STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014922	A. BUILDING: _____ B. WING _____	C 12/18/2014

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ALDEN ORLAND PARK REHAB & HCC	16450 SOUTH 97TH AVENUE ORLAND PARK, IL 60462

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S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS 300.610a) 300.1210a) 300.1210b) 300.1210c) 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 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	S9999		

Attachment A "Statement of Licensure Violations"

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S9999	Continued From page 1	S9999		

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 resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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 REGULATIONS WERE NOT MET AS EVIDENCED BY:

Based on observation, interview, and record

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S9999	Continued From page 2	S9999		

review, the facility failed to follow their fall prevention policy and implement fall prevention interventions for 4 of 6 residents (R1,R3,R11,R12) reviewed for falls. This failure resulted in R1 falling, sustaining a fractured left hip, and requiring surgery to fix the fracture.

Findings include:

Closed record documents R1 was admitted to the facility on 5/30/14 with diagnoses of difficulty walking, muscle weakness, history of falls, and stroke. Fall Risk Assessment 5/30/14 and 5/31/14 score R1 as a high risk for falls. Fall Care Plan initiated on 5/30/14 has the intervention of personal or pressure sensitive alarms when resident is in chair or bed, ensure no-slip socks are used, and provide proper, well maintained footwear. Occurrence Report 5/31/14 12:50am, R1 was visually observed sitting on the floor by the bedside. R1 stated he was trying to get back in bed after going to the bathroom when he slid to the floor. Preventive Measures at the Time of Fall document "alarm - none". Follow Up documents R1 had 3 falls in the 3 days prior to admission to the facility on 5/30/14. Recommendations added after the fall are re-orient resident to surroundings "frequently" and perform "frequent" rounding on resident while in the room. Occurrence Report 6/1/14 12:00am documents a bed alarm was sounding. Z6(Nurse) ran down the hallway and saw R1 standing by the doorway, then turned. When Z6 arrived at the room, R1 was sitting on the floor with his back to the door and legs extended. R1 stated to Z6 that he got up to use the bathroom. General Follow Up documents upon investigation, R1 stated he wanted to use the bathroom; R1 has a history of being impulsive and "requires constant redirection" due to poor safety awareness; R1's

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S9999	Continued From page 3	S9999		

left leg is noted to be laterally rotated and painful. Hospital records document R1 has diagnoses from 5/27/14 of shuffling gait and falls. Consent to Operation 6/2/14 documents "pinning of left hip femoral neck fracture". Emergency Room Note 6/1/14 document R1 fell at the facility while walking to the bathroom, family is at the bedside. Physician History and Physical 6/1/14 R1 stated R1 got up from bed and while walking, made a sudden turn, slipped, and fell down. X-ray is positive for a femur neck fracture.

On 11/25/14 at 6pm, by phone, Z12(Family) stated R1 wore his own white athletic socks at the facility, they did not give him the socks with anti-skid strips on the bottom.
On 12/4/14 at 2:30pm, by phone, Z7(Family) stated R1 had an alarm clipped to him after the fall on 5/31/14, not before. R1 wore his own white athletic socks the entire time he was at the facility. R1 was not provided with anti-slip socks. R1 had his own socks on at 9pm 5/31/14, and still had them on in the emergency room on 6/1/14 after the second fall. R1 told Z7 that he slipped and fell because he was wearing regular white socks and the floor was slippery.
On 12/4/14 at 2:40pm, by phone, R1 stated during the night of both falls (5/31/14 and 6/1/14) he turned on the call light because he had to go to the bathroom but no one came. The second night when no one answered the call light, R1 got up by himself, walked to the door, looked down the hallway, and called to the nurse. "It was kind of a slippery floor and I didn't have those silicone socks on. I turned and fell on my hip." R1 clarified that "silicone socks" were the colored socks with sticky strips on the bottom that prevent slipping, and that he wore his own white socks the entire time at the facility.
On 12/15/14 at 9:20am, by phone, E4(Nurse

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S9999	Continued From page 4	S9999		

Aide) stated she was assigned to R1 but was late for the night shift on 6/1/14 and was not there when R1 fell.
On 12/15/14 at 10:05am, by phone, Z3(Nurse) stated she does not remember R1 or the falls on 5/31/14 and 6/1/14.
On 12/15/14 at 11:15am, by phone, Z5(Physician) stated R1 had multiple falls at home before admission to the facility. Z5 stated that when R1's alarm is activated, they need to get to him fast. Additional interventions for R1 would be to keep him at the nurse's station, move to a room closer to the station, anti-skid socks, personal alarms, reminders not to get out of bed, and check on him more frequently. Z5 does not remember if R1 wore socks.
On 12/15/14 at 12:10pm, E2(Director of Nursing) stated fall care plans are specific to the resident's needs. A resident assessed as high risk for falls will have interventions such as falling star program to alert staff that the resident is a risk for falls, low bed, call light, floor matts, therapy evaluation, alarms, proper footwear, and "frequent monitoring" more than the standard every 2 hours. All interventions should be in place to attempt to prevent falls. E2 could not specify or clarify how "frequent" R1 needed to be monitored. E2 could not provide any documentation on how frequently R1 was being monitored. E2 stated fall interventions for residents are to be put into place as documented on the care plans.
Eight attempts (12/15/14-10am, 11:30am, 4:15pm, 6:50pm; 12/16/14 - 8am, 1:20pm; 12/17/14 - 9:14am, 12pm) were made to reach Z6(Nurse) by phone regarding R1's fall on 6/1/14 which resulted in a fractured femur. The number provided for Z6 would not accept any messages. Unable to reach Z6 for an interview.

On 11/28/14 at 2:20pm, R3 sat in a recliner. A

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S9999	Continued From page 5	S9999		

chair alarm was on the chair, but was turned off and was not attached to R3. R3 was moving around and leaning forward in the chair. Each time R3 leaned forward, his momentum would move the chair forward. At 2:35pm, R3 leaned forward to reach for the counter at the nurse's station, attempting to stand up. E15(Nurse) asked E16(Nurse Aide) to move R3 closer to where staff was sitting. Both E15 and E16 did not notice that the chair alarm was not on or attached to R3. At 2:40pm, E2(Director of Nursing) approached E15 and discovered that the alarm was not on or attached to R3. Occurrence Reports 11/9/14 and 11/21/14 document R3 had falls. Fall Care Plan 11/21/14 documents the use of alarms when R3 is in the chair or bed and 11/8/14 use proper maintained footwear. Occurrence Report 11/21/14 R2 was found on the floor by the bed, footwear is documented as socks only, slipper socks or shoes were not in use. Fall Risk Assessment 11/9/14 and 11/21/14 document R3 as a high risk for falls.

On 11/28/14 at 11:45pm, R12 was sitting in a reclining chair at the nurse's station. R12 did not have any socks or shoes on his feet. Occurrence Reports 10/25/14 and 11/6/14 document R12 got out of bed and fell. Footwear is documented as socks only, not slipper socks. Fall Care Plan 8/1/14 documents the use of proper footwear as a fall prevention intervention for R12. Fall Risk Assessments 10/25/14 and 11/6/14 document R12 is a high risk for falls.

On 11/30/14 at 12:10am, R11 was in bed, restless and moving around. R11 had white athletic socks on, without anti-skid bottoms. Occurrence Report 10/27/14 documents R11 had a fall. Fall Care Plan 7/22/14 documents the use of non-skid footwear as a fall prevention

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S9999	Continued From page 6 intervention. Fall risk assessment 10/27/14 scores R11 a high risk for falls. Prevention of Falls 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's 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. Fall Risk Assessment policy - The resident who scores 12 or greater will have individualized High Risk interventions implemented. Falling Star Program - Educate the resident and/or family on the Falling Star Program and the resident's individualized high risk interventions. (B)	S9999		