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
	IL6010110	A. BUILDING: _____ B. WING _____	C 06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY NURSING & REHAB CENTER	6909 WEST NORTH AVENUE OAK PARK, IL 60302

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S 000	Initial Comments Complaint Investigation 1792702/IL93808	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210d)6) 300.1220)b)3) 300.3240a) 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. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/19/17

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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 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 record review and interview the facility failed to identify risk factors and provide interventions for one high risk for fall resident (R1) of three residents reviewed for falls in a sample of 4 residents. This failure has resulted in R1 sustaining a cut over the left eyebrow requiring 8 sutures.

Findings Included:

Medical record documented R1 was 84 years old admitted to facility on 5/10/2013 with diagnoses to

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include Dementia and Cognitive Communication Deficit. Minimum Data Set for R1 dated 3/12/2017 scored 2 out of 15 for the Brief Interview for Mental Status(BIMS). According to MDS, R1 was ambulatory with supervision and needed supervision from staff with cueing and oversight for transfer. MDS of R1, Section G0300 A, B,C, D and E on balance during transitions and walking documented,"Not steady, but able to stabilize without staff."

Fall risk assessment for R1 dated 3/12/2017 checked off as not being high risk for falls. Fall assessment for R1 dated 5/12/2017 noted she was High risk for falls.

Care plan for R1 noted problem of behavior as being compulsive and was high risk for falls related to unaware of safety needs initiated on 11/11/2013 and revised on 5/4/2017. Interventions included, "to anticipate and meet residents' needs." There was no intervention which addressed compulsiveness of R1 and the way facility will anticipate and meet her safety needs.

Final report of R1's incident sent to Illinois Department of Public Health (IDPH) from facility and written by Physician noted, "Resident's fall is due to resident poor safety awareness and medical condition. Resident's gait is unsteady due to her Scoliosis. Resident was rushing in the activity at the time and due to her impulsiveness stood up and walked rushing, lost balance and fell."

Facility's incident report for R1 dated 5/2/2017 documented a witnessed fall by R1 who got up from chair as she left activities, walked fast and fell. She sustained a cut over left eyebrow which

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was sutured with 8 sutures from the community hospital according to records.

On 6/1/2017 at 11:00AM, E3 (Activity Aide) said she was the activity aide on 5/2/2017 when R1 fell, however, she did not see R1 and did not have R1 in her activity program that day. She said at that time R1 always walked fast in the hallway and sometimes she leaned on one side. She said every staff knew about R1's posture and her fast pace when she walked.

On 5/30/2017 at 2:10PM, E6 (Certified Nursing Assistant, CNA) said R1 always walked fast and always leaned to one side. She said whenever R1 gets up from a sitting position, she was always in a hurry. E6 said she was afraid for R1 even before she fell and all the staff was aware of R1's posture when walking.

On 5/31/2017 at 1:45PM, Z2 (family member of other resident) said about one month ago he saw R1 leaned to one side and walked so fast in the hallway that he was surprised she did not have a fall prior to 5/2/2017. He said he was afraid for her safety and notified management of what he observed.

E2 said there was no policy for Incidents and Accidents and the abuse policy incorporated accidents and incidents. She said she did not have a written care plan policy.

On 5/30/2017, care plan added one intervention of chair and bed alarms for R1.

Surveyor unable to contact Physician. However, on 5/3/3027 at 10:21AM, physician wrote, "Was rushing and unsteady and not able to keep

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S9999	Continued From page 4 balance as Scoliosis is throwing off balance also." Facility fall policy dated 5/2012 noted, "The root cause of the fall will be identified and new appropriate interventions will be implemented." The fall policy also noted, "Every fall incident will be reviewed by the fall IDT (interdisciplinary team) committee to determine whether fall interventions are appropriate." (B) Section 300.1810 Resident Record Requirements c) Record entries shall meet the following requirements: 3) Medical record entries shall include all notes, orders or observations made by direct resident care providers and any other individuals authorized to make such entries in the medical record, and written interpretive reports of diagnostic tests or specific treatments including, but not limited to, radiologic or laboratory reports and other similar reports. This Requirement was not met as evidenced by: Based on record review and interview, facility failed to document observations in medical record of one resident (R1) of three residents reviewed for fall in sample of 4 residents. Findings Include:	S9999		

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Medical record documented R1 was 84 years old admitted to facility on 5/10/2013 with Diagnoses to include Dementia and Cognitive Communication Deficit. Minimum Data Set for R1 dated 3/12/2017 scored 2 out of 15 for the Brief Interview for Mental Status(BIMS). According to MDS, R1 was ambulatory with supervision. She needed supervision from staff with cueing and oversight for transfer.

Facility's incident report for R1 dated 5/2/2017 documented a witnessed fall by R1 who got up from chair as she left activities, walked fast and fell. She sustained a cut over left eyebrow which was sutured with 8 sutures from the community hospital according to records.

There was no documentation in R1's medical record about the incident and that she was sent out to community hospital for evaluation.

Facility had electronic records.

On 5/30/2017 at 12:45PM, E2 (Director of Nursing, DON) said the facility does not document incidents in the charts.

On 5/31/2017 at 2:10PM, Z3 (Family of R1) said he told E2 that he was made to understand that R1 fell on 5/27/2017 around lunch time.

There was no record of the allegation of fall in R1's chart.

On 5/31/2017 at 1:40PM, E2 said she did not do anything about the allegation because nothing happened. There was no written investigation.

Facility has surveillance camera, but E2 said the camera stopped working 2 days ago.

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S9999	Continued From page 6 On 5/31/2017 at 2:45PM, E6 (Certified Nursing Assistant, CNA) who was on duty on 5/27/2017 said she heard a loud scream when she was in the dining room at lunch time on 5/27/2017. She said when she inquired she saw R1 on the floor in the hallway. She said after R1 fell, then she saw other staff come to see where the noise came from. According to her, the two nurses assisted R1 from the floor. She said she did not hear any alarm. On 6/1/2017 at 12:05PM, E8 (Licensed Practical Nurse/LPN) said R1 placed herself on the floor on 5/27/2017 and she did not fall. He said he caught her and she had no injuries. E8 said he did not document anything as there was nothing to document. Facility's fall policy also noted, "Every fall incident will be reviewed by the fall IDT committee to determine whether fall interventions are appropriate." (AW)	S9999		