STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015630	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEKALB COUNTY REHAB & NURSING	2600 NORTH ANNIE GLIDDEN ROAD DEKALB, IL 60115

(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 Facility Reported Incident of January 10, 2024 IL169113	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)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 resident to meet the total nursing and personal	S9999		

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S9999	Continued From page 1	S9999		

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 are not met as evidenced by:

Based on interview and record review, the facility failed to ambulate residents with the assistance of a gait belt to ensure residents were ambulated in a safe manner. This failure applies to 2 of 4 residents (R1, R2) in the sample of 4 reviewed for safety and supervision. This failure resulted in R1 falling while ambulating with staff, resulting in R1 fracturing her left femur (upper leg) and requiring hospitalization.

The findings include:

1. The facility's Witnessed Fall incident report, dated 1/10/24, showed R1 was walking in her room, with the use of her walker and with V7, Certified Nursing Assistant (CNA), present, when R1's "knees buckled" and R1 fell to the floor. The report showed R1's left leg got caught under a bedside dresser during the fall. R1 complained of pain to her left leg. 911 was called. R1 was transferred to a local hospital via ambulance.

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R1's hospital records, dated 1/11/24-1/15/24, were reviewed. The records showed R1 was admitted to the hospital with a diagnosis of a "displaced distal femoral fracture" after sustaining a witnessed fall at the facility. R1 was discharged from the hospital on 1/15/24, when she returned to the facility.

R1's Fall Scale assessments, dated 10/25/23 and 1/10/24, each showed R1 was at high risk for falls.

R1's care plan, revised on 10/25/23, showed R1 was at risk for falls due to her history of previous falls, impaired cognition, weakness, and poor vision. The care plan showed, "I have a history of bilateral knee buckling during ambulation... " The care plan showed R1 required the extensive assistance of one staff, with the use of a gait belt, for all transfers and ambulation. R1 was cognitively impaired related to her diagnoses of dementia and Alzheimer's disease.

On 1/24/24 at 8:30 AM, an attempt to interview R1 about her fall on 1/10/24 was unsuccessful, due to her impaired cognition.

On 1/24/24 at 9:18 AM, V7, CNA, stated she was the only staff member with R1 when she fell on 1/10/24. V7 CNA stated she did not have a gait belt on R1 when ambulating her on 1/10/24. V7, CNA, stated, "I was walking with (R1). Her knees buckled and she went down. I think her left leg broke because it got stuck under the dresser. It happened so fast. I couldn't catch her. I should have been using a gait belt on her. She complained of pain to her leg right away."

On 1/24/24 at 9:35 AM, V8, Nurse, stated she

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was called to R1's room, by V7, CNA, on 1/10/24. V8 stated, "When I got to the room, (R1) was on the floor. She complained of pain to her leg. (V7) did not have a gait belt on (R1)."

On 1/24/24 at 11:11 AM, V4, Restorative Nurse, stated staff are to use a gait belt when transferring or ambulating any resident that requires any level of staff assistance to do so. V4 stated, "The purpose of the gait belt is for staff to help lower a resident to the floor, if they start to fall, to prevent any injury... Prior to (R1's) fall on 1/10/24, she required the assistance of one staff. with use of gait belt, when walking. She has a history of previous falls and her knees buckling when she walks."

On 1/24/24 at 11:01 AM, V5, Nurse Practitioner, stated, "Staff should refer to a resident's care plan or get report on how to transfer a resident. All staff should be using a gait belt when transferring or walking a resident. That is pretty much the standard."

2. The facility's Witnessed Fall incident report, dated 12/21/23, showed R2 was walking in her room, with V6 CNA, when "the resident lost balance and began to fall." R2 was assisted to the ground by V6 CNA. R2 received no injuries from the fall. The report showed, "Resident lost her balance while ambulating with staff. Staff to use gait belt..."

R2's Fall Scale assessment, dated 12/19/23, showed R2 was at high risk for falls.

R2's care plan, revised on 6/29/23, showed R2 was at risk for falls due to her history of repeated falls, impaired cognition related to her dementia diagnosis, obesity, and generalized weakness.

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S9999	Continued From page 4 The care plan showed, "I need limited-extensive assistance from one staff member with one of their hands on my gait belt during ambulation." On 1/24/24 at 9:40 AM, V6, CNA, stated she was the only staff member with R2 when she fell on 12/21/23. V6 CNA stated she did not have a gait belt on R2 when ambulating her on 12/21/23. V6, CNA, stated, "We were walking back from the bathroom. She was using her walker. (R2) started to lose her balance and went down. I tried to catch her and guide her to the floor. I grabbed her arm and under her butt to lay her down on the floor. I was not using a gait belt. I should have been." On 1/24/24 at 11:11 AM, V4, Restorative Nurse, stated R2 required the use of a gait belt, one staff member, and a walker when ambulating due to her history of previous falls. The facility's Transfer/Gait Belt policy dated March 2015 showed, "Gait belts/Transfer belts are to be properly used in the transfer and ambulation of any resident needing assistance with those activities." (A)	S9999		