STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006126	A. BUILDING: _____ B. WING _____	C 02/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENSINGTON PLACE NRSG & REHAB	3405 SOUTH MICHIGAN AVENUE CHICAGO, IL 60616

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S 000	Initial Comments Incident Investigation of 2/23/2016-IL83592 Licensure Findings	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. Section 300.1210 General Requirements for Nursing and Personal Care 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 Regulations were not met as evidenced by: Based on observation, interview and record	S9999		

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S9999	Continued From page 2	S9999		

review the facility failed to provide supervision for a resident attempting to get up from bed unassisted and implement the use of a functioning bed or chair alarm for a resident at risk for falls. This failure applies to four of six residents (R1, R2, R5 and R6) reviewed for falls, in a sample of six.

As a result, R1 who has a history of a fall, attempted to get out of bed unassisted and fell. R1 sustained a hip fracture.

Findings Include:

-R1's face sheet diagnoses include dementia, pseudobulbar affect, osteoarthritis and muscle weakness.

R1's fall risk observation dated 2/14/16 indicates that R1 was at high risk for falls with a score of 21. On 2/25/16 E7, Licensed Practical Nurse/Restorative Nurse stated that a score of 21 on R1's fall risk observation is considered high risk.

R1's progress note dated 2/2/3/16 indicates that R1 was noted lying on the floor with left leg/hip under the right leg. R1's progress note indicates that R1 was admitted to a local hospital with the diagnoses of hip fracture and fall.

R1's facility incident report dated 2/23/16 indicates that R1 fell out of bed and was noted lying on the floor with left leg and hip under right leg. R1's report indicates that R1 was sent to the hospital with the diagnosis of left hip fracture.

R1's hospital radiology report dated 2/23/16 indicates that R1's hip x-ray was positive for an acutely displaced fracture of the subtrochanteric

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S9999	Continued From page 3 left femur with overriding of the fracture fragments. R1's fall care plan dated 1/21/16 includes an interventions for bed/chair alarm to alert staff to postural changes and ensure proper functioning of alarm devices. R1's statement of witness dated 2/23/16 from E5 Certified Nursing Assistant (CNA) indicates R1's room call light was activated and upon entering the room R1 was noted on the floor between his bed and his roommate's bed. R1's statement of witness dated 2/23/16 from R4 indicates R1 was trying to get out of bed and fell between R1 and R4's bed and the call light was activated for help. On 2/25/16 at 9:30 am R4 (R1's roommate) stated that R1 was trying to get up out of bed. R4 stated that shortly before R1 fell a nurse came into the room and told R1 to lay back down in bed because R1 was trying to get out of bed like he usually does. R4 stated that R1 laid back down in bed at the nurse request but started trying to get out of bed again after the nurse left the room. R4 stated that he observed R1 on the floor between R1 and R4 beds. R4 stated that R1 fell on the floor and was not on the floor mat when he fell. R4 stated that there was not an alarm sounding and he (R4) had to pull the call light to get help. On 2/25/16 at 10:27 am E5 CNA stated that she did rounds on R1 at around 11:35 pm and R1 was trying to get out of bed like he usually does and she instructed him to stay in bed. E5 stated that she responded to the call light in R1 and R4's room shortly after rounds and observed R1 on the floor between R1 and R4's bed. E5 stated that	S9999		

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R1's leg didn't look normal. E5 stated that R1 was lying on the floor and there was not an alarm sounding in the room. E5 stated that R1 had one floor mat which was on the opposite side of the bed from which he fell.

On 2/25/16 at 12:52 pm E6 Licensed Practical Nurse (LPN) stated that she was alerted by the CNA that R1 needed help. E6 stated that R1 was observed on the floor in an upright position. E6 stated that she did not hear an alarm sounding upon entering R1's room.

On 2/29/16 at 9:00am Z1 (R1's Physician) stated he is aware of R1's fall and hip fracture. Z1 stated that R1 is not a candidate for surgery for hip repair because of his age. Z1 stated that not all falls are preventable but preventative measures should be put in place to try and prevent accidents if a resident has dementia

-R5's face sheet diagnoses include muscle weakness, difficulty walking and dementia.

R5's fall risk observation assessment dated 1/5/16 documents R5 is at high risk for falls. R5's fall care plan dated 6/25/14 includes an intervention for bed and chair alarm.

On 2/25/16 at 9:45am R5 was sitting in the 2nd floor dining room. R5 positioned in the wheel chair with an alarm device hanging off the back of the wheelchair. No wheelchair pressure mat was noted in place to connect to the alarm device. This device alerts staff if R5 is attempting to rise. E4 (Quality Assurance Nurse), who was present at the time of the observation stated, R5 is at high risk for falls.

-R2's face sheet diagnoses include abnormal

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involuntary movement and epilepsy. R2's fall risk observation assessment dated 2/17/16 documents R2 is at high risk for falls.

R2's occurrence report dated 1/17/16 indicated R2 suffered a fall in the dining room. R2's report includes an immediate action to apply alarming wheelchair pressure mat.

On 2/25/16 at 9:50 am R2 was in a chair while in the 2nd floor dining room. R2 had a safety helmet in place. R2 was observed with a chair alarm mat in place. The surveyor wanted to confirm if the alarm was working. E4 (Quality Assurance Nurse) assisted R2 to a standing position. However the alarm did not sound when R2 was assisted by E4 (Quality Assurance Nurse) to a standing position. E4 stated R2 is at high risk for falls.

On 2/25/16 at 1:15 pm E7, Licensed Practical Nurse/Restorative Nurse stated that R2 should have a chair alarm as a care plan intervention.

- R6's face sheet diagnoses include Alzheimer's, delusional disorder, muscle weakness, difficulty walking and history of falls. R6's fall risk observation dated 1/28/16 indicates that R6 is at high risk for falls. R6's fall care plan dated 9/5/15 includes an approach to apply bed/chair alarm to alert staff of postural changes.

On 2/25/16 at 9:55 am with E4, R6 was observed sitting in the 2nd floor dining room with a chair alarm pad in place. R6's chair alarm failed to sound when assisted to a standing position by E4.

On 2/23/16 at 1:15pm E7 Restorative Nurse stated care plans are updated 24 - 72 hours after

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S9999	Continued From page 6 a fall depending on the day of the incident. E7 stated that interventions are put in place immediately after a fall. E7 stated that R2, R5 and R6 should have chair alarms in place. E7 stated that R1 did not have an intervention for floor mats. E7 stated that R1 had the intervention for bed alarm just in case the nursing staff felt it was necessary to put interventions in place. E7 stated nursing staff often use safety alarms as an immediate intervention. (B)	S9999		