STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005227	A. BUILDING: _____ B. WING _____	C 07/07/2022

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LAKEVIEW REHAB & NURSING CENTER	735 WEST DIVERSEY CHICAGO, IL 60614

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S 000	Initial Comments COMPLAINT INVESTIGATION: 2285038/IL148444	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 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. Section 300.1210 General Requirements for Nursing and Personal Care 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:	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 observation, interview and record review, the facility failed to ensure that staff followed the facility's fall protocol for two (R1, R4) residents reviewed for falls. This failure resulted in R1 sustaining a 4 cm frontal hematoma with mild abrasion and transferred to local trauma hospital. Findings include: 1) R1's Admission Record documents, in part, R1's diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, encephalopathy, altered mental status, cognitive communication deficit and lack of coordination. R1's Minimum Data Set (MDS), dated 9/6/21, documents, in part, that R1's Brief Interview for Mental Status (BIMS) score is a 4 which indicates that R1 has severe cognitive impairment. R1's MDS (9/6/21) documents, in part, for Functional Status for Activities of Daily Living (ADL) Assistance that R1's "Bed Mobility - How resident moves to and from lying position, turns side to side, and positions body while in bed" for Self-Performance is coded as "Extensive	S9999		

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S9999	Continued From page 2 Assistance" and for Support is coded as "Two + (plus) persons physical assist." R1's Functional Limitation in Range of Motion for Upper Extremity is coded as "Impairment on one side," and Lower Extremity is coded as "Impairment on both sides." On 7/5/22 at 2:34 pm, V3 (Former Licensed Practical Nurse, LPN) stated that V3 recalled R1's fall from the bed on 10/20/21 at approximately 5:00 am. V3 stated that V4 (Former Certified Nursing Assistant, CNA) physically came to the nurse's station where V3 was located and informed V3 of R1's fall from the bed. V3 stated that both V3 and V4 then went back to R1's room. When asked when V3 entered R1's room after being notified by V4 about R1's fall, which other staff members were in R1's room, V3 stated, "Just the CNA (V4)." V3 stated, V4 told V3 that V4 turned R1 in bed, and R1 "fell out of the bed." V3 stated that R1's bed was open on both sides where staff can perform care (not up against the wall on one side), and that R1 fell off the bed to the floor closer to the outside wall of the room. V3 stated that V3 did a full body assessment and observed R1 with a forehead hematoma and that R1 complained of pain. When asked about R1's injury and size of R1's forehead hematoma, V3 stated, "It (hematoma) must have been visible if I (V3) saw it." V3 stated, "(V3) I remember what (R1) told me: '(R1) fell off'." V3 stated, "(R1) was verbal. I (V3) remember (R1) spoke to V19 (R1's Family Member)" on the phone after the fall. V3 stated that V3 notified V27 (Nurse Practitioner, NP) who ordered for R1 to be sent to the local hospital for evaluation. When V3 was asked about V3's documentation in R1's EMR (Electronic Medical Record) about the ambulance routing R1 to a trauma hospital, V3 stated, "If I (V3) wrote it, it is what happened."	S9999		

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S9999	Continued From page 3	S9999		

In R1's Incident Note, dated 10/20/21 at 4:57 am, V3 documented, in part, "(V3) called by (V4) that (R1) in on the floor. Per (V4), (R1) fell when (R1) was turned over to be changed. Per (R1), 'I (R1) fell off.' Full body assessment done, bump noted to (R1's) forehead ... (R1) complained of pain 5/10 (5 out of 10 pain scale) ... MD (V27, NP) notified with order to send (R1) to (local hospital emergency room) for evaluation ... 5:22 am: (V19) made aware and was able to speak to (R1)."

In R1's Nursing Progress Note, dated 10/20/21 at 8:41 am, V3 documented, "Per (Ambulance Company), (R1) was transferred to (trauma hospital)."

On 7/6/22 at 2:32 pm, V19 (R1's Family Member) was interviewed and stated that V19 was informed by V3 of R1's fall from the bed in the facility on 10/20/21 at approximately 6:00 am and that V19 requested to speak with R1. V19 stated that the facility staff have always brought an intercom or speaker phone into R1's room to allow R1 to speak to V19 since R1 is unable to hold the telephone with R1's right hand, and R1's left side is paralyzed. V19 stated that R1 was saying to V19 over the phone, "I (R1) told (V4) that I (R1) was falling. And (V4) was saying 'I (V4) got you (R1). I (V4) got you (R1).' Then (V4) dropped me (R1) on the floor."

On 7/6/22 at 1:03 pm, V6 (Former Director of Nursing, DON) stated that V6 was the DON of the facility on 10/20/21 and remembered R1. V6 stated that V6 was notified on 10/20/21 by V3 (Former LPN) about R1's fall, but that V6 could not recall any details of R1's fall. After this surveyor read to V6 the incident note authored by

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S9999	Continued From page 4 V3 on 10/20/21 at 4:57 am, V6 stated, "That information, what you (surveyor) just said is what I (V6) was made aware." V6 stated that per the facility's fall protocol, the nurse will complete an incident report after a resident fall, and any interviews (statements) from the staff members present during the fall will be typed into the incident report. When asked if V4 (Former CNA) received an in-service about proper turning and bed mobility after R1's fall on 10/20/21, V6 stated, "Yes." In R1's Fall Incident Report, dated 10/20/21, V6 documented, in part, "Notes: IDT (Interdisciplinary Team) met to discuss (R1's) fall ... Conclusion: (R1) was being changed by (V4). (V4) turned (R1) to (R1's) side and while cleaning (R1), (R1) rolled of (off) the bed ... (V4) returned demonstration training." In R1's Fall Incident Report, dated 10/20/21, V3 documented, in part, "Injuries Observed at Time of Incident: Injury Type: Other. Injury Location: Forehead ... Witnesses: Name: (V4). Date: 10/20/21. Statement: While changing (R1). (R1) was turned to the side, my hand never left (R1) body. During this time, I (V4) felt (R1) slipping and I (V4) tried to catch (R1) but was unable to completely break (R1's) fall. I (V4) alerted (V3) for help. Name: (V3). Date: 10/20/21. Statement: Per (V3), I (V3) was at the nursing station when (V4) alerted me (V3). I (V3) then got up and went to assist (R1)." On 7/6/22 at 1:25 pm, V17 (CNA) stated that V17 remembers caring for R1 as a CNA while R1 resided in the facility. V17 stated that V17 would get another staff member to assist with turning R1 in bed for incontinence care because "(R1) was not really able to maintain his body	S9999		

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S9999	Continued From page 5 alignment." V17 stated, "If a CNA does (turning in bed) with one person then that can worsen the situation. Some residents don't turn at all, and they don't understand how to turn. That's why I (V17) need the help of another. The other CNA will be on one side and hold them (the resident) and so I (V17) can give care." On 7/7/22 at 11:53 am, when V25 (Covering Physician) was asked where a resident should be positioned in the bed during care, like R1 with hemiplegia, paralysis on R1's left side, as an extensive assist, V25 stated, "Resident should be positioned nearest the middle of the bed for safety." When asked if a resident like R1 who is coded as a two-person assist is being turned in bed for nursing care with only one staff, what is the likelihood that the resident could experience injury from a fall from the bed, V25 stated, "Well ideally, the railing should be up. There should not be a fall. This is a standard of care. This is for safety." In R1's trauma hospital records, on 10/20/21 at 8:39 am, V30 (Emergency Hospital Physician) documented, in part, "Chief complaint: Trauma, s/p (status post) fall ... Per EMS (Emergency Medical Services), (R1) was getting rolled and changed at nursing home when (R1) fell off the bed and hit (R1's) head ... Exam: ... 4 cm frontal hematoma with mild abrasion." In R1's trauma hospital records, on 10/23/21 at 7:54 am, V29 (Hospital Physician) documented, in part, that on 10/20/21, R1 "presented to ED (Emergency Department) as a trauma activation s/p mechanical fall at NH (Nursing Home). Per EMS, the NH staff were rolling (R1). (R1) got rolled too far and fell off the bed."	S9999		

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S9999	Continued From page 6 R1's Fall Risk Care Plan, dated 8/28/21, documents, in part, a problem statement of "(R1) is at risk for falls R/T (related to): Cognitive Impairments, Communication Impairments, Decreased Safety Awareness ... Requires ADL assistance for Transfers and Mobility, Impaired Range of Motion and/or Loss of functional Movement of joints, Incontinence, Decreased Strength and Endurance, DX (Diagnosis): CVA (Cerebral Vascular Accident) with possible Hemiparesis or Hemiplegia" with approaches/interventions listed as "Anticipate and meet needs" with an added intervention on 10/20/21 (after R1's fall) as "Assessment for siderails." R1's Restorative Nursing Care Plan, dated 9/6/21, documents, in part, a problem as "(R1) have been assessed for my bed mobility self-performance needs and support and (R1) require the following assistance: (R1) will be designated as 'Extensive Assistance' with '2 staff member(s)'" with R1's goal as "(R1) will receive my current bed mobility needs assistance and will maintain my current level of function with no avoidable decline in bed mobility abilities." R1's Restorative Program Care Plan, dated 9/6/21, documents, in part, a problem statement of "Self-Care Deficit: Requires Extensive to Total Staff Assist with ADL's d/t (due to) contributing diagnosis: Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side, Dysphagia, Unspecified Convulsions, Encephalopathy, Altered Mental Status" with approaches/interventions listed as "Provide set up for task such as bathing, dressing, grooming, oral care." In R1's Occupational Therapy Evaluation and	S9999		

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S9999	Continued From page 7	S9999		

Plan of Treatment, dated 8/30/21 at 10:31 am, V22 (Occupational Therapist Registered, OTR) documented, in part, "Initial Assessment: ... Functional Skills Assessment - Mobility During ADLs: Bed Mobility - Prep for ADLs: Bed Mobility = Max/2 (Maximum Assist with 2 Persons Assist); Rolling = Max/2 ... Functional Mobility During ADLs = Max/2 ... Risk Factors: Due to the documented physical impairments and associated functional deficits, (R1) is at risk for falls."

R1's Fall Risk Review, dated 8/28/21, documents, in part, a fall risk category for R1 as "High Risk for Falls."

R1's Order Review Report, dated October 2021, was reviewed with no orders for side rails.

Per this surveyor's request for R1's assessment for bed side rails, V1 (Administrator) emailed that V1 was not able to locate a bed rail assessment for R1.

In this surveyor's review of R1's EMR for a bed rail assessment, a message was noted and highlighted in red, "313 days overdue: 8/28/21 Side Rail Review (Nursing)."

R1's Census List, documents, in part, that R1 was admitted to the facility on 8/28/21 and was discharged from the facility on 10/20/21.

2) R4's Admission Record documents, in part, R4's diagnoses of cerebrovascular disease, hemiplegia, vascular dementia with behavioral disturbance, lack of coordination, and weakness.

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S9999	Continued From page 8 R4's MDS, dated 6/1/22, documents, in part, that R4's BIMS score is a 6 which indicates that R4 has severe cognitive impairment. R4's MDS (6/1/22) documents, in part, for Functional Status for ADL Assistance that R4's "Bed Mobility - How resident moves to and from lying position, turns side to side, and positions body while in bed" for Self-Performance is coded as "Extensive Assistance" and for Support is coded as "Two + persons physical assist." R4's Functional Limitation in Range of Motion for Upper Extremity is coded as "Impairment on both sides," and Lower Extremity is coded as "Impairment on both sides." On 7/6/22 at 9:31 am, this surveyor observed only V10 (Agency CNA) turning and holding R4's body to the side while applying a clean incontinence brief. V10 then rolled R4 flat on R4's back and straightened out R4's flat sheet under R4 in the bed. R4's bed height is elevated from the floor while V10 was standing on top of R4's elevated floor mat on left side of the bed. On 7/6/22 at 9:33 am, V10 stated that V10 will get some help to pull R4 up in the bed. While R4's bed height is in the highest position from the floor, V10 physically walks out of R4's room, through the nurse's station to the opposite hallway and returns with V28 (CNA). V10 and V28 (standing on both sides of R4's bed which remains high) then use R4's flat sheet and pull up R4's body in bed. On 7/6/22 at 9:38 am, V10 (Agency CNA) stated that since R4 is contracted and has a low air mattress, there's no pad (draw sheet) underneath R4 so V10 needed help pulling R4 up in the bed. When asked V10 about staff assistance for bed	S9999		

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S9999	Continued From page 9 mobility with R1, V10 stated that V10 turned R4 by V10's self in bed. On 7/6/22 at 9:41 am, When V11 (CNA Supervisor) was asked about fall precautions relating to a resident's height of their bed, V11 stated that CNAs are to put the bed all the way down in the lowest position and should not be "left up with no staff in the room." V11 stated that if staff leave the bed height elevated with no staff present in the room, this "could cause greater risk of injury" from a fall. On 7/6/22 at 1:25 pm, V17 (CNA) stated that V17 is very familiar with R4's care. V17 stated that R4 is a high fall risk, keeps the floor mats in place, and maintain the lowest height of R4's bed after rendering care. On 7/5/22 at 12:25 pm, V15 (LPN) stated, "(R4) leans when (R4's) in bed. (R4) will rock in bed until (R4) moves off the bed." V15 added that R4 is visually impaired. R4's Fall Risk Review, dated 6/29/22, documents, in part, a fall risk category for R4 as "High Risk for Falls." R4's Care Plan, dated 3/31/22, documents, in part, a focus of "(R4) at risk for falls as evidenced by the following risk factors and potential contributing diagnosis: Cognitive Impairment, Decreased Strength and Endurance, Diagnosis: H/O (history of) or S/P (status post) CVA (Cerebral Vascular Accident) with Hemiparesis or Hemiplegia, Heart Failure, Dementia, Osteoarthritis, Depression, Lack of Coordination" with an intervention of "(R4) would like staff to provide me with ... my bed in the lowest position."	S9999		

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S9999	Continued From page 10 R4's Care Plan, dated 6/20/22, documents, in part, a focus of "(R4) require extensive assistance x (times) 2 staff with bed mobility, transfer, dressing, toileting, personal hygiene, bathing" with an intervention of "Staff will assist me in positioning." R4's Care Plan, dated 3/21/22, documents, in part, a focus of "(R4) have a 'Self Care Deficit' and (R4) require assistance with ADLs to maintain the highest possible level of functioning AEB (as evidenced by) the following limitations and potential contributing factors: Hemiplegia, Osteoarthritis, Weakness, Lack of Coordination" with an intervention of "Provide assistance with all ADL's as required per the residents need dependence: ... Bed Mobility." Facility document listing resident fall incidents from 5/1/22 to 7/5/22 includes two fall incidents for R4 on 5/3/22 and 6/29/22. Review of R4's Fall Incident Reports for 5/3/22 and 6/29/22 indicate that R4 had fallen from the bed. On 7/7/22 at 10:54 am, V2 (Interim DON) stated that fall precautions, "the bed should be in the lowest position." V2 stated, "Staff can raise the height of the bed while they are with the patient, but if they (staff) walk away, they must put the bed back in the lowest position for the resident's safety." When asked if staff are walking away from a resident in bed with the bed height in an elevated position, is there a greater possibility of a resident falling, and V2 stated, "Yes." When V2 was asked about bed mobility during care, V2 stated that staff should align the resident's body in the middle of the bed for safety. V2 stated that when a resident is coded for a two person staff assistance for bed mobility, the resident wouldn't be able to provide but minimal assistance if any.	S9999		

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S9999	Continued From page 11 When asked if a resident is coded for a two person staff assistance for bed mobility, is it your expectation that two staff members turn and reposition the resident in bed, and V2 stated, "Yes." Facility policy dated 8/3/17 and titled "Fall Prevention and Management," documents, in part: "Fall Prevention Protocol: Risk Assessment: ... III. Fall Prevention. A. Identify risk factors. B. Implement individualized approaches/interventions based upon resident risk ... V. Care plan. A. Interdisciplinary care plan is implemented for residents at risk and may include: ... 4. Supervision as appropriate." Facility policy, undated and titled "Activities of Daily Living," document, in part, "Policy: ... ADL care is provided throughout the care planned and/or as needed ... Assisting with movement ... as indicated and care planned." Facility Job Description, undated and titled "Certified Nursing Assistant," documents, in part: "Position Summary: The Certified Nursing Assistant provides each assigned resident with routine daily nursing care and services in accordance with the resident's assessment and care plan ... The person holding this position is delegated the administrative authority, responsibility, and accountability for carrying out the assigned duties and responsibilities in accordance with current existing federal and state regulation and established company policies and procedures to ensure that the highest degree of quality care is maintained at all times ... Essential Job Functions: ... C. Role Responsibilities - Personal Nursing Care: ... 3. Assists residents with bath functions (i. e. 'that is', bed bath ...) as directed ... 10. Position bedfast residents in	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005227	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW REHAB & NURSING CENTER	735 WEST DIVERSEY CHICAGO, IL 60614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 12 correct and comfortable position ... 19. Assists with lifting, turning, moving, positioning, and transporting residents into and out of beds ... H. Roles Responsibilities - Safety: ... 6. Follows established safety precautions in the performance of all duties." Facility Job Description, undated and titled "Licensed Practical Nurse," documents, in part: "Position Summary: The Licensed Practical Nurse provides direct nursing care to the residents and supervises the day-to-day nursing activities performed by nursing assistants. The person holding this position is delegated the administrative authority, responsibility, and accountability for carrying out the assigned duties and responsibilities in accordance with current existing federal and state regulation and established company policies and procedures to ensure that the highest degree of quality care is maintained at all times." (B)	S9999		