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	IL6009849	A. BUILDING: _____ B. WING _____	C 10/03/2024

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ALDEN LINCOLN REHAB & H C CTR	504 WEST WELLINGTON AVENUE CHICAGO, IL 60657

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S 000	Initial Comments FACILTIY REPORTED INCIDENT SURVEY Facility Reported Incidents: of 8/06/2024 - IL178510 of 9/23/2024 - IL178511	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)3) 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	S9999		

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S9999	Continued From page 1	S9999		

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.

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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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 are not met as evidenced by:

Based on interview and record review, the facility failed to follow their facility's change in condition policy and failed to follow the Care Plan for one resident (R3) reviewed for resident injury. This failure resulted in R3 falling and sustaining bilateral subdural hemorrhages; and, R3 was admitted to the intensive care unit.

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S9999	Continued From page 2	S9999		

Findings include:

R3 no longer resides in the facility. R3 was discharged to the hospital on 9/23/24.

R3's Facility Reported Incident (IL178511), that occurred on 9/23/24, documents, in part, "On 9/23/24 at approximately 8:00 am, resident was observed by staff coming out of room bent forward and fall in the hallway, and staff immediately went to assist resident... MD (physician) gave order to send her (R3) to ER (emergency room) for evaluation. Facility was notified at approximately 5:00 pm that resident will be transferred to (Hospital) for bilateral subdural hematoma ..."

R3's face sheet, documents, in part, diagnosis including but not limited to Alzheimer's disease with early onset; traumatic subdural hemorrhage without loss of consciousness, initial encounter; dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; aphasia and insomnia. R3's BIMS (Brief Interview of Mental Status), dated 9/23/23, is 99 which indicates R3 was unable to complete the interview.

R3's Care Plan, date initiated 9/13/24, documents, in part, "(R3) requires assistance with ambulation. Resident requires task segmented directions to participate in ambulation activities with staff. Balance problems, Risk for falls, Weakness related to impaired cognition. Interventions/Task: Stand alongside of resident to provide verbal cues/guidance/assist while ambulating ... Interventions/Tasks: Monitor for changes in ability to navigate the environment."

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S9999	Continued From page 3	S9999		

R3's progress note, dated 9/22/24 3:40pm, by V5 (Licensed Practical Nurse/LPN), documents, in part, "Patient came accompanied by (V12-R3's family), very anxious and with unusual behavior."

R3's progress note, dated 9/23/24 at 7:11am, by V9 (Registered Nurse/RN), documents, in part, "Patient woke with high anxiety, walking very fast from room to room appeared as if she was looking for an exit. She was howling while pacing when someone would try to restrain her from the fast pace. Call to (Physician) and to (Nurse Practitioner) with request for patient to be evaluated by family hospice. Asked for order of Lorazepam. NP (Nurse Practitioner) text back order for Psych consult. Patient after 2 hours of movement fell asleep on bed."

R3's progress note, dated 9/23/24 at 9:25am, by V5 (Licensed Practical Nurse/LPN), documents, in part, "Resident transferred out by 2 (ambulance) paramedics via stretcher to (hospital) for evaluation at 09:20 am. Resident left unit stable and responsive."

R3's progress note, dated 9/23/24 1:05pm, by V5 (Licensed Practical Nurse/LPN), documents, in part, "Writer was handing out medication and noticed R3 sleeping in bed, a few minutes later the CNA (certified nursing assistant) called and said she saw R3 come out of the room bent forward and fall in the hallway hitting her head on the floor. Patient able to sit and pivot holding her head, NOD (nurse on duty) assessed from head to toes, no bleeding noted, no skin tear, Able to move all extremities. NOD noted a lump visible on patient left side of the forehead. Writer called V14 w/(with) orders to send resident to (Hospital), orders noted and carried out, resident POA

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S9999	Continued From page 4	S9999		

(power of attorney) made aware. DON (director of nursing) made aware. Will continue to monitor per staff."

R3's Hospital Records, documents, in part, "H&P (History and Physical) Notes," dated 9/23/24, documents, in part, "The patient (R3) was taken out of the nursing home over the weekend for a visit with (V12-R3's family). (V12) reports she (R3) was her usual self until yesterday AM, when patient (R3) seemed anxious and restless and began "running around my house." (V12) took the patient back to the NH (nursing home) and alerted staff of patient's (R3) anxiety/restlessness. Per reports, she (R3) did not settle down and was up most of the night, getting out of bed, walking around still unassisted, but much more hurried and unsteady appearing. Staff put her (R3) back to bed a few times, but she (R3) got up again early this AM and fell in the hallway, hitting her head ..."

R3's CT (computed tomography) of the brain, dated 9/23/24, documents, in part, "1. Mixed density right subdural hemorrhage with internal septations along right frontoparietal convexity. Another small isodense subdural collection along left frontoparietal convexity. No midline shift.
2. Left frontal scalp hematoma."

On 10/01/24 at 11:24am, V2 stated, " "A couple things we use to see what types of fall precautions a person needs. There's Gait issues, cognitive issues. "The Fall Assessment" identifies those things. We (staff) put things in place for resident to be as mobile as possible and at the same time as safe as possible. We (staff) do frequent rounds and use a gait belt to transfer for a resident with an unsteady gait for example. When they (residents) are on fall precautions, it

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN LINCOLN REHAB & H C CTR	504 WEST WELLINGTON AVENUE CHICAGO, IL 60657

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S9999	Continued From page 5	S9999		

(fall precautions) is put it in the Care Plan and there is also a fall binder on each unit that shows what is in place for each resident. When the Fall assessments are done all questions may not be answered, only questions that are applicable." When asked about question #5 on R2's post fall "Fall Risk Assessment," dated 8/6/2024, V2 replied, "It should have been answered." When asked the reason for answering the question, V2 replied, "So the resident is on the right level of fall precautions for safety." When asked what is "proper maintained footwear, V2 replied, "Looking for shoes, nonskid, non-slide able bottoms. We have different types of shoes here and sometimes residents prefer different ones. We ask for nonslip soles."

On 10/1/24 at 12:50pm, V8 (Certified Nursing Assistant/CNA) said, "I (V8) was working that floor that day R3 fell. I (V8) was by the nurse's station and heard her (R3) scream. The whole morning R3 was restless and running around. I (V8) heard her (R3) scream and seen R3 walking fast out of her (R3) room and leaning forward, and she (R3) fell. It seemed she (R3) hit headfirst. She (R3) didn't use her (R3) hands to cushion her fall. I (V8) went over there, and she's (R3) not really that responsive normally... she (R3) was her (R3) regular self. She (R3) normally doesn't hold conversations. She (R3) just had a bump ahead. We were keeping extra eyes on her (R3). Last time I (V8) seen her (R3) she (R3) was in room asleep. When she (R3) was restless she (R3) was leaning forward the entire morning. We were worried that she (R3) was going to fall that's why we were trying to get her (R3) to sit down and lay down. Leaning forward was something new for R3. R3 did not normally lean forward while walking."

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S9999	Continued From page 6 On 10/1/24 at 1:56pm, V11 (Nurse Practitioner) stated, "I (V11) know her (R3). I (V11) last seen her 9/17/24, I (V11) believe. She (R3) was sent out that 23rd of September. The family took R3 that weekend. When she (R3) came back, she (R3) was aggressive, anxious, walking back and forth. I (V11) told the nurse (V9, Registered Nurse/RN) to have her (R3) seen by psych because they wanted to do Lorazepam and hospice. She's (R3) ambulatory with steady gait. She (R3) would not pass for hospice. Before Lorazepam, I (V11) wanted her (R3) to be seen by psych. Lorazepam would make her (R3) fall. I (V11) wanted her (R3) to be seen by psych to see if they can prescribe a better med than Lorazepam. If she (R3) was wheelchair bound that would be a different story. I (V11) was not notified that she was leaning forward while pacing for 2 hours before falling asleep. I (V11) was not notified that R3's gait was different. I (V11) would have had them put her (R3) in a closer room. If her (R3) gait is somewhat acute I (R3) would have sent her out, ordered a wheelchair, close monitoring. Giving a benzo (benzodiazepine) with that would make her at a higher risk. I (V11) would have asked more about the leaning. Is it right sided, send them out. They might come back but we at least we have an evaluation from the ED (emergency department). Even without the leaning forward, I (V11) feel that anyone that is confused and leaning forward will eventually fall. She (R3) was admitted subdural hematoma. I (V11) mean if she (R3) has subdural hematoma, yeah, it caused harm to her (R3). Any ambulatory person, even us, will fall eventually with a forward leaning gait. I (V11) rely on the nurse for thorough report of the patient, especially phone calls. If they are in distress, I (V11) say send them out. I (V11) ask if this is new, send them out."	S9999		

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S9999	Continued From page 7	S9999		

On 10/2/24 at 10:23am, V9 (Registered Nurse/RN) said, "She (R3) was very, very not sociable at all. I (V9) was able to gain her (R3) trust and she (R3) would walk down the hallway with me. That day (9/23/24) she (R3) was overly agitated and walking very fast. Faster than her (R3) usual. I (V9) seen it (R3's fast pace) as being fearful. She (R3) didn't want to be touched. She (R3) almost looked like she (R3) was looking for an exit. She (R3) was up most of the night pacing and I (V9) let her pace. I (V9) thought she (R3) would get tired and lay down. She (R3) got more agitated, and the aide (V15, Certified Nursing Assistant/CNA) was worried about her falling due to the walking of the back and forth. V15 sat with her (R3) for a while in the community room. Meanwhile I (V9) called the NP (V11, nurse practitioner) and no response. I (R3) called the doctor (V14, Medical Director) and no response so I (V9) left a message. Was thinking maybe hospice and get some Ativan. I (V9) called V11 (nurse practitioner) again and no response. Then V11 texted me later to get a consult for psychology. I (V9) thought that would take too long. I (V9) walked R3 to her room and she (R3) collapsed in bed like she (R3) was exhausted and fell asleep. I (V9) talked with V5 (Registered Nurse/RN), the new nurse for day shift, and gave her (V5) report. R3 was agitated, not violent but walking very fast. It was different from her (R3) usual walking, almost like she (R3) was scared. V15 thought she (R3) was leaning more, but I (V9) thought it was the way she (R3) was moving so fast. R3's gait was just moving a lot faster, kinda scary, like if she (R3) bumped into something she would fall. Before R3's gait was slower and steady. This was more of a gallop. I (V9) don't think she (R3) was leaning forward. She (R3) leans more towards her left. My aide (V15) thought it was more. I (V9) was more

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 8	S9999		

concerned for anxiety. Her (R3) gait was different. It was fast. She's (R3) so tiny. If she (R3) falls over she (R3) would hurt self. She (R3) was more tilted to the left. I (V9) thought maybe something happened when she (R3) was with her (R3) family, so I (V9) checked her (R3) skin and there were no bruises. I (V9) did not mention anything to V11 about R3's gait. I (V9) was more concerned with anxiety. I (V9) might have said I (V9) was afraid she (R3) might fall. I (V9) can't remember. I (V9) was hoping to get an order to send her (R3) out or at least for some Ativan but V11 just ordered for psychology to see her (R3)."

Upon review of R3's post fall, "Fall Risk Assessment," dated 9/23/24, completed by V5 (Licensed Practical Nurse/LPN), it was observed that question #5"History of Falls (past 3 months) was not answered (incomplete).

On 10/02/2024 at 11:01am V5 (Licensed Practical Nurse/LPN) said, "Yes, I'm familiar with (R3). I (R3) came. I (R3) was first shift. Came at 7am. She (R3) was sleeping in bed. I (V5) started passing meds. Checked on her (R3) one more time and she (R3) was sleeping. I (V5) went to other side to pass meds and V8 (Certified Nursing Assistant/CNA) said R3 had a fall. I (V5) examined her (R3). No bleeding. Alert, vitals were within normal range, called doctor and put ice pack. And called ambulance. Ice on left side of head cause of lump. I (V5) called a regular ambulance not 911. I (V5) called the ambulance right after I (V5) hung up with the doctor, V14 (Medical Administrator). She (R3) had a little lump on left forehead. Per V8 she fell on her head when she (R3) stepped out of room and bent herself and fell. I (V5) did not see her (R3) walking at all. She (R3) was sleeping the whole time. For that reason, we sent her out to see if

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S9999	Continued From page 9	S9999		

she had a head injury. No mental status change. Didn't look like a head injury." When asked about question #5 on R3's post fall, "Fall Risk Assessment," dated 9/23/24, being left blank and not answered V5 replied, "Maybe I (V5) missed it. She (R3) came from another facility, so I (V5) didn't have the fall history. I (V5) didn't fill it out because I didn't have the history. I (V5) meant to contact the POA (power of attorney) and go back to it, but I (V5) forgot."

On 10/2/24 at 1:03pm, V2 stated, "Yes, subdural hematomas are serious injuries but those are diagnosis not made within house." When this surveyor inquired about a change of condition in a resident, V2 replied, "I (V2) expect that the nurses are going to do a full assessment, notify physician, and let them know exactly how they're (resident) doing. Get a full set of recent vitals. Have the injury location and appearance of the injury upon calling physician, then take orders and carry out those orders. Do all the required documentation and notify family. When asked if there was a change in a resident's gait would that be considered a change of condition for the resident and should the physician be notified, V2 replied, "All information on the resident should be reported to the physician if it is a change for their norm (baseline)." When inquired about the interventions and tasks for Care Plans, V2 replied, "All interventions implemented are to be followed. If there is a change or something is not working, we need to be made aware so we can adjust accordingly."

On 10/2/24 at 12:48pm, V1 (Administrator) said, "Initial Fall Assessment to determine what the person can do, and then quarterly, annually, post incident and also significant change. Yes, Fall Assessments should be completely and

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S9999	Continued From page 10	S9999		

accurately done. Change of condition and notify physician of change in condition. Uh, yes, subdural hematoma is a serious injury, we don't diagnose it here. For resident's that have a change of condition, I (V1) expect them to notify the doctor so the doctor can clearly state what to do for the resident. A change in gait?... I (V1) consider that a change in condition and they should notify the doctor of the change in condition and then the doctor can notify them on what to do. Employees should be following interventions in resident's care plans and then notify us on whether it is working and not working so we can make changes and make it person centered."

On 10/3/24 at 2:51pm, V15 (Certified Nursing Assistant/CNA) said, "I (V15) am very familiar with R3. On September 23 when she (R3) got up, she (R3) was moving too fast for me (V15). I (V15) don't like the way she (R3) moving. She (R3) moving too fast. I (V15) sat with her (R3) like 2 times. She (R3) was extra busy. Just moving too fast, just extra. More than normal. I (V15) don't remember how long R3 was moving like that. I (V15) just wanted to slow her (R3) down. She (R3) move a lot. Then nurse (V9, Registered Nurse/RN) took her (R3) to room, and she (R3) fell asleep."

Facility policy titled, "Change of Condition (Resident)," dated 9/2020, documents, in part, "Purpose: To ensure that the resident's physician/physician on call /NP and responsible party is kept informed regarding the resident's change in condition. 1. Attending physicians or physicians on call /NP and responsible party will be notified of all changes in condition ... 5. Place call to responsible party to notify them of the resident's change in condition."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009849	A. BUILDING: _____ B. WING _____	C 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 11 Facility policy titled, ""Comprehensive Care Planning," dated 11/2017, documents, in part, "An individualized, person centered comprehensive care plan, including measurable objectives with timetables to meet Resident's physical, psychosocial and functional needs, is developed and implemented for each Resident ... Interdisciplinary team will develop and implement a person centered, comprehensive plan of care. Care plans are comprised of Focus statements, Goals, and Interventions. The Resident's comprehensive, person-centered care plan will be kept consistent with the Resident's rights to participate in the development and implementation of his or her plan of care, including the right to: ... f. Receive the care and services as outlined in the plan of care; ... The comprehensive person centered care plan will: ... Describe the services that are to be provided to attain or maintain the highest practical physical, mental and psychosocial well-being." Facility policy titled, "Dementia Care," dated 8/2022, documents, in part, "The facility will provide appropriate treatment and services to meet the highest practicable physical, mental, and psychosocial well-being of residents diagnosed with dementia. 5. Facility staff will collaborate with other providers, that may include but not limited to: primary care, psychiatry, specialists, physical/occupational therapy to manage the resident's dementia and co-occurring conditions, as applicable." Facility policy titled, "Incident/Accident Reports," dated 9/2020, documents, in part, "Physical harm would include a broken bone, or blood flow not stopped by a band-aid or hospital or emergency room treatment that involves more than diagnostic evaluation."	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009849	A. BUILDING: _____ B. WING _____	C 10/03/2024

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S9999	Continued From page 12	S9999		

Facility policy titled, "Fall Management Program," dated 8/2020, documents, in part, " ... it is the facility's policy to act in a proactive manner to identify and assess those residents at risk for falls, plan for preventive strategies and facilitate a safe environment."

Facility policy titled, "Management of Falls," dated 8/2020, documents, in part, "7. Monitor for changes in medical condition and notify physician as necessary to manage changes in status of the resident."

Facility policy titled, "Resident Rights," dated 11/17, documents, in part, "The facility will respect and uphold residents' rights."

Facility job description titled, "Administrator," dated, 12/2019, documents, in part, "The Administrator must operate the facility according to all Facility policy and procedures, and State and Federal Regulations. This shall include overall accountability for driving the business to successful outcomes both clinically and fiscally ... B. Assure that all procedures are followed in accordance with established policies."

Facility job description titled, "Director of Nursing," dated 1/2015, documents, in part, "The objective is to ensure the highest degree of quality care is maintained at all times. Assure all Nursing procedures and protocols are followed in accordance with established policies. Make daily rounds to ensure nursing personnel are performing required duties and to ensure that appropriate procedures are being followed. Review nurses' notes/EHR to ensure they are informative and descriptive of the nursing care being provided, and they reflect the customer's

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S9999	Continued From page 13 response to the care. Ensure changes in customer condition are reported to family and attending physicians." Facility job description titled, "Staff Nurse (Registered Nurse/License Practical Nurse)," dated 1/2015, documents, in part, "The objective is to ensure the highest degree of quality care is maintained at all times ... Assume all Nursing procedures and protocols are followed in accordance with established policies ... Chart nurses' notes in an informative and descriptive manner that reflects the care provided to the customer, as well as the customer's response to the care ... Contact the customer's physician for: Nursing assessment of change of condition." Facility job description titled, "Certified Nursing Assistant," dated 3/2023, documents, in part, "Makes rounds to assure customers are safe and comfortable ... S. Observes customer's physical condition, attitude, reactions, appetite, etc., and reports any changes and/or unusual findings to the Nurse/RCC so care plan can be updated." (A)	S9999		