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
	IL6005227	A. BUILDING: ______ B. WING ______	C 11/17/2023

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
S 000	Initial Comments Complaint Investigation 2385225/IL165068	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.690a) 300.1210b) 300.1210c) 300.1210d)1)3) 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 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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.

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:

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

These requirements were not met as evidenced by:

Based on interviews and records review, the facility failed to conduct an ongoing assessment

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of one resident (R4) following an incident, out of 3 residents reviewed for improper nursing care. This failure resulted in a delay in care for R4, who sustained a left femur fracture, causing R4 to suffer pain level of 10 out of 10 and not receiving care for the fracture until being sent to the hospital on 9/30/23.

Findings include:

On 11/14/23 at 09:50 AM, R7 stated, "It wasn't like a big sound; it was more like R4 slid in slow motion to the floor. It was not a hard fall. R4 has fallen before. I called the nurse (R7's room is right in front of the nursing station). They came right in. I don't remember their names. I think it was an agency nurse and a Certified Nurse Assistant (CNA). They pulled R4 up and put her in bed. R4 was yelling "my leg, my leg" in Spanish. I called R16 (CNA)to translate. R16 is the one who said R4 was saying my leg in Spanish. R4 was sitting in the floor because I could see her legs and her shoulder. I saw her leg, there was nothing there, there was no visible injury at that time. I put the sheet on her. I saw her leg and there was no visible bruise or anything there. I think it was evening. The niece (V43) came in the next day and uncovered R4's leg and it was black and blue and swollen. I think she slid out of bed. The fall was on the west side of the bed. V45 (nurse) didn't know about the fall; apparently the nurse (V46) did not write it in the chart. V45 was worried V45 was getting in trouble because nobody wrote down as an accident. We have a lot of agency people."

On 11/14/23 at 10:20 AM, R8 (R4's roommate) said R4 fell and had just come out of the hospital. R8 said, "I heard when she (R4) fell. She was laying down in the floor. R7 called the nurse to

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help R4. R4 wasn't yelling."

On 11/14/23 at 12:31 pm, V43 (R4's Power of Attorney/niece) stated, "(R4) fell on September 29th, Friday night. It was after dinner because the roommate, R7 told me. R7 said she heard the fall. I went to visit R4 just to make sure everything was okay with her. I arrived there on 9/30/23 around 3:30 pm and it was a normal visit. No one had called me. I found R4 distressed, she was showing pain in her facial expression, she was grimacing, about to cry, and she was saying that she was in pain 10 out of 10. R4 said in a shaky voice that she had fallen last night. When I asked where, she showed her knee, and it was black. I told V45 (Nurse) and he said, "no, she didn't fall," and that no one had reported it. V45 continued denying the fall. 'I said look at her knee!' Several people, including Certified Nursing Assistant (CNA), said they thought it was strange that R4 hadn't gotten up that day and wasn't in the dining room for breakfast and lunch. Someone said R4 complained of pain, and they gave her Tylenol, but I don't think they checked why she was in pain. The case manager, V25, came after I talked to V45. V45 called V39 (nurse coordinator) and V25 (case manager). V25 went to see R4, they couldn't believe R4 had fallen that bad and hadn't been reported. They called the ambulance, which I waited for 6 hours. When R4 arrived at the hospital, she had not been treated for a femur fracture for 24 hours. When I arrived, her leg (R4) was swollen, and she smelled like urine. After I made a big deal, everyone was there. The CNA was changing her. I helped them change R4 and noticed her feces was dry and stuck to her butt. The urine was already dry on the bed. I don't know, but this wasn't her first fall. R4 had fallen several times, I know that. Every time she fell, they called me, so I was surprised when she fell,

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S9999	Continued From page 4 and they didn't call me." On 11/14/23 at 01:53 pm V17 (nurse consultant) stated, "In case of fall we have to do neuro checks and observation for 72 hours after the fall. Since we have 12 hours shift, it should be twice a day, every 12 hours, and as needed. We must stay with resident. The nurse should do the assessment, check if there is no injury or pain that it is a concern. The nurse should move the resident up off the floor with the Hoyer lift. If there is a concern of injury, we are not moving the resident and should let the doctor know and transfer to ER per MD orders. The assessment should include a skin check, range of motion, pain, neuro checks. We would ask the resident to move the extremities, see if the resident is in the base line. If there is any pain indication, such as touching their limbs, grimacing or showing any other signs of pain. The assessment should be one time initially, neuro check should be 72 hours and the range motion checking while you're doing the neuro checks. As needed, we should check if the resident is complaining of pain or you see anything that is abnormal. We should check based on that. If a fall happened after dinner time, we should check again the next day morning. Neuro checking should be every time 30 minutes for a certain time and then, after 12 hours. We also check the range motion since you are there, you want to access your resident, see if there is any change of the baseline assessment. I believe they are doing the neuro checks on paper. Obviously, there should be progress notes. For a fall there is a document on the portal. A risk management is different for fall risk assessment form. It tells you what happened and what and actions taken, if there any statement, family notification, we put it in there. We did report it to the State agency. If someone is in the floor, they need to report to lets us know so you can guide	S9999		

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them. The CNA should report to the nurse, the nurse report to the doctor. At minimum the nurse assesses the resident and let the family knows and call the doctor. What I do know is that we observed a skin alteration and swollen of R4's leg and she was having pain. We sent her to the hospital for evaluation since she had an injury. The resident herself (R4) said she had fallen. I believe she said to the family in the day she was sent out. That is the day she said to staff. Maybe she thought she fell, and it was a misinterpretation is what the staff told us is in the risk manager report".

Surveyor asked to whom R4 verbalized she had fallen, V17 said, "I don't know could be the niece, but she verbalized in general, she had a fall. I don't know if she is falling risk. There should be a fall risk form completed, care plan and intervention should put in place."

On 11/15/23 at 11:39 am V17 said, "We found out about the incident on 9/30/23, the day of the incident report was filled out. The incident report is our investigation. The incident report contains the name of the nurse who was at the facility when the incident happened".

On 11/15/23 at 12:12 PM V34 (CNA) stated, "The nurse asked me to help her pull the resident. The bed was flat. R4 was lying at the bottom of the bed. I'm not sure who helped before. When I got there R4 wasn't on the floor, she was lying at the foot of the bed. We grabbed the chucks (disposable pads) and slid her up. The resident was saying "dolor" and she was kind of holding her leg, I said to the nurse "I think she is saying she is in pain". The nurse said I already have pain meds for her. I'm pretty sure it was around 9:50-10pm because I had done my work and was

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available and that's why I helped the nurse. I was not the CNA for R4. V18 was the CNA assigned to R4. The only thing I noticed she was holding her leg and saying "dolor". R4 is easy going and never complains. R4 is not one of those people who yells. Once I saw her saying pain out loud and she was trying to get my attention (V34 then demonstrates with body language how R4 was trying to get her attention by touching V34 in his arms), so I knew that she was in pain. I told the nurse what she meant by 'dolor' because I don't think the nurse understood. I spoke to V39 almost a week later. That happened on Friday, and I think I came back Tuesday. V39 asked me what happened. V39 asked if I remember coming into the room because they checked the cameras. I told them that the nurse had asked for general help and I told V39 what I saw."

On 11/15/23 at 2:22 pm, V25 (Social Services) stated, "As I recall, the POA (V43) was there and had reported to staff in general, that R4 was in pain and her leg was swollen and bruised. V39 was there and we both noticed that R4 had a bruise on her knee. They (nurses) were giving her pain meds. I saw a big bruise on her knee and they (nurses) were doing everything they have to do to send her to the hospital. When I saw R4 she was in kind of pain. If there is any family concern, we (social services) got involved. That's why they called me. I spoke to V43 and let her know we would send R4 to the hospital and update her on any changes."

On 11/17/23 at 12:06 V39 (Nurse Coordinator) stated, "At the time I was made aware is the time I charted. V24 (RN) came to get me, but V45 (RN) was the nurse in charge of R4. V24 told me they wanted me to look at R4, to assess R4. They did not say R4 had a fall. I looked in R4's leg.

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R4's leg was swelling, warm and bruised. I initiated an investigation to see what may have caused the injury. I notified management and I interviewed staff that were working that day and went back to see who was working the day before. They told me R4 did not fall, that she was not complaining any pain and they didn't observe her in the floor. The staff notified me because R4's leg was swelling. I don't know how the staff learned about the swelling. The niece maybe told them. All this information is in the incident report. The incident report form is the investigation. I don't remember, the exact date I reported to Illinois Department of Public Health (IDPH) but was in the frame which is in 24 hours When I saw R4 she was complaining of pain, and I called the NP and got an order for pain medication. The pain level R4 was presenting is the pain level documented in the pain assessment. I assume a bruise, and swelling is a type of injury. I wasn't sure what had cause it, not at the time. Based on the investigation, it was concluded that she potentially could had hurt herself when she is scooting or trying to sit on the side of the bed. She was not observed on the floor. I interviewed all the staff and they did not observe R4 on the floor. I also spoke with roommate who did not observe either. I spoke with the nurse from the previous shift (V46), and she said there was no fall and no need for documentation. I think the nurse had been repositioning R4 by herself the first time, and then called for assistance from another staff the second time. R4 had a knee replacement and femur, she has severe osteopenia. R4 did not fall. The reason of the delay in transfer R4 to hospital, would be the transportation. I have no control of that. I called for the ambulance. I don't remember the time. I think the nurse documented it".

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V39 stated regarding V39's expectation of what the nurse should have done or not done, "I think the nurse (V46) did what was supposed to be done. The nurse ultimately assessed the resident for pain, and it there was no obvious sign, bruise or swelling. Ideally, the nurse should have written a note saying what she did. Because there is no observation the resident was in the floor, she did not document it."

R4's progress notes reviewed and there is no documentation dated 09/29/23 in regarding any incident or R4's complaining of pain.

Pain Review documentation dated 9/30/23 at 4 pm documents R4 was presenting pain 10/10 with pain documented 1-2 days, non-verbal pain scale showing "hurts a whole lot", face expression, site lower left extremity/knee and saying the pain had initiated the day before and it was constant, and the pain last since the last night.

The medication Administration Record (MAR) review shows no medication for pain was given to R4 on 09/29/23. MAR documents pain scale is documented as zero, no pain on 9/29 on both 12 hours shifts, and zero in the 12 hours (7 am -7pm) of the 9/30/23. V46 (nurse) documents pain zero on 9/29/23 second shift - no pain med given at any time. There is no pain medication recorded as given on 9/29/23 7 pm to 7 am PRN (as needed).

MAR documents pain was documented on 9/30/23 on the second shift as level 6 (moderate) and acetaminophen was given on 9/30/23 at 20:47 pm. MAR documents pain medication (Norco) was given on 9/30/23 at 05:49 pm after facility made aware by R4's niece of R4's leg

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injury.

Physician Order sheet shows order for Norco 10-325 mg one time for left knee dated 9/30/23 at 16:05

R4's progress note dated 10/1/23 at 05:24 am reads: Writer spoke with RN and was informed resident will be admitted for a traumatic femur fracture. NOD made aware.

R4's progress note dated 10/1/23 at 08:49 AM signed by V 39 reads: Nurse Practitioner updated on resident's status, communicated resident admitted to IMMC with diagnosis traumatic femur fracture.

Hospital records reads: R4 is an 83-year-old female with past medical history of dementia, hypertension who presents status post unwitnessed fall at nursing home. Per Emergency Medical Services (EMS), nursing home residents reported hearing patient yelling for help last night. Unclear from Nursing Home report whether pt fell. Power Of Attorney (POA)/patient's niece visited patient today and called EMS due to pt's complaint of headache and Left knee pain. Mental Status at baseline per POA.
Impression and plan: Injuries: Left intra-articular distal femur fracture. Consults: Orthopedic Surgery
Procedure: Left complex total knee arthroplasty with distal femoral replacement
Exposure: Left knee swelling and ecchymoses;
Physical exam: Musculoskeletal: Left knee swelling and ecchymoses, left thigh swelling. Left thigh compartments soft and compressible.
Pre -op diagnosis: Left commuted distal femur fracture and left knee arthritis; Procedure: Left complex total knee arthroplasty with distal

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femoral replacement.

Facility policy titled Incidents/Accidents/Falls reads"
Policy: It is the policy of the facility to ensure that any incident/accident to include falls is reported immediately to the nurse or appropriate person designated to be in charge. After the resident has had immediate attention and their safety is established, a written report will be entered into Risk Management (usually Risk Management section of pcc). The facility will ensure that incidents and accidents that occur involving residents are identified, reported, investigated, and resolved. The facility will create a data base related to incidents/accidents as part of the QAPI process to enable trending and tracking. This information will be used to implement corrective actions to include any needed training to prevent reoccurrences when possible. It will be part of the QAPI (Quality Assurance-monthly meeting) Agenda.
Procedure:
3. The nurse responsible for the oversight and care of the resident will complete an incident/ accident report (usually Risk Management section of PCC). When possible, a descriptive statement(s) will be obtained from the resident and/or any witnesses,
6. The incident/accident report will be completed as soon as information is obtained. The report should be finished as much as possible before the nurse ends the shift. The nurse who completes the report is the nurse who signs the report. An exact description of the circumstances (not opinion or conjecture) surrounding the incident/accident are to be documented.
9. Documentation of the physical and mental status of the resident(s) involved will be

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S9999	Continued From page 11 completed each shift (every 8 hours minimally) over the next 72 hours or until the resident(s)'s condition improves. Neuro checks will be completed after any head trauma as well as after any unwitnessed fall (even if the resident states they did not hit their head) as per policy. 10. The occurrence is to be communicated shift to shift as part of the report until the resident is stabilize. (A)	S9999		