STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005177	A. BUILDING: _____ B. WING _____	C 03/01/2016

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LAKE SHORE HLTHCARE &REHAB CTR	7200 NORTH SHERIDAN ROAD CHICAGO, IL 60626

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S 000	Initial Comments Complaint Investigation 1680673/IL83213 - F278, F280, F323 1680701/IL83246 - F164	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 300.1220)b)3) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or	S9999		

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S9999	Continued From page 2 agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on interview and record review the facility failed to implement an intervention for fall prevention as care planned for a resident, monitor and supervise a resident left alone in a room with a behavior of standing without assistance and have an element in place to reduce injury from an impact of a fall while a resident is sitting in a chair. This failure applies to 1 of 3 residents (R9) reviewed for falls, in a sample of 10. As a result, R9 fell from a chair while in a room unsupervised by a staff member. R9 sustained a laceration requiring sutures and an acute subdural hemorrhage. Findings include: An incident report entitled "State Report" dated 2/3/16 at 1:15pm stated, At around 1:15 pm, resident (R9) had a fall incident. According to initial reports resident has been requesting to be placed in chair instead of being in bed, and a few minutes while sitting, attempted to stand and fell, NOD (nurse on duty) noted a change in condition and mentation. Immediate action taken included sending R9 to a local hospital. The emergency department nursing assessment dated 2/03/2016 documented for clinician history of present illness: Laceration is the result of impact from direct trauma. Laceration caused by fall 2/03/2016.	S9999		

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S9999	Continued From page 3 Computerized tomography (CT) of brain at receiving hospital done on 2/03/2016 at 7:48 pm notes, "Comparison: CT brain performed at an outside institution 2/3/16 4:54 pm. Findings: Relatively stable large, high density extra-axial collection consistent with acute subdural hemorrhage (new brain bleed)." According to R9's hospital emergency department nursing transfer form entitled "Patient Discharge Transition Record dated 2/03/2016," R9 had a primary diagnosis of Subdural hematoma and Subarachnoid hemorrhage." This document also documented R9 had a laceration. The laceration was described as "an uncomplicated horizontal laceration located over the right side of forehead which is 1cm (centimeter) in length," and the skin closed with 3 sutures. According to the hospital's transfer consent form R9 was transferred to another hospital critical care unit (CCU) on 2/03/16 at 18:30 (6:30pm). R9's face sheet on admission to the facility lists the following diagnoses not limited to: Schizophrenia, Dilated cardiomyopathy, encephalapathy, Heart failure, Alchohol dependence, Left Ventricular Assist Device 2012, Diabetes, Anemia, Epilepsy, Dysphagia, Hypothyroidism, general anxiety disorder, Major Depression. Nursing note on admission to facility dated 12/12/15 at 12:36 am includes additional diagnoses of "cardiomyopathy, encephalapathy, s/p (status post) fall subdural hematoma with right temporal craniotomy (prior to admission to facility) and clostridium difficile." Facility nursing admission note of 12/12/15 documents a fall with subdural hematoma occurred on 10/2015.	S9999		

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S9999	Continued From page 4 Additional documentation titled EP (electrophysiology physician) from post 2/3/16 fall on 2/4/16 indicates R9 "suffered CVA (cerebral vascular accident) in 11/2015 and has been having seizures from it." Original admission date to facility listed on face sheet is 12/11/15 with a date of birth of 10/20/1967, making R9 48 years old at the time of his death. R9 is at high risk for falls based on 1/22/16 fall risk assessment and has upper body ability to move based on fall out of bed of 12/16/15. On 2/25/16 at 1:25 pm via telephone, E12(Assistant Director of Nursing) agreed 1/22/16 fall risk assessment score placed R9 at high risk for falling. Mobility section of risk evaluation and screening tool has section titled "Rising from Chair" notes an increase in key risk factor for fall if pushes up with arms. R9 had 2 falls based on nursing documentation and incident reports on 12/16/15 and 2/3/16 while in the facility. 12/16/15 nursing note at 6:55 am described an unwitnessed fall out of bed onto right side of bed. R9 explained reason for fall as, "I fell when I tried to go to work." This fall did not result in any injuries. R9 has some ability to move as he was able to fall out of bed on 12/16/15 and fell on 2/3/16 while sitting in a chair. Neurological evaluation flow sheet of 2/3/16 at 1:15 pm notes R9's hand grasps as equal and Minimum data set completed 1/28/16 with an assessment date of 1/22/2016 denoted R9 had cognitive impairment and needed physical assistance for bed mobility, transfer and walking.	S9999		

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S9999	Continued From page 5	S9999		

Z12 (Attending physician for R9) on 2/24/16 at 4:25 pm via telephone described R9 (whom he saw 3 times) as "confused," "screaming all the time," and "unpredictable." Additional nursing notes previous to fall indicate R9 was confused and exhibiting agitated behavior. 12/18/16 3:51 pm note indicates R9 constantly trying to get up and out of bed. Resident educated on the importance of not trying to get out of bed due to resident being unstable with standing. Resident continued to try to get out of bed....12/19/15 at 5:32 pm, "At 3:00 pm resident noted physically aggressive and agitated pulling g-tube, LVAD (Left ventricular assist device) tube and trying to climb out of bed. 12/23/15 at 5:34 pm, "At 3:00 pm resident noted physically aggressive and agitated screaming, yelling, pulling g-tube, LVAD tube and trying to climb out of bed. On 1/3/16 at 7:00 pm resident noted physically aggressive and agitated screaming, resisting patient care from CNA's, yelling pulling g-tube, LVAD and trying to climb out of bed. On 1/25/16 at 6:41 pm "resident is alert and confused..." 1/29/16 at 10:07 pm R9 is described as, "alert, with bouts of confusion...on lo bed due to fall risk." 2/1/16 nursing note indicated R9 was sent out to hospital for replacement of Gastrostomy tube (feeding tube).

E8 (Licensed Practical Nurse) who consistently worked dayshift of section where R9 resides stated on 2/19/16 at 11:26 am, "worked with him (R9) full time....On admission pretty antsy; trying to stand up majority of time from bed. Unsteady on feet. Unable to use call light for help. He didn't know where at or time. Would respond to name. No safety awareness. Told him please sit down; would continue to try and get up; stand up. Not daily, times when calm with eyes open. No way of knowing when he was going to try to get

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S9999	Continued From page 6	S9999		

up. He was unpredictable and impulsive. Not redirectable." Day of R9 fall of 2/3/16, E8 continued her statement describing R9 as "antsy," "Unsteady on feet. Unable to use call light for help. He didn't know where at or time. Would respond to name. No safety awareness." "Ativan would work off and on. Ativan didn't work day of fall and other times where it hasn't worked. Did not have chair alarm on (day of fall). Bed pads (yes). Chair, no pad on floor." "Ativan would work off and on; and in room 209 right across from me (day of fall). Med cart there. I could turn around and see him. Preparing meds (medications) for patient. While in room reclining just sitting there. Reclined looking at t.v. He's calm.. He's unpredictable. He's sat in (type of) chair in room; been calm while watching t.v. He's also sat in (type of) chair, gotten agitated without warning. Took 60 seconds for him to fall. I walked away." E8 stated she was right outside of R9's room with her back turned when R9 fell.

R9's fall care plan with goal date of 4/22/16 states problem of "risk for falls R/T (related to) poor safety awareness, poor judgement of mobility limitations" has interventions which include: "Use fall risk screen to identify risk factors," "Report falls to physician and responsible party," "Remind resident and reinforce safety awareness." E8 stated R9 had "no safety awareness" and problem statement includes assessment of "poor safety awareness." Intervention to remind resident and reinforce safety awareness in a resident with cognitive impairment and "unpredictable" behavior combined with chair alarm are measures in place for fall. Interventions also include "observe for side effects of any drugs that can cause: gait disturbance, orthostatic hypotension, weakness, sedation, lightheadedness, dizziness, change in mental

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S9999	Continued From page 7	S9999		

status." Interventions for fall also include: "provide bed/chair alarm as ordered 12/16/15," "keep personal items within reach," "Draw labs as per doctor's orders 12/16/15," Provide low bed 12/16/15," "resident discharged to the hospital 2/3/16," and "will reevaluate upon readmission 2/3/16." Care plan for falls requires a chair alarm be in place which E8 in her signed statement reports was not in place day of fall. Level of supervision required is not addressed while in R9's care plan and there are no fall interventions listed to decrease the impact of a fall.

At time of R9's fall he was on antipsychotic of Olanzapine 5 mg at bedtime and Lorazepam a benzodiazepine, 2mg intramuscular every 4 hours as needed. Medication administration record includes documentation of administration of Lorazepam on 2/2. E8 stated on 2/19/16 at 11:26 am this was a mistake in charting which she would correct by late entry and that Ativan was given intramuscular on 2/3/16 (day of fall) at approximately 10:00 am.
Requested fall policy and procedure. Facility presented handout titled, "Fall Management Guidelines," as their procedure for management of falls. Under purpose of fall management document states, "The falls management guidelines are an interdisciplinary process. They are designed to assist in the development of systems to provide individualized person centered care; to assist the resident in obtaining and/or maintaining their highest level of function and minimize the risk of falls and fall related injuries. Facility failed to address how they would minimize the risk of fall related injuries for R9 while in the chair given his history of falls and unpredictability and as per their policy.
R9 expired on 2/14/16. This was 11 days after the fall and being transferred to (2) additional acute

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S9999	Continued From page 8 hospitals. R9 death certificate dated 2/14/16 lists cause of death included : closed head injury and fall. (A)	S9999		

IMPOSED PLAN OF CORRECTION

Lake Shore Healthcare & Rehab
Complaint Survey 1680673/IL83213, exit date 3-1-2016

300.610a)
300.1210b)
300.1210d)6)
300.1220)b)3)
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:

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 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Attachment B
Imposed Plan of Correction

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

This will be accomplished by:

I. The facility will conduct an investigation of the incident and take appropriate actions. The assessments for all residents identified as high risk for falls and all residents requiring supervision will be reviewed for accuracy of the assessment and will be revised as necessary based on the outcome of the review. Care plans for those residents will be updated to include interventions to prevent injury or death.

II. All staff will be in-serviced on resident supervision, as well as follow-up assessment and monitoring of residents who are experiencing a change in condition and/or need to be reassessed for safety or level of supervision. The in-services will include all staff and will cover, at a minimum, assessment of resident risk for falls, follow-up of incidents and identifying resident changes or indicators that may require reassessment or other interventions to prevent injury or death.

III. Documentation of in-service training, assessments and related follow-up actions will be maintained by the facility.

IV. The Administrator and Director of Nurses will monitor Items I through III to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Ten (10) days from receipt of this Imposed Plan of Correction.