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
	IL6009849	A. BUILDING: ______ B. WING ______	C 03/25/2024

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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S 000	Initial Comments Facility Reported Incident of 3/1/24 IL170823 Facility Reported Incident of 3/10/24 IL170840	S 000		
S9999	Final Observations Statement of Licensure Findings: 1 of 2 300.610a) 300.690b) 300.690c) 300.1210a) 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 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident	S9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/18/24

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that causes physical harm or injury to a resident.

c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the

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resident's guardian or representative, as applicable.

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 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 are not met as evidenced by:

A.Based on observation, interview and record review, the facility failed to ensure (R2's) functional assessment was accurate, failed to timely revise (R3's) care plan (post fall) to prevent an additional fall, failed to ensure that staff are aware of resident fall prevention interventions, failed to implement fall prevention interventions, and failed to provide supervision for three of three residents (R1, R2, R3) reviewed for falls. These

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failures resulted in the following: R3 fell on 3/9/24 and sustained a head laceration requiring staple repair. R3 also fell on 3/10/24 (the following day) and sustained a laceration to bridge of nose, laceration to upper lip, nasal fracture and (left) 3rd-8th rib fractures. R2 fell on 1/15/24 and sustained a head laceration requiring staple repair. R1 fell on 3/4/24 and sustained an eyebrow laceration.

B.Based upon record review and interview the facility failed to notify IDPH (Illinois Department of Public Health) of serious injuries within regulatory requirements for three of three residents (R1, R2, R3) reviewed for falls, failed to ensure that (R2, R3's) reported injuries were accurate, and failed to ensure that (R3's) 3/10/24 initial Incident/Accident Notification report provided to the State Surveyor was congruent with the report submitted to IDPH and unaltered. These failures have the potential to affect 84 residents.

Findings include:

The (3/17/24) facility census includes 84 residents.

R3's diagnoses include dementia, epilepsy, history of falling and traumatic brain injury.

R3's (1/11/24) BIMS (Brief Interview Mental Status) determined a score of 4 (severe impairment).

R3's (1/11/24) functional assessment affirms supervision or touching assistance is required for walking.
The facility fall log affirms R3 fell on 3/9/24 and 3/10/24 however actual injuries were excluded.

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R3's (11/10/22) care plan states resident is at risk for falls related to history of fall, use of psychotropic medications, poor safety awareness, unsteady gait, poor balance, incontinence, and diagnoses of epilepsy and dementia. Interventions: Encourage appropriate use of walker. Monitor for changes in gait or ability to ambulate. Keep bed in lowest position. Keep floor mats while in bed. Use proper fitting, non-skid footwear (initiated 3/9/24). Staff will monitor resident during meals in dining room (initiated 3/10/24). ["supervision or touching assistance" provided while walking is excluded]

On 3/18/24, surveyor requested R3's (March) Facility Reported Incidents from V1 (Administrator) and V2 (Director of Nursing) however the requested documentation was not provided until the following day (3/19/24).

R3's progress notes state (3/9/24) at 4:30pm, I was informed that resident fell. When I arrived to dining room, resident was laying on the floor in supine position with blood coming from her head. Pressure was applied with a towel. Resident was transferred to (hospital). 7:57pm, Report received from (hospital) resident will be returning to facility tonight with laceration to head, closed with staples. (3/10/24) at 10:06am, upon making round, CNA (Certified Nursing Assistant) noticed resident on the floor, on the left side of her body. Noticed resident with active bleeding on left side of face and from her nose and mouth. Called 911, resident transferred to (hospital) for evaluation and treatment. (3/11/24) Received report from Nurse at (hospital) resident was admitted for fall with diagnoses of laceration of upper lip, nose fracture and left 3rd-8th rib fracture. Bruising noted on left upper back, left upper arm and face.

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R3's (3/9/24) hospital history and physical affirms patient brought from nursing home for unwitnessed mechanical fall. Patient fell backward, laceration noted to back of head. Procedures: laceration repair.

On 3/18/24 at 2:15pm, surveyor inquired if IDPH was notified of R3's (3/9/24) fall V2 (Director of Nursing) stated "There was no major injury, so it wasn't reported." [R3 sustained a head laceration which required staple repair therefore "serious" injury].

R3's progress notes include (3/10/24) CNA (Certified Nursing Assistant) noticed resident on the floor. Noticed resident with active bleeding on left side of face and from her nose and mouth. Resident transferred to (hospital) for evaluation and treatment. Per Nurse at (hospital) resident is admitted with diagnosis of fall and fracture of 3rd rib.

R3's (3/10/24) hospital history and physical states patient brought from nursing home for unwitnessed fall. [R3's (3/10/24) fall incident report affirms "No witnesses found"]. Per EMS (Emergency Medical Service) patient was being fed breakfast by nursing assistant, and nursing assistant had stepped away to attend to something else. When he returned after a few minutes, patient was found on the floor. Patient presents with laceration to bridge of nose and upper lip. Patient with similar presentation yesterday, did sustain a laceration to posterior scalp which required a staple.

R3's (3/11/24) after visit summary includes "nasal bone fracture."

R3's Initial Incident/Accident Notification Report

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submitted to IDPH states on 3/10/24, staff heard a thud and when they went to check observed resident (R3) on the floor on the side of her bed. Nurse noted resident with a skin tear on lip and redness/swelling on the face [R3 sustained an upper lip "laceration" per history and physical]. No other abnormalities noted [laceration to R3's bridge of nose is also excluded]. Facility was notified that resident will be admitted for fall and fracture of 3rd rib.

On 3/18/24 at 3:34pm, surveyor inquired about R3's cognitive status V9 (Licensed Practical Nurse) stated "She's (R3) alert and oriented times 1 or 2. She (R3) can respond to their name and sometimes answer questions but sometimes not appropriate." R3 was subsequently observed seated at a table in the dining room, V10 (CNA/Certified Nursing Assistant) was sitting next to R3. Surveyor inquired about R3's fall prevention interventions V10 stated "Um, make sure her (R3) bed is low, make sure someone is always by her so she doesn't fall" however additional interventions were excluded. R3's face was severely bruised from the eyebrows to the chin, scab was noted across the bridge of R3's nose and R3's (left) hand was also severely bruised. Surveyor inquired about R3's bruises V9 responded "She got 2 falls. She (R3) fell on her face on the 10th (3/10/24). She (R3) fell and hit the back of her head March 9th (2024)." Surveyor inquired about R3's fall prevention interventions, V9 replied "She's (R3) supposed to have the bed in low position, the walker and call light within reach, and assisted when taking a shower." [R3 was in the dining room however a walker was not present]. V9 instructed R3 to sit in a wheelchair nearby however she had difficulty standing up and refused to do so at this time. Surveyor inquired if R3's fall care plan was revised on

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3/9/24 (post fall) V9 accessed R3's EMR (Electronic Medical Records) and responded "No." Surveyor inquired what should have been added (3/9/24) to R3's care plan to prevent the (3/10/24) fall and V9 replied "We should go and check the room and make sure the environment is safe if we want to prevent it from happening again. This person (R3) needs assistance with getting around and call light instruction for needing help, move closer to nursing station or put on a 1 to 1 monitor" [none of which are on R3's fall care plan]. Surveyor inquired if R3 is currently on 1 to 1 supervision V9 stated "No she's (R3) not a 1 to 1, I don't think we have a staff for that, but she needs a lot of attention, we need to monitor" [supervision and/or frequent rounds to ensure resident safety are also excluded from R3's fall care plan].

On 3/19/24 at 9:50am, surveyor inquired about the regulatory requirements for serious injuries sustained at the facility V1 (Administrator) stated "If it's a fall with a major injury were required to report it within 24 hours of the injury and then we have 7 days to complete the final report." Surveyor inquired why R3's (3/9/24) laceration was not reported to IDPH V1 responded "I ended up reporting it the next day, I got notified around 4:30pm that there was a potential rib fracture from the other fall" (referring to 3/10/24 incident) however R3's (3/10/24) initial Incident/ Accident Notification report (received by IDPH) excludes any information regarding (3/9/24) fall and/or laceration. V1 presented R3's (3/10/24) initial Incident/Accident Notification report to surveyor at this time however it was incongruent with the information submitted to IDPH [the following statement was added "Resident had a fall with one staple behind head and no acute findings on 3/9/24"].

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S9999	Continued From page 8 On 3/19/24 at 1:19pm, surveyor inquired about R3's (3/10/24) fall/injuries V6 (LPN/Licensed Practical Nurse) stated "The social worker called me to help out with the patient (R3). When I (V6) went there (2nd floor), the CNA told me (V6) this lady (R3) was on the floor, so I rushed into the room and see her (R3) laying on the left side. I (V6) could see her (R3) bleeding, her whole face was full of blood and there was blood on the floor. I (V6) think she (R3) had a small cut on her lip, it's more like laceration so I initiated 911 and informed the NP (Nurse Practitioner). I (V6) did not know she (R3) fell the day before until someone told me later." On 3/20/24 at 9:43am, surveyor inquired who altered R3's (3/10/24) initial Incident/Accident Notification report which was provided to the State Surveyor on 3/19/24 V1 (Administrator) stated "It wasn't altered." Surveyor inquired who has access to the facility Incident/Accident Notification forms V1 responded "I do." Surveyor inquired if anyone else had access to R3's (3/10/24) initial Incident/Accident Notification report V1 replied "No." Surveyor presented R3's (3/10/24) initial Incident/Accident Notification report which was submitted to IDPH electronically and R3's (3/10/24) initial Incident/Accident Notification report provided to State surveyor on 3/19/24, read aloud the inconsistencies between the reports and inquired why they were incongruent V1 replied "I (V1) might have given you (State Surveyor) a different one." On 3/20/24 at 1:21pm, surveyor inquired about R3's (3/9/24) fall, V11 (CNA) stated "I (V11) told (R3) it's time to eat so I ushered her (R3) to the seat, she (R3) was sitting before I left her. I (V11)	S9999		

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was out of the dining area and heard screaming." Surveyor inquired if the dining room was supervised by staff when R3 fell, V11 responded "There were only 2 CNAs and both of us were passing trays" and affirmed there was not. Surveyor inquired about R3's cognitive status. V11 replied "She's (R3) demented and usually walks and cries that's why I (V11) was 1 on 1 with her, that was the first time I left her. I cannot be there and be doing 2 things at the same time, everybody needs to be served." Surveyor inquired about R3's fall prevention interventions. V11 stated "We usually have her on 1 on 1 in the dining room and I always sit beside her. Somebody is there whenever I go and attend to other residents, that's all I know." Surveyor inquired if resident fall prevention interventions are accessible to CNAs, V11 responded "I don't know about that, all I know is I ask the nurse on duty."

On 3/20/24 at 1:46pm, surveyor attempted to interview R3 however she was crying stating "Take me home." Surveyor inquired how R3 fell, R3 responded "Help me." Surveyor inquired again how R3 fell, R3 pointed to herself and replied, "Stupid."

On 3/25/24 at 1:13pm, surveyor inquired about potential harm to a resident that sustains a fall V12 (Medical Director) stated "You are going to have fractures, you are going to have bleeding or something like that."

R2's diagnoses include vascular dementia, hemiplegia and hemiparesis affecting right dominant side.

R2's (2/28/24) BIMS determined a score of 9 (moderate impairment).

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R2's (1/15/24) fall risk assessment determined a score of 5 (at risk).

R2's care plan includes (10/6/23) high risk for falls due to use of psychotropic medication, impulsivity, impaired cognition, incontinence, and diagnosis of dementia. Interventions: Promote placement of call light within reach. Ensure that the bed is in the appropriate lowest position. (12/6/23) Resident requires assistance with ambulation. Encourage resident to ambulate with staff assist as needed.

R2's (2/28/24) functional assessment states resident can walk "independent" however R2's diagnoses include hemiplegia/ hemiparesis and R2's care plan affirms assistance is required - therefore inaccurate.

The facility fall log affirms R2 fell on 1/15/24 and 1/18/24.

R2's (1/15/24) final Incident/Accident Notification report states resident was noted by staff on the floor. Resident was noted with a skin tear to her head [resident sustained a laceration - per progress note]. Nurse Practitioner gave orders to send her to ER (Emergency Room) for evaluation. Resident returned to facility with a laceration on posterior head measuring 2cm and containing 4 staples. IDPH was notified on 1/24/24 (9 days after the incident occurred).

On 3/18/24 at 3:05pm, R2 was lying in bed in high position without a call light in reach [R2's call light was behind the curtain and on the floor]. Surveyor inquired if R2 recently fell at the facility, R2 stated "I fell and they took me to the hospital after that I don't know nothing, every little bit I remember

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something. They tell me I fell here in the hall. I lost many blood." A large scar and lump were noted on the back of R2's head at this time.

On 3/18/24 at 3:23pm, surveyor inquired about R2's cognitive and functional status V9 (LPN) stated "(R2) is oriented times 2 to 3 with periods of confusion and delusions. She's ambulatory, she uses a walker, and she's a fall risk." Surveyor inquired about R2's fall prevention interventions V9 responded "She has a walker, and her bed is usually in the low position and the call light within reach" [staff assistance with ambulation was excluded]. Surveyor inquired about the location of R2's call light, V9 searched behind the curtain and replied, "It's here, I found it hanging on the side behind the curtain" and affirmed it was on the floor. V9 subsequently handed the call light to R2. R2 stated "It's the first time I saw this in 2 days." Surveyor inquired about the height of R2's bed, V9 responded "Her bed right now is not in the low position, its thigh level." V9 attempted to lower R2's bed with a handheld device however the bed did not move. V9 stated "It's not even working." R2 responded "No work, it broken. No working, never work."

On 3/18/24 at 3:48pm, surveyor observed R2 walking near the Nurse's station, V9 was present however provided no assistance or redirection at this time.

On 3/20/24 at approximately 11:40am, surveyor inquired if R2's (1/15/24) final Incident/ Accident Notification report was submitted to IDPH on time if it was received 9 days after the incident occurred, V1 affirmed it was not.

On 3/18/24 at 2:38pm, R1 was observed in his room with family members present. V7 (Family)

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(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
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stated (R1) recently sustained a head injury (of unknown origin) while residing in the facility and presented a (cell phone) picture of R1 with forehead bruising/edema. R1 was non-verbal at this time.

R1s diagnoses include dementia with severe behavioral disturbance.

R1's (3/11/24) BIMS states resident is rarely/never understood. Cognitive skills for daily decision making moderately impaired.

R1's (3/11/24) functional assessment affirms "toilet transfer, sit to stand, walk" were not attempted due to medical condition or safety concerns. Resident uses a wheelchair.

R1's (11/28/20) care plan states resident is at high risk for falls related to history of falling, dementia, vision impairment, weakness, poor judgment, impulsivity, and lack of coordination. Intervention: (2/15/24) Place resident near nurses' station to always be within sight of staff.

The facility fall log affirms that R1 fell on 2/15/24 and 3/4/24.

R1's (3/4/24) incident report states upon round making, resident is noticed in prone position on his right side, next to his bed [therefore not "near the nurse's station" and/or "within sight of staff"]. Noticed a small cut at area above his right eyebrow. Resident unable to give description. Injury type: laceration. No witnesses found. Informed Nurse Practitioner received order to send resident to (hospital) for CT (Computed Tomography) and evaluation.

R1's (3/4/24) post occurrence documentation

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	IL6009849	A. BUILDING: ______ B. WING ______	C 03/25/2024

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affirms "Laceration is noted above right eyebrow."

On 3/21/24 at 1:54pm, surveyor inquired if R1's (3/4/24) fall/laceration was reported V1 stated "That was not reported to IDPH because there was no acute findings [R1 sustained a laceration] nor did the resident require sutures or stitches. He (R1) didn't require anything more than first aid." [Repair of R1's injury was not documented by facility staff however the laceration is a "serious injury" therefore reportable. R1 also required hospital evaluation and a head CT therefore more than first aid].

The (08/2020) management of falls policy states the facility will assess hazards and risks, develop a plan of care to address hazards and risks, implement appropriate resident interventions, and revise the residents plan of care in order to minimize the risks for fall incidents and/or injuries to the resident. Develop a plan of care to include goals and interventions which address resident's risk factors. Assess and monitor resident's immediate environment to ensure appropriate management of potential hazards. Review and /or modify the residents plan of care at least quarterly and as needed in order to minimize risk for fall incidents.

The (09/2020) incident/accident reports policy states 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. An incident/accident report is to be completed and shall include physical assessment; injuries noted. The Director of Nursing, Assistant Director of Nursing or Nursing Supervisor must notify: IDPH of any serious incident or accident. The facility shall, notify the Regional Office within 24 hours after

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each reportable incident or accident. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven (7) days after the occurrence.

(A)
2 of 2

300.3240a)
300.3240b)

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee, or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act)

These requirements were not met as evidenced by:

Based upon record review and interview the facility failed to provide a descriptive summary of abuse allegation to IDPH (Illinois Department of Public Health) including names/titles of staff, substantiated/unsubstantiated outcome of investigation, termination or return of accused staff, and failed to ensure that staff report abuse allegations immediately to the abuse coordinator and/or designee for one of three residents (R3) reviewed for abuse, this failure has the potential to affect 84 residents.

Findings Include:

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The (3/17/24) facility census includes 84 residents.

On 3/7/24 at 3:12pm, IDPH received the Initial Incident/Accident Notification Report which states Date of Occurrence: 3/1/24. On 3/7/24, facility was informed by a former employee that (R2) informed her that a male staff member hit (R3) last Friday (6 days prior). [Names and/or titles of staff were excluded].

On 3/12/24 at 5:04pm, IDPH received the (3/1/24) Final Incident/Accident Notification Report which excludes outcome of the investigation (substantiated/unsubstantiated) and whether the accused staff member was terminated or returned to work. The Final Incident/Accident Notification also states, "Staff were re-in serviced on abuse policy."

On 3/18/24 at 1:30pm, surveyor inquired about the regulatory requirement for abuse V1 (Administrator) stated "Whenever I'm notified of abuse, I (V1) have to respond within 2 hours and report to IDPH then I have 5 days to submit the investigation on the final report." Surveyor inquired if the aforementioned abuse allegation occurred on 3/7/24 or prior to that date V1 responded "It occurred prior to that date, she V3 (Activity Aide) was stating it occurred the prior Friday I believe it was March 1st. I was notified March 7th by (V3). She (V3) said that resident (R2) said she seen a male CNA that was Hispanic or Filipino hit resident (R3). We (Facility) determined that she (R2) was referring to (V4/Certified Nursing Assistant) because he (V4) was working that particular floor that day, she (V3) said it happened on Friday (3/1/24). I asked if she (V3) had told anybody she said no."

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Surveyor inquired if the (3/1/24) abuse allegation was substantiated V1 replied "No, it was not substantiated." Surveyor inquired if (V4) was terminated or returned to work V1 stated "He returned to work I believe it was 3/13/24." Surveyor inquired why V3 was terminated, V1 responded " She (V3) was termed for her performance and was under the 60-day probationary period. She (V3) wasn't following her duties as scheduled, wasn't following instructions by her supervisor and called the supervisor incompetent. She (V3) worked that Friday (3/1/24) and didn't tell anyone about the incident, that's why we re-in serviced the staff on the abuse policy to avoid stuff like this from happening again."

The (09/20) abuse policy states employees are required to immediately report any occurrences of potential mistreatment they observe, hear about, or suspect to a supervisor or the administrator. Within 5 working days after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation will be sent to the Illinois Department of Public Health.

(C)