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
	IL6013353	A. BUILDING: ______ B. WING ______	11/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

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S 000	Initial Comments Licensure Violations Complaint Investigations 2096793/IL126236 2098608/IL128238	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210d) 300.1210d)6) 300.3240a) 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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1	S9999		

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.

Section 300.1210 General Requirements for Nursing and Personal Care

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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

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S9999	Continued From page 2	S9999		

These Regulations were not met as evidenced by:

Based on interview and record review, the facility failed to ensure supervision and monitoring for a resident assessed as a high fall risk, failed to ensure that a resident was safely transported back to the facility with a medical transportation service and failed to ensure comprehensive fall investigations were conducted to prevent further falls which affected two residents (R5, R23) of four residents reviewed for falls in the sample. These failures resulted in R5 falling from a wheelchair, hitting her head on the floor and sustaining a subdural hematoma which required intensive care monitoring in an acute care hospital.

Findings include:

R23's Admission Record documents the following Medical Diagnoses: Covid, History of Falling, Hypotension, Lack of Coordination, Weakness, Hemiplegia/Hemiparesis affecting Left Side and Unsteadiness on Feet.
R23's Fall Risk Assessment dated 9/18/20 documents that for Mobility, R23 requires the use of a mechanical lift.
R23's Minimum Data Set (MDS) dated 9/30/20 documents that R23 is Cognitively Intact and requires extensive assistance from two plus persons physical assist for transfer.
R23's medical record documents that R23 was recently referred to physical therapy (PT) in September 2020 for bilateral lower extremity strengthening to improve functional mobility and

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S9999	Continued From page 3	S9999		

to enable R23 to safely maneuver and improve limb stability during transfers. The recommendation of PT on discharge was: Community Mobility = Wheelchair Management Max(imum) Assist.
R23 is care planned as a risk for falls related to history of CVA (Cardiovascular Accident) with left sided hemiplegia (paralysis), weakness, non ambulatory wheelchair bound, use of diuretic, DM (Diabetes Mellitus) and Hypertension. R23 is also care planned for potential of extreme fatigue and weakness due to Anemia.

On 11/4/20, V14 (Transportation Coordinator) confirmed that the medical transportation service that was arranged to transport R23 to her appointment on 10/28/20 was not the service that transported R23 back to the facility after her appointment. V14 indicated that R23's appointment went later than expected and that the medical transportation company could not come back for R23. V1 (Administrator) then set up for a non medical mode of transportation for R23 to return back to the facility.
On 11/4/20 at 4:06pm, R23 stated, "The driver let me go. He was pulling me up the ramp reverse style. Not pushing me up the ramp so that I'm leaning back. He was pulling me and I leaned forward and because there was nowhere to put my legs, those metal leg things weren't there, I leaned forward and fell on my head. He was pulling me backwards. We had made it up the hill (ramp) already and were getting ready to go in door and I fell. I slid out (of the wheelchair)."
On 11/4/20, V55 (Receptionist) confirmed the incident and stated that when she looked out onto the ramp, she saw R23 on the ground with the wheelchair tipped over and the driver standing next to R23.
On 11/4/20, V1, V2 (DON-Director of Nursing)

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S9999	Continued From page 4	S9999		

and V14 all confirmed that R23 required medical transportation to and from her appointment. V1, V2 and V14 confirmed that the transportation that returned R23 back to the facility was a non medical mode of transportation which put R23's safety at risk.
On 11/4/20, V14 indicated that Z54 (Family Member) contacted her to let her know that R23 would arrive at the facility in 20 minutes. Z54 indicated that she let V14 know the arrival time, as instructed by the facility, so that they could prepare for R23's arrival. V14 indicated that she did not report R23's arrival time to any staff because she had already left the facility for the day. V55 confirmed that she did not notify any staff when she saw transportation pull up to the front of the facility with R23. As a result, V2 confirmed that staff was not present to assist the transportation company in safely transferring R23 from the car into the facility.
On 11/5/20 at 12:52pm, V57 (Transportation Manager) confirmed that it was his company that had arrangements to transport R23 to and from her appointment. V57 stated, "We are a medical trained transportation company to handle skilled patients and all drivers are certified." V57 confirmed that at first they were not going to be able to pick R23 up from her late appointment but indicated that his company did show up and R23 was already gone. V57 indicated that this was communicated to the facility.

A facility Incident Report to the State agency dated 10/28/20 documents: "(R23) was returning to the facility from an appointment with transportation company. (R23) was noted by (V55-Receptionist) to have a fall while being transported by the transportation company."

R23 was transferred to an acute care hospital on

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S9999	Continued From page 5 10/28/20 to be monitored for a subdural hemorrhage. R23 returned to the facility on 10/29/20 without incident. During observation on 10/27/20, droplet precaution isolation for Covid-19 posted on resident door, R5 awake and alert in bed. During interview on 10/28/20, V11 LPN Licensed Practical Nurse stated, "I had my back towards her. The resident was behind me in the hallway next to the nurse's station. I did not see R5 fall. From what I was told, R5 was going to fall from the wheelchair. A CNA (Certified Nurse Assistant) ran to try and prevent R5 from falling. She wasn't able to get to her. I'm just going by what the CNA told me. I can't remember what CNA it was. The CNA's are assigned to all of our residents. R5 had a hematoma to her head, I sent her to the hospital." During interview at 9:52 AM, V2 DON Director of Nursing stated, "She was near the nursing station and started to lean forward and she fell from the seat of the wheelchair. R5 would reach on the floor, she would see something and reach forward to pick it up. She would take naps in her wheelchair, so we would lay her down." During interview at 10:53 AM, V21 Restorative Nurse stated, "R5 is on the dementia unit, she needs assistance with her wheelchair. Everyone on that unit requires some type of supervision." During interview on 10/29/20, V2 DON Director of Nursing confirmed that formal fall investigations were not conducted in order to find the root cause analysis of the falls and that everything was conducted verbally and not documented.	S9999		

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S9999	Continued From page 6	S9999		

During interview on 11/4/20, V29 C N A Certified Nurse Assistant stated she did not see R5 fall because she was taking care of other residents.

Inquired V21 of interventions that would have prevented R5 from falling from the wheelchair. V21 stated, "Increased monitoring and to be within reach of the staff. She could be at the nurse's station or in the dining room close to the staff. If someone was close they could have pulled her back."

R5's progress notes from V48 Medical Doctor states: Patient seen and evaluated on 06/13/2020. A/P (anatomy/physiology) 1. CVA (cerebrovascular accident): monitor and assist patient, fall precautions, continue therapy as tolerated. 5. Fall precautions: monitor and assist patient.

Record review of R5's progress notes on 6/28/20 states: R5 fell from wheelchair while sitting in the common area. Resident observed slowly leaning forward with risk of falling. Staff unsuccessfully rushed to her to prevent fall. Resident landed on face resulting in hematoma to her right eyebrow area. Resident sent to hospital for CT (computed tomography) scan.

The post occurrence documentation states R5's vital signs, completed body check, hematoma, description of occurrence, notification to family and physician and R5 sent to the hospital. There are no statements from staff regarding the fall incident.

R5's hospital report on 6/28/20 states: diagnosis of subdural hematoma. R5 required intensive care monitoring while hospitalized.

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S9999	Continued From page 7	S9999		

R5 had 2 fall incidents this year: 3/14/20 and 6/28/20. On 5/20/20 R5's BIM score=4; unable to interview. On 7/29/20, R5's BIM (Brief Interview for Mental Status) score=3; unable to interview.

R5's care plan states: noted at risk for falls r/t impaired balance, impaired vision related to cataracts, dementia, history of falls, unsteady gait, Left hemiplegia, occasional incontinence, HTN (hypertension), depression, arthritis, pain and Seizure Disorder.

The care plan interventions state: Monitor resident for tolerance and endurance. Encourage resident to Call, Don't Fall. Encourage R5 to ask for assistance in reaching for items on floor and items out of her reach. Offer reacher, remind and encourage resident to use reacher to pick things up from floor.

R5's post fall care plan intervention on 6/28/20 states: offer rest periods in bed as needed.

R5's 4/21/20 physical therapy assessment states: wheelchair mobility=Supervised. Risk Factors: due to the documented physical impairments and associated functional deficits, the patient is at risk for: falls, further decline in function, decrease in level of mobility and decreased ability to return to prior level of assistance.

R5's 4/23/20 occupational therapy summary states: patient presents with impairments in balance, fine motor coordination, gross motor coordination, sensation, mobility and strength resulting in limitations and/or participation restrictions in the areas of general tasks and demands, mobility and self-care.

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S9999	Continued From page 8	S9999		

R5's 3/14/20 Fall Risk Assessment states: score=12 High Risk, post fall, mobility-unsteady gait and/or use of ambulatory device (wheelchair), decreased muscular coordination (jerky movements), impaired memory or judgement, history of 1-2 falls in the past 3 months, medications that have a diuretic effect or GI (gastrointestinal) motility, affect the thought process and create a hypotensive effect.

The 5/20/20 Fall Risk Assessment states: score=9 At Risk, significant change, mobility-unsteady gait and/or use of ambulatory device (wheelchair), impaired memory or judgement, history of 1-2 falls in the past 3 months, medications that have a diuretic effect or GI (gastrointestinal) motility, affect the thought process and create a hypotensive effect.

The 6/28/20 Fall Risk Assessment states: score=5 At Risk, post fall, decreased mobility, impaired memory or judgement and requires total assistance with elimination.

The 08/2020 Management of Falls states: Policy: The facility will assess hazards and risks, develop a plan of care to address hazards and risks, implement appropriate resident interventions, and revise the resident's plan of care in order to minimize the risks of fall incidents and/or injuries to the resident.

Procedure:
3. Develop a plan of care to include goals and interventions which address resident's risk factors. Risk factors may include but are not limited to the following: Contributing diagnoses/disorders/disease processes/active infections/ other comorbidities, history of fall incidents, incontinence, medications (narcotic,

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S9999	Continued From page 9	S9999		

antihypertensives, etc.), assistance required with ADL's (activities of daily living), gait/transfer/balance issues, behaviors and/or cognitive status.

6. Assess and monitor resident's immediate environment to ensure appropriate management of potential hazards.

7. Monitor for changes in medical condition and notify physician as necessary to manage changes in status of the resident.

9. Review and/or modify the resident's plan of care at least quarterly and as needed in order to minimize risk of fall incidents and/or injury.

The 08/2020 FALL MANAGEMENT PROGRAM states:
Policy:
The facility is committed to minimizing resident falls and/or injury so as to maximize each resident's physical, mental and psychological wellbeing. While preventing all resident falls is not possible, it is the facility's policy to act in a proactive manner to identify and assess those residents at risk for falls, plan for preventative strategies and facilitate a safe environment.

Procedure:

2. Educate patient, family or responsible party related to:
a. Fall Prevention;
b. "Call, Don't Fall" for cognitive residents;

3. Educate staff members to check during room rounds the 4 P's
a. Pain;
b. Positioning;

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S9999	Continued From page 10 c. Placement of personal items; d. Personal Needs 5. Use standard fall/safety precautions for all residents: a. All staff will be trained on the Fall Management Program. (A)	S9999		