STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015499	A. BUILDING: _____ B. WING _____	C 09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEK AMERICAN REHAB CARE CTR	220 N FIRST STREET WHEELING, IL 60090

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S 000	Initial Comments Complaint Investigation: 229668/IL150415	S 000		
S9999	Final Observations Statement of Licensure Violation 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 Requirements were NOT MET as evidenced by: Based on interviews and records reviewed, the facility failed to follow policy and procedures, failed to provide a safe transfer and failed to follow resident's Care Plan to prevent an avoidable accident. This affected 1 of 3 residents R1 reviewed for safety during care. This failure resulted in R1 falling to the floor suffering a left femoral intertrochanteric hip fracture. Findings include: Facility incident report dated 7/30/2022 documents the following sent to IDPH and another received from facility: IDPH incident report: conclusion: resident attempted to self transfer from bed to wheelchair although she was aware that staff was on their way to assist her.	S9999		

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S9999	Continued From page 2 Facility incident report: Conclusion: after investigation - wheelchair was placed next to the bed and resident decided to transfer herself to the wheelchair. She is normally a 2 person transfer. She was unable to sustain her balance and fell to the floor. Review of hospital records dated 7/30/2022 documents the following: page 17: Hospitalist History and Physical Chief Complaint: Fall, Hip Pain. HPI: R1 is a 84 year old female with history of Cerebrovascular accident, Hypertension, Hyperlipidemia, and Diabetes Mellitus who presented from nursing home after an unwitnessed fall. She was being changed in the bed by an aid who sat her on the edge of the bed, but then stepped out of the room to get something. When she returned, the patient was on the floor complaining of left hip pain. Family says there have been a few falls similar today in the course of her 4 years living here, but none this severe. Daughter notes that the patient has severe spinal stenosis and is unable to sit up unassisted, and therefore is frustrated that she was left alone sitting which caused the fall. The patient is complaining of moderate pain in the left hip, but denies any other symptoms. Page 20: Imaging/other studies: Xray Femur MIN 2 views LT. Result date 7/30/2022. Impression: Comminuted, angulated left femoral intertrochanteric fracture. Page 29 dated 7/31/2022 Ortho Consulted for further recommendations: Dr. has examined the patient and recommended surgery to repair the fracture. Review of R1's MDS section C dated 6/10/2022 documents R1 has severely impaired cognitive	S9999		

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S9999	Continued From page 3 functions as evidenced by a BIMS of 7/10. R1's Care Plan dated 10/19/2020 documents: The resident is at high risk for falls r/t (related to) hearing impairment, poor safety awareness and history of falls. Interventions: 11/24/2018- Re-do of transfer competencies given to CNA giving showwr, 2 person transfer and gait belt to be used at all times. 12/9/2021 Staff educated on the facility's protocol and policy on transferring residents who require two-person assist. 12/30/2018- Resident was assessed for use of sit to stand lift for all transfers x 2 assists, resident was informed and will be referred for PT (physical therapy) evaluation due to repeated falls. 4/30/2019- Staff instructed to stay with resident in the washroom until done with grooming. On 8/30/2022 at 10:55 AM R1 is sitting at nurse's station in a wheelchair. Appears clean and comfortable. R1 is very hard of hearing. Points to her ear and mumbles something as if she does not hear surveyor. R1 is unable to be interviewed. R1 has unclear speech. On 8/30/22 at 12:23 V3 (LPN) states R1 is alert and oriented times 2, hard of hearing, complaint with care. V3 states she has been taking care of R1 for a few years here. V3 states R1 does not ambulate and is a two-person assist. V3 states she was the nurse on duty the morning R1 fell on 7/30/22. V3 states she was passing medications in the dining room when V4 (agency CNA) came to her. V3 states that V4 (CNA) said R1 had fallen. V3 states, V4 said she was getting R1 dressed. V3 states that V4 stated she left R1 "sitting at the side of the bed to go get help and when she came back she was on the floor." V3 states the CNA put R1 in a wheelchair and brought R1 to me. V3 states, "I told the CNA who	S9999		

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S9999	Continued From page 4	S9999		

found her that it is not protocol for them to put her in a chair. She should have called the nurse immediately." V3 states R1 requires one person assist for dressing and for Toileting and shower is 2 person assist. V3 states, V4 (CNA) and another CNA V5 helped R1 into the wheelchair. V3 states, the standard protocol is bed low position, call light at bedside everything in reach. R1 did not have pads on the floor. V3 states I learned that on 7/29/22 a CNA took R1 to restroom R1 couldn't balance and CNA placed her on the floor and R1 had no injury. V3 states, they don't normally sit R1 at the side of bed and leave because R1 has poor trunk control.

On 8/30/2022 at 12:52 PM V6 (LPN) states when leaving a resident who is high fall risk in her room, she would leave them in bed, with the call light, and bed low position. V6 states, she would make sure the bed alarm or pads on. V6 states, they should never leave the patient sitting at the side of the bed if high fall risk. V6 states, CNA's are not supposed move resident's post fall. V6 states, "CNA's should call the nurse right away because we don't know if the patient had any fractures."

On 8/30/2022 2:12 pm in first floor conference room. V4 (CNA) states, R1 does not walk. V4 states R1 talks, tells what she wants, and alert to person. V4 states R1 is a fall risk. V4 states R1 is Wheelchair bound. V4 states she believes R1 is a fall risk and up with two-person assist. V4 states, "She [R1] is 2-person assist with transfers." V4 states R1 has always been a 2-person assist. V4 states she remembers the incident of 7/30/22. V4 states, in the morning R1 was her last resident to get up. V4 states, when she got to R1's room R1 had had a bowel movement. V4 states, " by then breakfast was

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S9999	Continued From page 5 being served. I changed her. I told her to wait for me to get someone to help her into the wheelchair. I lowered the bed before I left. I brought the wheelchair nearby and left her at the side of the bed." Surveyor asked V4 to clarify where R1's feet were. V4 states, "She [R1] was sitting at the side of the bed feet on the floor. I had just finished dressing her. V4 states, "yes, She had her shoes on and everything. I had just finished dressing her." V4 states she put R1's bedside table in front of her so she didn't move and the wheelchair to her left that was locked to box her in so she didn't move. V4 states, "I did it that way to make sure she didn't move." V4 states she was gone not even 2 minutes. V4 states, she saw V5 (CNA) waved to her to help her and went back to the room. V4 states, when she came back the table was moved forward away from the where she left it and R1 was between the table and the bed. V4 stated, she figured R1 wanted to go with everyone else to eat. V4 states, "I didn't pull the call light because I thought no one would come because they were passing food." V4 states, I would press the call light and would stand by the door so she could see me. V4 states, she puts them flat on bed and put wedges if have them and put the alarm on. V4 states, "I think she [R1] lost confidence I was coming back." I don't remember if R1 had an alarm. V4 states she definitely did not have a wedge. V4 states she has had R1 in her care before. V4 states, V5 came and they lifted R1 to the wheelchair after they found her on the floor. V4 states, "after that I was taught that I should not have done that. If possible should use the hoyer." V4 states, she was told don't lift residents until the nurse assesses them. On 8/30/2022 2:51 pm V7 (Restorative Nurse) investigated R1 fall on Monday after fall. V7	S9999		

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S9999	Continued From page 6 states, the nurse said it was an unwitnessed fall. V7 states, R1 has never gotten out of bed previously. V7 states R1 does not walk. V7 states, R1 requires 2 person assist for bed mobility and transfers. On 8/30/22 3:15PM V2 (DON) states V2 states, " I don't expect someone who is high fall risk to be at the side of the bed for any amount of time. With R1 everything done correctly, except leaving her at side of the bed. V4 stepped away to call someone to help." V2 states. In retrospect, V4 would have laid her down. V2 states, V4 was gone only a short time. V2 states, after a fall the Protocol is that a resident should stay on floor until nurse assesses them in case there is an injury, you don't want to move them and make injury worst. On 8/31/2022 at 1:07 PM V5 (CNA) states she usually works on 1st floor. She is not too familiar with the R1 because don't work on 2nd floor. V5 states she remembers the incident. They were getting everyone ready for breakfast. V5 states V4 (CNA) came to her and she said to help her transfer someone. V5 states, I immediately followed V4 and when we got there we saw R1 on the floor on the side of her bed. V5 states the resident kept saying we should get her up. We got her up and put her in wheelchair with a gait belt. V5 states, she is not sure if R1 said she was in pain. V5 states, she just looked like she was in pain and said get her up in the chair. V5 states it is policy that we are supposed to call the nurse so she can assess the scene and figure out what happened before we get a resident up who has fallen. V5 states, "I didn't do it because the patient kept saying we should get her up." V5 states, because "there might be an injury or something that we may not know." V5 states,"	S9999		

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S9999	Continued From page 7 first I make sure they are dressed and ask for help to get them up. I put the resident in the bed, bed low, and call for help. I make sure they don't sit on the bed, they lie down on the bed." V5 states, I make sure they are not in the sitting position. V5 states, because maybe they are at fall risk. On 9/1/2022 at 9:16 AM V2 states, she submitted the conclusion on the incident report. V2 states R1 had an unwitnessed fall on 7/30/2022. V2 states that, V4 said she was just gone for a couple minutes and when she came back the bedside table was pushed forward. V2 states, in her experience when resident's see a wheelchair near they try to get into it. V2 states, "It is possible R1 had fallen forward. Review of R1's MDS section G dated 6/10/2022 documents R1 requires extensive 2 person assist for bed mobility and transfers. Review of R1's nursing note by V3 (LPN) dated 7/30/22 documents the following: Writer informed by assigned CNA that resident was observed on the floor. Per assigned CNA, she was getting resident dressed for breakfast. Placed the bed in lowest position and went to get help form another CNA. Per assigned CNA, left the room for approximately 5 min. Resident put back into bed. Resident complained of pain to left lower extremity. Noted with decreased range of motion on said site. No discolorations, abrasions noted at time of assessment. Administered as needed Tylenol. Supervisor called to assess resident. Power of Attorney and Medical Doctor notified. Per Medical doctor sent resident to the hospital for evaluation. Review of nursing note by V10 on 7/30/2022 documents: called hospital for the status of the	S9999		

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S9999	Continued From page 8 resident, admitted with left hip fracture. Review of R1's Fall Care Plan documents resident with history of fall on 9/4/20, 6/6/21, 12/9/21, 7/29/22 and 7/30/22. Review of R1 post fall follow up dated 12/17/21 documents the following: Staff educated about proper and safe way of transferring resident with emphasized on how to transfer residents who require two-person. Staff verbalized understanding on education. Review of R1's Morse fall scales dated 6/8/2022, 7/29/2022, and 7/30/2022 document R1 is a high risk for falls as noted by fall risk scores of above 45. The facility's Fall Prevention Program Policy dated 2/4/2022 documents the following: The facility is committed to reducing the number of falls, and to maximize each resident's physical, mental and psychosocial wellbeing. While preventing all residents from falling is not possible, it is the facility's policy to identify those residents at high risk by assessing, planning a preventive strategy, and maintaining as safe an environment as possible. (A)	S9999		