Planning for HC Residents at Risk for Falls or Who Have Fallen with a revised date of 1/24/23 states, " Fall prevention interventions will be developed, documented in the care plan, communicated to involved staff, and implemented based upon the assessment of resident- specific risk factors for falls." (A)	S9999		