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
	IL6007843	A. BUILDING: ______ B. WING ______	C 11/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALOS HEIGHTS REHABILITATION	13259 SOUTH CENTRAL AVENUE CRESTWOOD, IL 60418

(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 Investigations: 2397876/IL164637 2396393/IL162723 2396757/IL163228 2395277/IL161366 Facility reported incident of 04.13.23/IL158957 Facility reported incident of 09.07.23/IL164547	S 000		
S9999	Final Observations Statement of Licensure Violation: One of Two 300.610a) 300.1010h) 300.1210a) 300.1210b) 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 300.1010 Medical Care Policies	S9999	Attachment A Statement of Licensure Violations	

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h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act).

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

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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.

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to utilize two persons assist for bed mobility (R1), failed to utilize a gait belt to assist with transfers (R18), failed to ensure wheelchair leg supports were in place during transport (R9), and failed implement an effective plan to prevent or reduce the risk of falling with injury for a resident identified to be at risk for falling out of bed (R13). This affected (R1, R9, 18, and R13) reviewed for safety during care and fall prevention interventions on the sample list of 21. This failure resulted in R1 rolling off the bed onto the floor while staff was providing care. R1 sustained an impacted/displaced fracture to the left upper arm with abrasion to the left knee and toe. R9 sustained a closed nondisplaced fracture of the metatarsal bone of the right foot while being transported in the wheelchair by staff, and R13 being involved in an unwitnessed fall incident sustaining a closed displaced fracture of the right femoral neck and closed fracture of the orbital of

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the right zygomatic bone.

Findings Include:

1) R1 had the diagnosis of need assistance with personal care, reduced mobility, muscle wasting and atrophy, dizziness and giddiness. Minimal data set dated 3/9/23 documents: section C (cognitive pattern) documents a score of fifteen which indicates cognitively intact. Section G (function status) documents: R1 required extensive assistance with two person physical assist with bed mobility (how resident moves to and from lying position, turns side to side and position body while in bed) and toilet use. R1 care plan dated 1/25/23 documents: R1 is at risk for fall due to general weakness.

On 10/20/23 at 11:28am, R1 who was assessed to be alert to person, place and thing said, she had diarrhea, V4 (cna) was providing incontinence care. V4 rolled her over but she was not over far enough. R1 said, she did not having any bed rails. V4 rolled me over little more, R1 said, her legs started too slid off the bed. R1 said, she fell out the bed, hit the radiator then the floor on her left side. R1 said, she hit her head, skinned her knee and fractured her shoulder and elbow. R1 said, her pain was a ten out of ten. R1 said, staff caused her more pain by trying to get her up off the floor. R1 said, she could not straighten up her left arm.

On 10/24/23 at 10:15am, V9 (nurse) said, V4 (cna - certified nursing assistant) informed me, R1 had fallen off the bed. R1 was on the floor against the wall and complaining of shoulder pain, we could not get R1 up off the floor based on R1's position. V9 said, she had to call 911. V4 was the only cna in R1's room providing care. R1

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required two person assist with being changed/ incontinence care and transfers.

On 10/24/23 at 11:24am, V10 (ADON- Assistant Director of Nursing) said, if a resident requires two person assistance with bed mobility and toileting means two staff members need to assist with those items/bed mobility and toileting.

Progress note dated 4/13/2023 documents: (V9) Writer was called into (R1) patient's room by (V4) cna. V9 went into room and observed R1 lying on the floor against the wall next to bed on her left side. V9 asked R1 what happened and R1 stated, "I was lying on my side while V4 was changing me and when I was going to lay back my hand gave out and I fell off the bed. R1 said, she hit the back of her head and complained of left shoulder pain ten out of ten. Unable to get R1 off the floor with mechanical lift due to position R1was lying on floor. 911 called.

Event Report dated 4/13/23 documents: witnessed fall. Location of injury: left should pain, range of motion painful/limited in upper extremity and rotation/deformity of upper left extremity. First aid-immobilize/splint area. Sent to emergency room for evaluation.

Incident Investigation: R1 explanation of the incident: slid of the bed. Mode of transfer: two staff maximum.

Fall observation dated 4/13/23 documents: V4 was present in room at the time of fall. R1 fell off the bed. Two person assist.

Fall root cause analysis form dated 4/13/23 documents: root cause determination: slid out of bed during changing. New Interventions and

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recommendations need to be implemented: Staff educated to use two person assist with transfer and change.

Facility reportable dated 4/20/23 documents: R1 expressed, I'm sliding, I'm sliding and reached out to brace herself on the wall that was a few feet from the bed.

Hospital paperwork 4/13/23 documents: R1 presented with to the emergency room after a fall causing injury to head and left shoulder. R1 rolled on the bed on her side with the help of the side earlier this morning. R1 rolled over all the way, left shoulder, left side of forehead to floor with no loss of consciousness but R1 complained of pain to left shoulder with decreased movement. Chest x-ray of R1's left should showed evidence of an acute fracture was noted in the humeral head (upper arm) extending from the humeral tuberosity (the bump of bone at top of the upper arm that serves as the attachment for two rotator cuff muscles) to the humeral neck which is impacted and displaced (shift out of placed). R1 also had an abrasion to anterior left knee and left toe.

2) R9 was diagnosed with generalized osteoarthritis, intervertebral disc degeneration (lumbar region) difficulty walking and restless leg syndrome.

On 11/02/23 at 2:21PM, R9 who was assessed to be alert to person, place and time said, she was being pushed in her wheelchair to physical therapy by V27 (restorative aide). R9 said, she had one foot crossed over the other with both of her legs raised/extended out in front of her. R9 said, her legs got tired, her right leg slipped down, buckled underneath the wheelchair and she fell

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forward landing on her knee.

On 11/7/23 at 2:41PM, V26 (restorative nurse) said, R9 was being pushed in the wheelchair by the V27. R9 was holding her feet up. R9's foot drop while she was being pushed causing her to fall forward out of the wheelchair. R9 did not have any leg rest because she normally self -propel. R9 should have had leg rest while being pushed.

On 11/7/23 at 3:02PM, V27 said, she was pushing R9 from unit one to unit two, R9 normally does not get tried. R9 was holding her legs out and up in front of her, flipped over and fell out the chair hitting her knee first on the ground.

Progress note dated 9/7/23 documents: R9 stated, I fell. I fell right knee first, my right ankle twisted a little bit but I'm fine I didn't hit my head or anything my brain is still intact, my right foot got stuck under the chair as I was being pushed by restorative (V27). R9 denied pain, I get a pain pill in couple of hours. NP (nurse practitioner) made aware ordered x-ray of the right knee/ankle.

Post fall observation dated 9/7/23 documents: root cause of the fall: R9's right foot got stuck under her wheelchair while being pushed down the hall. Witnessed V27.

Additional fall follow-up questions dated 9/7/23 documents: V27 was pushing R9 in wheelchair, told R9 to hold legs up and let V27 know if legs get tired. V27 was pushing R9, R9 placed her foot on the floor and fell forward without warning landing on the floor.

X-ray results dated 9/8/23 documents: right knee: soft tissue swelling with uncomplicated revised

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right knee arthroplasty. Right ankle: findings are concerning for an acute to subacute, avulsion fracture of the avulsion fracture of anterior talus.

Hospital paperwork dated 9/8/23 documents: Reason for visit: fall, knee/ankle injury. R9 said, she is wheelchair-bound for issues with mobility and that she was being wheeled by a CNA yesterday. R9 states, that her feet were not resting on the foot rest and that they got dragged under her and she fell forward onto her knees and twisted her right ankle. R9 denied utilizing her hands to stabilize herself. R9 said, she was feelings pain mainly at the top of her foot where her shoes lay. X-ray right foot documents: Closed oblique nondisplaced fracture of metatarsal bone of right foot (5 digit).

Assisting a client to use the wheelchair not dated given was created after R9's fall.

Employee in-service dated 9/10/23 documents: All residents must have leg rest on their wheelchair during transport.

3) R18 was diagnosis with Dementia, cognitive communication deficit, hemiplegia and hemiparesis following unspecific cerebrovascular disease affecting right dominate side, abnormalities of gait and mobility, repeated falls, need for assistance with personal care, muscle wasting and atrophy. Minimal data set section C (cognitive pattern) brief interview for mental status dated 10/12/23 document a score of eleven which indicated moderately impaired. Section G (functional status) dated 4/11/23 document: R18 need extensive assistance with one person physical assist with transfers. Balance during transitions and walking documents: surface to surface transfer (transfer

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between bed and chair or wheelchair) not steady, only able to stabilize with staff assistance. Quarterly Observation dated 4/18/123 documents: R18 was at high risk for falls.

On 11/2/23 at 12:56PM, R18 who was pleasantly confused, said, she was in the shower by herself, had a fall and an unknown female co-peer helped her up off the floor.

On 11/3/23 at 1:13PM, R18 was observed being transferred from the wheelchair to the bed safely by one staff member who used a gait belt.

On 11/7/23 at 1:08PM, V25 (cna) said, she transfers R18 safely by herself utilizing a gait belt.

On 11/07/23 at 1:22PM, V23 (cna) said she, (on 6/16/23) was transferring R18 from her wheelchair to the shower chair, She instructed R18 to hold on to the shower bar, told R18 they were getting ready to turn/pivot, as R18 turned, R18 fell down. V23 said, she did not use a gait belt with R18's transfer.

On 11/7/23 at 2:55PM, V2 (DON- Director of Nursing) said, CNA's must use a gait belt for all transfers to help support the resident and break falls.

Nursing note dated 6/16/23 documents: V23 (cna) notified writer that while assisting R18 to the shower chair the R18's knees buckled. V23 helped lower R18 to the ground. R18 complained of leg pain.

Event report dated 6/16/23 documents: While assisting R18 to shower chair, R18's knees buckled and V23 help lower R18 to the ground.

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Fall root cause analysis dated 6/16/23 documents: R18 knees buckled during transfer to shower chair. Incident Investigation documents: Resident's explanation of incident: My legs gave out. Activity: getting ready for shower. Aide with resident at the time of event.

Gait belt policy dated 2/23 documents: a gait belt is a safety device made of cloth that buckles securely around a resident's waist. The device provides a secure grasping surface to aid during transfer and ambulation. Commonly used for residents who are at risk for falls and those who require assistance during transfers. A gait belt can support a lower to the floor if the resident begins to fall or loses balance during transfer or ambulation. If the resident has one side weakness, position the destination surface (wheelchair, commode or chair) on the resident's unaffected side, grasp both side of the using an underhand grip.

4) R13 was admitted to the facility on 1/8/2023 with a diagnosis of anemia, hypothyroidism, hypertension, atrial fibrillation, history of falling, and osteoporosis.

R13's minimum data set dared 6/6/23 under functional status bed mobility (how a resident moves to and from a lying position, turns side to side, and positions body while in bed documents a score of 4 for self-performance which indicates total dependence- full staff performance every time during entire seven day period under support a score of two which indicates one person physical assist

R13's point of care charting dated 7/13/23 documents under how resident moves in bed a score of four which indicates total dependence;

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S9999	Continued From page 10 Staff support provided for bed mobility documents a score of two which indicates one-person physical assist. R13's fall care plan interventions dated 9/8/22 documents: implement exercise program that targets strength, gait and balance; increased staff supervision with intensity based on resident need; obtain order for vitamin D, provide individualized toileting interventions; assessment and treatment for postural hypotension. R13's fall investigation dated 7/14/23 documents: was the cause of the fall known- No resident was in bed during sleep hours; Activity at time of fall- laying in bed; what fall interventions are listed on care card- documents not applicable for all except low bed which is not checked and documents error. floormat which documents started intervention placed on care card; were the interventions in place working at the time of the fall documents not applicable. What did the resident say they were trying to do or where were they going- she did not know how she fell. Under incident investigation documents resident explanation of incident- Roll out of bed. R13's fall risk assessment dated 10/24/21 documents a score of 13. Total score of 10 or above deems client at risk: initiate precautions R13's physical therapy plan of care dated 4/12/23 documents under mobility roll left to right prior level substantial/maximal assist-helper does more than half the effort. Helper lifts or holds trunk limbs and provides more than half the effort; under current level resident refused. R13's final fall reportable dated 7/25/23 documents: Upon further investigation, it has been determined that R13 experienced a fall	S9999		

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while attempting to self-reposition and resident rolled over causing a change in plane. Staff were interviewed and were able to confirm that R1 was laying in bed with her call light within reach prior to fall. Per staff interviews R13 had received peri care 15 minutes prior. Upon interview R13 was unable to recall how she fell and was not able to communicate additional events surrounding the fall. R13 was heard yelling out by CNA while rounding and upon entry to the room R13 was observed lying on her right side on the floor parallel to the bed on top of the metal base of bedside table wrapped in bed linen. CNA notified nurse for further assessment. R13 was immediately assessed, and first aid care rendered. R13 was sent to Emergency room for further evaluation and treatment. R13 returned to the facility with diagnosis of closed displaced fracture of the right femoral neck, nondisplaced fracture along the temporal process of the right zygoma, and adjacent fracture of the right lateral orbital wall.

On 11/7/23 at 1:44PM, V26 (restorative nurse) said R13 had been provided incontinence care about 15 minutes prior to fall. Staff was in the next room when they heard R13 fall. R13 was wrapped in her sheets and rolled out of bed. No side rails on bed and unclear if any halo bar in place. When asked how did R13 roll out of bed when she needs assistance with bed mobility, V26 said she was unsure.

On 11/7/23 at 3:42PM, V28 (Certified nursing assistant,CNA) said she provided incontinence care to R13 and roommate between four and five in the morning. R13 preferred to sleep in a fetal position and said R13 was in the middle of bed and bed in lowest position upon leaving the room. V28 said she went to the next room across the

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hall and heard help me and saw R13 on the floor in fetal position on top of bedside table base. Nurse came and she was assisted back to bed. She had a call light and can use it if she needs assistance, no behaviors that day, no changes observe that shift.

On 11/8/23 at 12:34PM, V32 (rehab director) said R13 was dependent on staff for transfer and bed mobility in April of 2023. Rolling R13 refused but previously required a maximum assist.

On 11/21/23 at 9:27AM, V49 (nurse) said she was nurse on duty at time of incident. V49 said staff informed her that R13 had a fall and when she entered the room, R13 was on the floor next to her bed on the bottom part of the bedside table. V49 said R13's bed was not in the lowest position but was not super high, unable to give any further details.

R13's hospital record dated 7/14/23 documents under visit diagnosis: closed displaced fracture of right femoral neck and closed fracture of orbital portion of right zygomatic bone

According to national library of medicine dated 6/27/22 fracture of zygoma is the second most common fracture of the face which can cause significant cosmetic and functional deformity. Fractures of the zygoma are almost always the result of high impact trauma. The most common mechanisms are assault, motor vehicle collisions, falls and sporting injuries.

(A)

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Two of Two

300.1210a)
300.1210b)
300.1210d)6)

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act).

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

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	IL6007843	A. BUILDING: ______ B. WING ______	C 11/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALOS HEIGHTS REHABILITATION	13259 SOUTH CENTRAL AVENUE CRESTWOOD, IL 60418

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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 interview and record review, the facility failed to supervise and monitor a resident with a history of wandering behavior (R12). This affects two of three residents reviewed for supervision and safety on the sample list of 21. This failure occurred when (R12) wandered into (R11's) room and resulted into a resident-to-resident altercation, R12 hit R11's arms with a remote control, and R11 hit R12 back on the hand.

Findings include:

Facility Initial reported incident, dated 8/25/23 reads in part: R11 was sitting in R11's room reading and R12 independently wheeled in and approached R11's table that was next to R11. R12 started reaching for things and R11 reports that R12 hit R11, so R11 hit R12 back. R11 yelled for help and the staff immediately intervened and came to help R12 out of R11's room, R11 has a broken fingernail. Body checked refused by R11 and R12 will be completed. No other injuries noted at this time. Investigation initiated.

Final report reads in part: R11 claims R12 came in to R11's room and hit R11 with remote control and the bedside table was between them, it was

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S9999	Continued From page 15 also being pushed at R11. R11 claims she was defending self and hit R12 on the hand. R12 is blind and R12 was not aware R12 was in wrong room. R11 has had daily follow up with nursing and did develop a slight bruising to R11's right forearm. On 11/8/23 at 11:30AM, R11 reported that back in August, R11 was in her room, up on her wheelchair, next to her bed; and bedside table was in front of her. R11 stated she was reading and dozed off and when R11 opened her eyes, R11 saw R12 on his wheelchair in her room, right in front of her, and dragging R11's cup on R11's table. R11 yelled and told R12, "it is my cup, don't take it". R12 said to R11 "this is my cup and my room". R11 then reported that R12 grabbed the remote and hit R11's right arm, and so R11 reported in hitting the arm of R12 to stop R12 from hitting R11 with a remote. Maintenance passed by and saw the incident and reported it to the nurse. The nurse then took R12 away of R11's room. R11 also reported that two month prior to this incident, approximately Month of May 2023, same resident (R12) wandered in R11's room. R11 coming from her shower, R11 entered her room and saw R12 in her bed, asleep. R11 yelled and asked the staff to take R12 off R11's bed. R11 reported that there were two separate occasions when R12 wandered in R11's room. On 11/8/23 at 11:10AM, V14 (Unit Manger) stated that nurses are around and other staff to keep a close look and monitor R12. Our intervention is to toilet or ask R12 if R12 needs to lay down back to bed if observed wandering the unit. Staff would ask R12 if he needs to use the toilet or assist him back to bed. On /9/23 at 915AM V1 (Administrator) stated that	S9999		

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S9999	Continued From page 16 R11 reported the incident to V1. "I think R12 may have wandered in R11's room few times before, With R11 as soon as R12 enters room R11 was able to redirect R12, except from the last incident when R11 I believe reported she fell asleep and did not see R12 came in her room." Staff knew R12 is a wanderer. My expectation is for staff to monitor all of our wandering residents. Staff to redirect R12 if noted wandering in the hallway. R12 was going in the dining because it was about the time for dinner, nurse thought R12 was going in the dining for dinner but somehow ended up in R11's room. On 11/9/23 at 9:30AM, V2 (DON) R12 has blindness and staff to redirect. Continue to guide R12. Able to move around and to keep his independence but for staff to redirect if observe with wandering behavior in the unit. We also encourage R12 to participate in activity to be able to monitor and R12 to stay occupied and not wanders the unit. Care plan for R12 dated 8/25/23 reads R12 often wanders in his wheelchair and goes into other resident rooms. Intervention: Staff will provide activities for R12, activity boards, folding clothes. Music therapy etc. Care plan for R12 dated 5/17/23 reads R12 experiences wandering and at times takes things that are not his. Interventions: Maintain calm environment and approach R12, and remove R12 from non-patient areas and return items that R12 may pick up. Care plan for R12 dated 5/15/23 reads R12 experiences wandering (moves with no rational purpose, seemingly oblivious to needs or safety). Interventions: Wander guard for safety. Check	S9999		

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S9999	Continued From page 17 placement every shift; Approach from the front. Walk in step with R12 first before redirecting; If R12 looks for family/significant other, reassure that others know where to find him/her; Maintain a calm environment and approach with R12; When R12 begins to wander, provide comfort measures for basic needs such hunger or toileting; And when R12 becomes physically abusive, stop and try later. Do not force to do task. Care plan for R12 dated 3/2/23 reads R12 experiences wandering by entering rooms of his peers and attempt to lay in their beds. Interventions: Approach from the front. Walk in step with R12 first before redirecting; and when R12 begins to wander, provide comfort measures for basic needs (e.g., pain, hunger, toileting, too hot/cold, restless etc). R12 progress notes reviewed dated 3/1/23 and reads in part: R12 was seen in the bed of another resident. Incident was reported to R12's nurse. Other resident was not in the room at the time of this incident. (B)	S9999		