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S9999	Final Observations	S9999		

Statement of Licensure Violation:

300.610a)
300.1210b)5)
300.1210d)6)
300.3240a)

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 care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

5) All nursing personnel shall assist and

Attachment A
Statement of Licensure Violations

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encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Requirements are not met as evidenced by:

Based on observation, interview and record review, the facility failed to follow their fall care plan interventions of bed in low position, floor mats and adequate supervision to avoid falls; failed to address root cause of injury to prevent further falls; and failed to follow facility policy and procedures to manage high risk frequent fallers. These failures affected 2 of 3 residents (R1, R2) reviewed for falls. These failures resulted in R1 sustaining a subdural hematoma, brain hemorrhage, and left wrist fracture and subsequently sustained a right hip fracture requiring surgical intervention. R2 sustained a right hip fracture requiring surgical intervention.

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Findings include:

1. R1 is an 86-year-old with diagnoses of chronic obstructive pulmonary disease, hypertension, Alzheimer's disease, hypothyroidism, and macular degeneration.

On 1/27/2020 at 11:03 AM R1 was observed sitting in her wheelchair in the hallway in front of two elevator doors. 3 other residents where congregated along with R1 with no staff present. Surveyor walked down a hall and went to the nursing office where V13 (RN) and V14 (LPN) were both sitting. Surveyor asked V13 if anyone was in the hallway supervising the 4 residents sitting in front of the elevators, V13 stated, "I don't know, I'm only registry here." Asked who was in charge, V13 pointed to V14 who stated, "I am the regular nurse here. We have 4 CNA's (certified nurse's aides) but one called in sick, so we have only 3 so they are splitting the floors." Asked which CNA's were splitting the floors, V14 stated, "I don't know." Asked who creates the CNA's schedules, V14 stated," they have their own assignments made."

On 1/27/2020 at 1:20 PM R1 was observed lying in her bed with her bed raised up to waist level. A blue-colored vinyl cushion was folded up and standing in the corner against the window. Surveyor asked V4 (sitter) how R1 was doing, V4 stated, "She's resting and had her lunch, but she likes to stay in bed because she fell several weeks ago and likes to stay in bed now." Surveyor asked about the blue vinyl cushions that were folded up against the window, V4 stated, " the CNA's are supposed to put that down on the floor when they put her back to bed so she don't

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fall. I cannot do anything for her because I'm not supposed to touch her or anything but I'm here, so I guess it's fine". Surveyor asked how often the staff was supposed to check on R1, V4 stated, "I don't know. When I'm here they don't come in at all because I guess they depend on me to watch her."

Facility fall risk assessments dated 11/9/2019, R1 scored a 13 meaning a moderate risk for falls (score of 16 and above is considered high risk for falls).

R1's Care plans dated 11/9/2019 states in part but not limited to, R1 is at risk for falls related to impaired balance, impaired judgement, behavior of swinging legs over her bed, attempt to transfer/mobilize without staff assistance. Interventions: re-educate resident on calling for assistance, keep bed at lowest position with wheels locked, floor mattress, keep personal items within reach, keep nurse call light within easy reach and instruct R1 to use call bell or call out for assistance.

R1's MDS (Minimum Data Set) dated 11/9/2019 however shows R1 with no behavioral problems that impacted her care; R1 requires extensive assistance from staff for bed mobility and locomotion and is totally dependent on staff to transfer from bed to chair.

On 11/9/2019 at 4:25 AM, R1 was found flat on her back on the floor at the foot of her bed with her feet extended towards the door. R1 was sent via 911 ambulance to the hospital emergency room, diagnosed and treated for a right brain hemorrhage and left-hand wrist fracture requiring immobilization and casting and spent four days in the hospital until being discharged back to the

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nursing facility.

A consecutive facility falls risk assessment dated 12/19/2019 score R1 as a 22 for very high risk for falls with a score of 16 and above considered high risk for falls.

On 1/7/2020 at 10:00 PM R1 was sent out 911 to the hospital emergency room as she was complaining of right hip pain earlier in the day during lunchtime. Hospital records dated 1/7/2020 show there is a comminuted (broken into pieces) intertrochanteric right hip fracture with fragmentation of the lesser trochanter. Hospital physician on 1/12/2020 wrote, R1 is an 86-year-old female with primary medical history of iron deficiency anemia, asthma, depression, hypertension, who presented to hospital emergency department after an unwitnessed fall at nursing home. On presentation to the emergency department, patient was found to have comminuted intertrochanteric right hip fracture. Of note patient was recently hospitalized after a fall sustaining a left wrist fracture which was managed non operatively. That hospital course was complicated by intracranial hemorrhage (brain bleed), after which time her Eliquis (blood thinner) was stopped. Status post right hip ORIF (Open Reduction Internal Fixation surgery) for Intertrochanteric right hip fracture after an unwitnessed fall. Post-operative course complicated by hypoxemia and atrial fibrillation requiring ICU (Intensive Care Unit) admission.

Interviews with V2 (Director of nursing) and V3 (Assistant Director of Nursing) on 1/27/2020 at 1:00 PM V2 stated, "We did a root cause investigation and determined (R1) had injury of unknown origin but didn't fall and that she could have bumped her hip based from our interview

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with her." Surveyor asked V2 if R1 was interviewable, V2 stated, "She speaks only Russian but we had an interpreter ask her what happened but she could not tell us whether she fell or not, but she mentioned that she may have bumped her leg and she also has behavior of dangling her legs." Surveyor asked whether it was a possibility R1 fell again, V2 stated, "Well, yes it's possible but she can't get up by herself. V2 and V3 both stated, R1 has osteoporosis she is prone to fractures. Surveyor asked what would determine osteoporosis in residents, V2 stated, "Bone density scans would determine this."

Bone density results obtained from R1's radiological report dated 1/7/2020 states: Normal bone mineral density for the patient's age. A second radiological report dated 1/7/2020 states, Normal bone density seen.

On 1/27/2020 at 2:00 PM interview with V10 (Certified Nurses Aide) stated," I generally work with (R1) and I went in 8:30 AM Tuesday (1/7/2020) to get her ready while in bed because she has a broken arm and placed her in the wheelchair and pushed her into the dining room for breakfast. After breakfast, I pushed her to common area, but she didn't want to stay there so I put her back to bed. She doesn't like to stay in the common area, so we always put her back in bed. When I went for lunchtime to get her up, she didn't want to get up and so I let the nurse know she didn't want to get up. The nurse came in and talked to her. I found out later she must have fallen so they sent her out and I found out she had a fracture." Surveyor asked V10 what care plan interventions there were to prevent R1 from falling a third time, V10 stated, "We just check on her a lot I don't know about care plans I don't do those." Asked if she has access to R1's

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care plans, V10 stated, "No, they don't show that to the CNA's (certified nurses aides)."

On 1/27/2020 at 2:30 PM interview with V4 (Sitter) stated, "I'm here six days week, every day except Tuesday. She (R1) was not complaining of pain on the day I was taking care of her. Her daughter called me on Wednesday that she was in the hospital. R1 likes to stay in bed but before she fell the first time, if she wants to she will just get up and go. She used to be independent. They hired me to watch her. I will call somebody and two people come (CNA's) and change her. She needs two people to transfer her and the facility told me they cannot allow me to transfer her so maybe she fell when that happened when I was off. I am here except Tuesdays and that's when she was sent to hospital. Most of the time when I'm here I just sit with her when she's in bed." Surveyor asked V4 how often staff come in to check on R1, V4 stated, "I don't see them come in when I am here, they just come when she gets up for lunch and they put her back to bed. They expect me to watch her all the time, so I guess when they see me, they don't think they have to watch her anymore. Maybe that's why on the day I'm not here she goes to hospital. They are supposed to watch her too."

On 1/27/2020 at 2:45 PM interview with V5 (Nurse Manager) states," (R1) was complaining of pain after lunchtime and I found out she had a fracture. I'm the manager for the 6th floor and I educate the staff to check (R1) frequently for fall monitoring and for fall prevention." Surveyor asked V5 to clarify what she meant by fall monitoring and fall prevention, V5 stated, "Staff should frequently check on R1. Frequent meaning every hour check on her (R1). We also have her on a bowel and bladder program. I

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usually call the nurses and check, but I do not see this for myself. R1 is in the falling leaf program, in the room there is a sign like falling leaf to show staff she is on the program." Surveyor's observations of R1's room conducted on two consecutive days show no signs of a falling leaf anywhere in the room or outside the room designating the fall program.

At 1/28/2020 at 12:16 PM interview with V9 (translator and activity coordinator) stated, "I manage the 6th floor activities and I provide activities on that floor and translate for our Russian residents. I provided translation to the nurse (V6) on Tuesday (1/7/2020) around lunch time. V6 needed to find out what was wrong with her leg. He asked me for help to translate. I went with the nurse to the resident's room. R1 was in her bed and she was complaining of pain, She was gesturing towards the left leg she has pain that's hurting. Her cognition is confused, and we'd ask her several times and she wouldn't be able to tell me what was going on and we couldn't get much information." Surveyor asked V9 if R1 verbalized anything about bumping her leg, V9 stated, "No she's confused, she was just pointing to her leg." Asked if R1 was one of the residents that attended activities on the floor, V9 stated," (R1) doesn't attend activities much. Very few times she's come. She likes music but mostly she's in her room."

On 1/28/2020 at 1:00 PM interview with V6 (Registered Nurse) stated, "On Monday (1/6/2020) I remember getting (R1) up around 7:30 for breakfast. She was in the wheelchair and she was trying to stand from the wheelchair, and she's been doing that for a couple of weeks when she came back from the hospital 2 months ago when she fell and had a left wrist fracture, was

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casted for it, but I don't know if (R1) had surgery. After she eats lunch, the caregiver comes around 11-11:30a.m. and usually she will go to her room after lunch. Around 12:30-1:00 (R1) is placed in bed until around 4:30 for dinner." Surveyor asked V6 what they do to prevent R1 standing from her wheelchair, V6 stated, "We supervise her more closely and put (R1) right outside the nursing office."

Surveyor asked V6 what happened the day R1 was sent to the emergency room, V6 stated, "On Tuesday (1/7/2020), I saw her in the wheelchair in the dining room. She ate her breakfast and I gave her morning medications. Around 9:30-9:45 the CNA (V10) said R1 wanted to go to bed so I said sure lets put her back. I asked her about pain, and she said no but I noted she wasn't her regular self, so we put her to bed. Around lunch time R1 was positioned on the bed and V10 called me and said R1didn't want to get up. She was sitting on edge of the bed and refusing to get up and she was holding her right upper thigh and rubbing it. I was asking if she was in pain and got the Russian translator (V9). According to V9, R1 kept pointing to the right thigh. We laid her back down and the translator tried to pinpoint where the pain was on her right leg. anything, but she didn't. I then called the NP (V7) and she ordered X-rays for entire leg and hip." Surveyor asked V6 how the facility planned to keep R1 from falling a third time, V6 stated, "we usually put her with CNA's to watch her. She's usually in activities all the time when caregiver is not here. She cannot be unsupervised, so I keep her in my supervision. The nursing office is in the D-wing. R1's room is in the A-wing so usually from 9:30-10:30 I place her right outside of nursing office." Surveyor asked V6 whether the nursing office was in a central location, V6 stated, "No, it's in an office located on the opposite side of the building but

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there's constant supervision and she has medication to calm her down given at 8:30-9 am." Surveyor asked V6 if putting her to sleep to calm her down was part of her plan of care, V6 stated," I don't know but it calms her down and she sleeps. When she's in bed we make sure bed is in lowest position, there's a fall mattress and her head of bed is up a little. She doesn't like to get up, but she likes to dangle her feet to face the window." Asked how she can dangle her feet if her bed is in the lowest position and there's a fall mat on the floor, V6 stated, "No I misspoke, her feet will actually touch the floor then." Asked if there's a possibility she may have fallen, V6 stated, "Yes she must have fallen because bumping her leg wouldn't do that."

1/28/2020 interview at 1:47 PM with V7 (Nurse Practitioner), states," The first incident I am aware of for (R1) happened over the weekend and I was notified she was sent to the hospital with a subdural hematoma and fracture. According to the hospital reports she hit her head and had a hematoma and wrist fracture. She was casted for her wrist but no surgery. She has progressive dementia and its worsening, and she doesn't call for help. Her balance isn't good either. She has chronic COPD (chronic obstructive pulmonary disease) and it is hard to manage her condition. Combination of everything she is 02 (oxygen) dependent and doing treatment management. The most recent event in the afternoon, the nurse called me V6 (RN) and said the patient is having pain and told me she was okay in the morning but in the afternoon, she was having pain while they were transferring her. I never expected a hip fracture because I was never notified of a fall. I don't know whether she fell or not. Since it was unwitnessed there is certainly a possibility that it occurred due to a fall.

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According to the hospital, they said it was an unwitnessed fall." Surveyor asked if R1 used to walk, V7 stated," (R1) used to walk independently with a walker but lately she doesn't walk much, and I see her in bed a lot."
Asked about fall prevention measures for R1, V7 stated, "She has behavioral management. Staff should be monitoring her more frequently. I don't really know the facility protocol, but someone can offer the family an overnight care giver. She's in a single room far away from nursing station. She should be in activities." Asked if a dangling feet or bump to her leg could cause this fracture, V7 stated, "If the patient has metastatic cancer perhaps but certainly not due to dangling of legs or a mere bump. If that is what they (the facility) are saying, I don't believe so. (R1)'s not reliable and confused so I don't know how they can even interview her because she's not reliable and can't tell you whether she fell or not."

1/28/2020 at 3:19 PM with V8 (Physician) states," I was informed about both falls and the latest by my partner (Doctor). I know (R1) had a fall twice and it was unwitnessed. (R1) has some dementia but she doesn't have any behavioral problem and is a very cooperative person. If she fell, she might not even tell anybody not even tell the nurse. She's definitely high risk for falls. She needs to be observed more after her recent falls and needs to be by the nursing station. At night she's more difficult because she should be checked more often. She should have a bed alarm. If you know the floors there, it is 4 wings, it's impossible to be stationed in a wing and monitor the patients so they know somebody is moving, that is why they need bed alarms, so they know when she moves from her bed. Sometimes they have floor mats but if she moves around in the room she can fall still so I don't know how helpful that is after all she

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was found beside her bed last time and I don't think there was a fall mat because she still got a fracture."
Asked about dangling feet behavior or whether a bump could cause this fracture, V8 stated," I do not think that can cause fracture not unless she was hanging from the bed from her leg. It should be a forceful movement to cause trauma and fracture, that I can understand but not just because it was dangling or a mere bump. Is that what they (facility) is saying because that is very unlikely. Someone did not watch her and I'm certain she fell. This is not good."

On 1/28/2020 at 4:08 PM interview with V11 (Certified Nurses aide) stated, "The 6th floor is my regular floor most of the time. I know (R1), she used to walk but she doesn't walk anymore after she fell. Since I started, I must check on her every two hours." Surveyor asked V11 about the plan of care for R1, V11 stated, "The nurse doesn't show me care plans, but I know how to care for her. I know, we check on her a lot. I don't see any care plan." Asked about the falling leaf program, V11 stated," I don't know about any leaf program nobody told me about that. Nobody told me she fell twice, just this last time."

2. R2 is an 84-year-old resident with diagnoses of congestive heart failure, hypertension, chronic kidney disease, and repeated falls.

R2's Risk assessment dated 12/23/2019 scored a 12 for moderate risk for falls with 16 and above considered high risk. R2 has a history of 6 falls from 3/17/2019 to 1/12/2020. On 3/17/19 R2 was found on the floor due to a wet floor; on 10/15/19 R2 was found sitting on the floor; on 10/20/19 R2 was found on bathroom floor; on 12/5/19 R2 was found lying flat on the floor and sent to the

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIEBERMAN CENTER FOR HEALTH & REHAB	9700 GROSS POINT ROAD SKOKIE, IL 60076

(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
S9999	Continued From page 12	S9999		

emergency room; on 12/22/19 R2 was found on the floor and sent out again to the emergency room; on 1/12/2020 R2 was found sitting on her floor mat in her room.

R2's care plan dated 3/7/19 to 1/12/20 states in part but not limited to, R2 is at risk for falls related to poor safety awareness, poor balance/decreased muscle strength. Resident also receiving anti-depressants and antipsychotic medication which can affect gait and motor function. Interventions: Resident was educated to ask for assistance by using the call light; offered to use a bed side commode; evaluate for proper attention to safety; implement safety measures, bathroom clear and well lit, select clothing that is easily removed for toileting, answer call bell quickly; instruct on safety measures to reduce the risk of falls (posture, changing positions, use of handrails); keep areas free of obstructions to reduce the risk of falls or injury.

On 12/4/2019 at 7:00 AM, R2 was found on the floor lying on her left side by her dresser. R2 was sent 911 to the hospital emergency room and admitted for fluid overload, congestive heart failure exacerbation, and closed fracture of the right hip. R2 required ORIF (Open Reduction Internal Fixation) Surgery and after a 9-day hospitalization returned to the nursing facility.

Facility policy dated 2015 titled "Fall Management" states in part but not limited to, A fall is defined as a sudden, unexpected descent form a standing, sitting, or horizontal position. Evidence of a fall is based on the recollection of the patient and/or a description of the fall from a witness. This definition includes patients slipping from a chair to the floor, patients found lying on the floor, and assisted falls. a. An episode where

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a resident lost his/her balance and would have fallen were it not for staff intervention is a fall. In other words, an intercepted fall is still a fall. b. A fall without injury is still a fall. c. When a resident is found on the floor, the facility is obligated to investigate and try to determine how he/she got there, and to put into place an intervention to prevent this from happening again. Unless there is evidence suggesting otherwise, the most logical conclusion is that a fall has occurred. d. If a resident rolled off a bed or mattress that was close to the floor, this is a fall. Policy and Purpose: This facility has a fall management policy designed to minimize the risk of falling and to minimize the ill effects of the fall that occurs. All residents will be screened for risk of falls at admission and at least quarterly. All disciplines participate in the identification of such residents, evaluation of causative factors, implementation strategies, and evaluation of efficacy of these strategies and their implementation. Residents who fall are assessed and have interventions implemented.

(A)