STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004014	A. BUILDING: _____ B. WING _____	C 11/17/2020

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ALHAMBRA REHAB & HEALTHCARE	417 EAST MAIN STREET, BOX 310 ALHAMBRA, IL 62001

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S 000	Initial Comments Complaint Investigations: 2048059/IL127644 2048694/IL128332 2048367/IL127979	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)6) 300.3240 a) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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:
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.

These regulations are not met as evidenced by:

Failures identified required more than one deficient practice statement.

A. Based on observation, interview, and record review, the facility failed to supervise and implement interventions to prevent falls for 2 of 4 residents (R1, R2) reviewed for supervision to prevent falls in the sample of 13. This failure resulted in R2 falling and sustaining on open nasal fracture and laceration to her forehead.

Findings include

1.R2's current Face Sheet documents R2 having the following diagnoses: Dementia, unspecified

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S9999	Continued From page 2 lack of coordination, unsteadiness on feet, abnormal posture, personal history of traumatic brain injury, muscle wasting and atrophy. R2's Minimum Data Set (MDS), with assessment reference date of 9/4/2020, documents R2 has severely impaired cognition. R2's MDS documents R2 requires extensive assistance of 2 plus staff persons for walking in room and corridor, extensive assistance of 2 plus staff persons for location on the unit. The MDS documents she is not steady and only able to stabilize with staff assistance during transitions and walking from seated to standing position. R2's Care Plan, initiated from 2/26 through 8/23/2020, documents she fell 10 times on the following dates: 2/26, 2/14, 2/19, 4/21, 6/12, 6/25, 7/22, 8/4, 8/17 and 8/23/20. R2's Care Plan Problem, initiation date 5/28/20, documents: "(R2) has unsteady gait and balance issues when standing." The Care Plan Interventions, with start date 4/22/20, are as follows: "assist her to stand, explain what you wish her to do; give step by step instructions; if very unsteady-use two staff assistance when ambulated or w/c (wheelchair)." R2's Care Plan Problem, with start date of 10/26/2016, documented "(R2) has the potential for falls/injuries related to confusion, wanders, unsteady gait, will slide self to edge of chair/wheelchair, aggressive behaviors, osteoporosis, and use of psychotropic meds. Also, she frequently bends over to pick items off the floor." Interventions to address R2's falls are as follows with the following initiating date: Assist her to position correctly/safely when up in chair/wheelchair (7/19/19); Do not leave	S9999		

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S9999	Continued From page 3 unattended in the dining room (2/7/20); Encourage to attend activities when out of bed (2/14/20); Refer to therapy (2/19/20); and position pillow to maintain lying in center of the bed (8/4/20). The Facility's Incident Report/Investigation, dated 9/2/20, documented R2 was observed sitting on the floor in the living room. The Investigation documented that R2 ambulates independently throughout the facility and has dementia. The Investigation documented the intervention put into placed to address this fall was "wear gripper socks at all times." The Facility's Incident Report/Investigation, dated 9/23/20, documented R2 was found sitting on the floor mat next to her bed. The Report Investigation documented "Resident moved closer to the nurse station." The Facility's Incident Report/Investigation, dated 9/30/20, documented at 4:50 AM, R2 was found face down with blood coming from around her face, on the floor in front of her wheelchair. The Report documented that R2 had bleeding coming from her forehead wound and bleeding coming from her nose. R2's Medical records from Local Hospital for the admission due to injuries sustained from incident of 9/30/2020 documents "Patient was transported to the E.D. (Emergency Department) and after evaluation/examination she was found to have an open nasal fracture with epistaxis. Laceration was sutured, and right nasal rocket was placed." R2's Hospital Discharge Summary documents "Open nasal fx (fracture), forehead laceration sutured, nasal laceration sutured."	S9999		

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S9999	Continued From page 4 On 10/29/2020 at 2:30 PM, V3 (Regional Nurse) stated, "I was called by the nurse and she said (R2) had fallen and they had found (R2) in front of wheelchair, blood on floor and had hit face. They said they checked vitals, and (R2's) sats (oxygen saturations levels) were low and they put on oxygen, the sat was around 73%. They called 911 immediately. There were 2 nurses and 2 CNAs on that night, so 4 people in building. The CNAs said (R2) was trying to get out of bed, so they went ahead and got (R2) up, cleaned (R2) up, and put (R2) in a wheelchair. They said within 20 minutes she was on floor." V3 stated when R2 is in bed, she has low bed, and a mat by the bed, but R2 was in chair and mat was against wall, no chair alarm was on when the incident occurred. V3 stated "When (R2) sits, she starts to rock to get herself up, so (R2) rocks body then she get up and walks on own. (R2) rocks every time to get up, she then gets her balance then takes off walking." On 10/30/2020, at 2:46 PM, V6, Registered Nurse/RN, stated she was R2's nurse the shift of 9/30/2020, in which the fall incident took place. V6 stated she was getting ready to pass morning medication when she passed by R2's room at approximately 4:50 AM. V6 stated she found R2 face down in front of the wheelchair with blood on the floor. V6 stated she yelled for the other nurse working and that nurse worked on stopping the facial bleeding while she called 911. When questioned if R2 had fallen from bed, V6 stated "No, I never thought (R2) fell from bed. I absolutely knew where (R2) fell from, (R2) was face down in front of the wheelchair, (R2) wasn't even by the bed. I did not tell family (R2) fell from the bed. I put in my nurse's notes what happened. it was obvious (R2) fell from the wheelchair. I asked the aides working that night when the last	S9999		

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time they were in the room. They told me it was when they started rounds and got (R2) up first at 4:30 AM."

On 11/4/2020 at 8:17 PM, V11 (Training Nurse Aide) stated that R2 was trying to get out of bed early in the morning. V11 stated "We have been told to go ahead and get them up, so they don't hurt themselves if they are wanting up. We went ahead and got (R2) washed up and put (R2) in her wheelchair. We went on to the next room to help another resident. When we got to about the third room, (V6,RN) came and asked us if we knew where the other nurse was because (R2) had fallen out of her wheelchair.' V11 stated they always put R2 in her in the wheelchair when we get her up. V11 stated R2 constantly rocked herself, back and forth in the chair. V11 stated "I even said, I bet (R2) was rocking herself and fell right out of the chair. (R2) always had to rock (R2's) self to get (R2's) balance to get up, and I bet (R2) just fell while rocking herself. It was about 15 minutes before the nurse came and told us (R2) had fallen out of (R2's) chair that we got (R2) up."

On 11/4/2020 at 4:29 PM, V10, R2's Physician, "Yes, I am aware, (R2) is very unstable on legs and has fallen numerous times and sustained a subdural hematoma from past falls." When asked about R2 being left alone in her room at 4:30 AM, V10 stated "I would expect closer observations but more importantly are the key words you used of resident being left alone. Yes, I would agree "leaving alone" should not have happened that early in the morning with them knowing the history of falls for (R2)."

2. R1 November 2020 Physician's Order Sheet (POS) documents R1 has diagnoses of difficulty

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S9999	Continued From page 6 walking, unsteadiness on feet, repeated falls and muscle weakness. On 10/29/2020, at 1:38 PM, an alarm was heard coming from R1's room. Staff in hall observed with no urgency to respond to alarm. Staff walked toward R1's room, stopped to talk to resident and staff in another room. V7 (Training Nurse Aide, TNA) then continued on to R1's room. V7 went into bathroom to check on R1. V7 was heard saying, "I don't know how to turn it off," several times. V7 came out of bathroom and looked around in room, continuing to say, "I don't know how to turn the call light off." V7 came out to hall telling this surveyor she was not sure how to turn off the light. V15, Certified Nurse's Aide/CNA, came down the hall and asked V7 what was wrong. V7 stated, "I don't know how to turn off the room light." V15 stated "That is (R1's) chair alarm, not the room light." V7 proceeded to go back into the bathroom with R1 and the alarm was turned off. V7 advised R1, V7 would be back, and immediately came back out of the bathroom. This surveyor asked if R1 had gotten on the toilet without help. V7 stated "Yes, that's why the alarm was going off." When questioned if R1 was supposed to get on the toilet by R1's self and if R1 should be left alone, V7 stated "I honestly don't know. I have only worked here for 4 days, but (R1) does a lot on his own he shouldn't, so he probably shouldn't be left much on his own." V7 stated they had no education on how to check what each resident's needs were to assist them that V7 could find in the room. V7 stated she was assigned to work with V15, but V15 was not with her at the time of this observation. On 10/30/2020, at 1:25 PM, R1 was attempting to go into a resident's room to use the bathroom. V7 redirected R1 to go to his own room to use the	S9999		

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bathroom. R1 became upset and started cussing, stating he needed to use the bathroom. V7 again instructed R1 to go to his room and V7 would come help R1. V7 walked away from R1 and went into another resident's room. R1 attempted to roll himself down the hall, upset due to having to go to the bathroom. R1 told V13, Licensed Practical Nurse/LPN, he needed to go to the bathroom. V13 pushed R1 to his room. V13 placed R1 in his room and advised him that V13 would get him help. V13 left R1 alone and R1 proceeded to go into the bathroom on his own. V13 was observed telling staff that were in another room, R1 needed help. V13 saw V14, CNA, in the hall and asked V14 to assist R1 to the bathroom. At 1:27 PM, V14 went to R1's room and saw that R1 was already in the bathroom and went in to assist. At 1:28 PM, V14 was coming out of R1's room and told V7, V14 had already assisted R1 in the bathroom. At the time of this observation, R1 had no floor mat in his room.

On 10/30/2020 at 1:51 PM, V14 stated that V14 did not have staff assistance with R1 in the bathroom at 1:27 pm when helping R1. V14 stated R1 had stood up to urinate at the toilet and V14 had assisted R1 by self. V14 stated R1 can roam wherever he wants to go, there are no interventions in place to try and keep R1 in supervised areas. V14 stated that R1 is not on a toilet program or a program to toilet R1 more often. V14 stated that staff take R1 every 2 hours as needed.

R1's MDS, dated 9/25/20, documents R1 has moderately impaired cognition. The MDS documents R1 requires extensive assistance from two staff person for transfers and toilet use. The MDS documents R1 is not steady and needs assistance from to stabilize when moving from a

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S9999	Continued From page 8 seated to standing position, moving on and off toilet and during surface to surface transfers. R1's Care Plan, from 1/20 through 6/8/20, documents R1 had 11 falls during this period. R1's falls were documented/dated on the Care Plan and are as follows: 1/20/2020 transferring self to toilet unassisted; 2/8/2020 fall from bed; 2/13/2020 fall from bed; 2/19/2020 fall while trying to transfer to bed by self; 2/28/2020 fall from bed; 3/15/2020 found on floor in front of toilet; 3/30/2020 found on floor in bathroom; 4/19/2020 fell from w/c while reaching; 5/21/2020 fell from w/c while leaning forward; 5/22/2020 fell while transferring self to toilet; and 6/8/2020 fell standing up from w/c without locking brakes. The Care Plan Approaches to address these falls were as follows: Give frequent reminder to lock his wheelchair when he wants to stand; Ask him frequently if he needs to go to the bathroom; Encourage him to stay in supervised areas after supper; Keep needed items within his reach; Refer to therapy; Remind him to wait for assistance to go to the bathroom; If noted to bed restless when in bed, get him p and bring to a supervised area; and start restorative toileting program. R1's Care Plan Problem, with initiation date of 1/20/2020, documents (R1) is unable to transfer self safely to the toilet and is incontinent of urine. The Interventions for this Care Plan problem documented "Assist of two staff with toileting" and "Remind him to not transfer without assistance." R1's Facility Incident Report, dated 9/11/20, documented R1 was found in his room on the floor next to the bed with his wheelchair behind him. The Intervention on this Report was to remind him to use his call light.	S9999		

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R1's Care Plan, revised on 9/11/20, documented that R1 was re-educated on waiting for assistance and staff were to assist resident to bed after meals.

R1's Facility Incident Report, dated 10/9/20 at 7:05 AM, documented he was found on the floor in his bathroom. He was on his left side with his back against the wall. The Report documented he sustained an abrasion to his mid back measuring 4 centimeters by 3 centimeters. The Immediate Action documented on this report was to refer R1 to therapy for transfers and for staff to make this resident a first get up due to him attempting to transfer to toilet.

R1's Care Plan, revised on 10/9/20, documented "Toileting Program to ensure resident is toileted before and after meals; OT/PT (Occupational/Physical) therapy to eval and treat."

R1's Facility Incident Report, dated 10/11/20 at 4:21 PM, documented he was found in his bathroom on the floor near the sink. This report documented "Resident to wheelchair alarm when available."

R1's Care Plan, revised on 10/11/20 documented "W/C alarm will be put into place."

R1's Nurse's Note, dated 10/24/20, documented that R1 was found on the floor. The Nurse's Note documented he had removed his personal alarm and tried to transfer self.

R1's Care Plan, revised 10/24/20, documented "Position alarm box out of my reach, offer to assist me to get into my w/c for super at later

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time, encourage me to stay in a more supervised area when up in my w/c, therapy screen for possible treatment."

B. Based on interview and record review, the facility failed to provide supervision to prevent elopement for one of 4 residents (R5) reviewed for elopement/supervision in the sample of 13.

Finding includes:

1. R5's November 2020 Physician Order Sheet, POS, documents R5 has diagnoses of Alzheimer's disease and schizophrenia.

R5's Minimum Data Set, MDS, dated 9/25/20, documents R5 as a 90 year-old with severe cognitive impairment. The MDS documents she needs supervision for bed mobility, transfers and walking.

Progress notes for the month of September 2020 documented R5 had several falls and incidents.

R5's Progress Note, dated 9/9/20 at 4:26 PM, documents, "Resident has been up ambulating requesting to go home. Has traveled to facility doors with supervision yet not attempting to open."

R5's Progress Note, dated 9/10/20 at 2:53 PM, documented R5 had fallen. The Note documented she missed her chair and landed on her bottom.

R5's Progress Note, dated 9/19/20 at 3:50 PM, documented R5 was found in office room sitting on the floor next to chair.

R5's Progress Note, dated 9/25/20 at 6:30 AM,

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written by V21, LPN, documents, "DON was doing rounds. When got to this resident's room, resident was not in room. DON let this nurse and other nurse know that resident was not in room and we needed to search rooms and everywhere in the building. Staff split up and half of staff started down c hall and other half started down a - hall. Staff searched every room closet bathroom locked rooms and shower rooms as well as cafe and living room dining room and kitchen. Resident was not found. Half the staff began search outside of facility. All ground around facility was searched." At 6:50 AM, V21 documented "Search cont. A couple staff members searched around the block up to one block down. 710am This nurse found resident sitting in front of shed. Staff then ran to get wheelchair and blankets for resident. This nurse stayed with resident and assessed her. No injury noted to legs. Two staff assisted to stand this resident up to sit (R5) in wheel chair. No grimacing noted during transfer. Resident covered with blankets and taken into facility building."

R5's Progress note entry on 9/25/2020 at 720 AM by V21, documents, "V/S (vital signs) taken 140/70 (blood pressure)-97.1 (temperature) -78 (pulse)-22 (respirations). SPO2 (oxygen saturation levels)-98% on RA (room air). Resident assessed by two nurses when taken to bathroom. Left hip area noted to be swollen with bruise measuring 7.5cm by 4cm. Under right buttock round red area noted. 6cm by 6cm. Area to right forearm circular bruise measuring at 3cm by 3 cm. No pain or disc (discomfort) noted. "

On 11/9/2020 V17, Previous employed CNA, stated she was working night/morning of R5's elopement, V17 stated: "I told them (R5) is a

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(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 huge fall risk I told them (R5) needed an alarm on so we knew when (R5) was standing up. When we are trying to get people up, we can't always keep an eye on everyone. I was just trying to keep (R5) safe. (R5) has schizophrenia, walked all over the place and was a fall risk. When I started, the old owner had an alarm on (R5), the new company took it off (R5). The wander guard only goes off if going out the door, we needed a different alarm. (R5) was there on my last bed check at 2:30 a.m., not sure when I left. V19 (former Director of Nursing) came in for me and she took over. The door alarm went off a little after 3:00 a.m., but we have this guy who is a smoker and they said it was him probably going out to smoke, so we turned off the alarm. I went outside and looked down the ramp but didn't see him or (R5). They said it wasn't that door that alarmed, it was the front door. I'm just not sure when (R5) left, not sure if that was the time or not. They started calling me around 6 a.m. in the morning, I was sleeping, I called them back and they asked when the last time was I saw (R5)." On 11/12/20 at 12:40 PM, V19, Former Director of Nursing, stated she came in early because V17 need to go home on 9/25/2020 around 4:30 AM. V19 stated she started on bed rounds and remembers had a couple messes to clean up prior to getting to R5's room. V19 stated around 6:00 AM, she and V15 (CNA) went into R5's room and R5 was not in the room. V19 stated, "We did a check of the entire building and could not find R5. (V1/Administrator) had also came in at 0600 and I reported (R5) missing. We did another sweep of whole facility including closets and bathrooms. When we couldn't find (R5). We called (V3, Regional nurse) to advise and we then went outside to start looking and found (R5), 2 blocks away."	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004014	A. BUILDING: _____ B. WING _____	C 11/17/2020

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S9999	Continued From page 13 On 11/12/2020 at 11:43 AM, V21stated she found R5 about 1.5 to 2 blocks from the facility on 9/25/2020. V21 stated she filled out a report and should also be in progress notes. V21 stated "We think (R5) walked down the road. I found (R5) sitting on (R5's) buttocks." V21 stated that R5 did not have injuries. V21 stated she was not sure why the wander guard had not gone off or if it did somehow and got missed. V21 stated she was not sure how long R5 was missing but she found R5 around 7 a.m. that morning. Facility Policy titled "Door Alarm Policy" undated, documents "1. All exit doors are alarmed/code locked and remain on 24 hours per day. 2. All facility exit doors are secured with an alarm that chimes when the doors are open. The alarm sound continuously until manually shut off. The purpose of the continuous alarm is to alert staff that an exit door has been open. Staff responding to the alarm should check on the reason for the alarm to be sounding. A thorough observation should be done to look for a wandering resident. 3. To assure the safety of the residents, after a thorough observation is completed, all residents should be accounted for. 4. No alarm should be silenced until a thorough observation is completed." Facility Policy titled: "Safety and Supervision of Residents" documents "Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility - wide priorities. Facility-oriented approach to safety: 2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring and reporting	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 14 processes; QAPI reviews of safety and incident/accident data, and a facility-wide commitment to safety at all levels of the organization. Individualized, Resident-centered approach to safety. 4. Implementing Interventions to reduce accident risks and hazards shall include the following: a. communicating specific interventions to all relevant staff. b. assigning responsibility for carrying out interventions. c. providing training, as necessary. d. ensuring interventions are implemented." (B)	S9999		