STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001119	A. BUILDING: _____ B. WING _____	C 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENTWOOD NORTH HC &REHAB CTR	3705 DEERFIELD ROAD RIVERWOODS, IL 60015

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S9999	Final Observations Statement of Licensure Violations: 300.1210a) 300.1210b) 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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. Restorative measures shall include, at a minimum, the following procedures: 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.	S9999		

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Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Regulations were not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide specific fall intervention, failed to modify care plan interventions after multiple incidents of falls and failed to provide supervision to prevent further falls to a resident who was identified as high risk for fall.

This applies to one resident (R1) reviewed for falls.

This failure resulted in R1 sustaining a large subdura hematoma after a fall on June 21, 2015, when left with out supervision, which led to the resident's documented decline in ADL (activities of daily living) and hospice care placement.

The findings include:

R1 is a 95 year old originally admitted to the facility on Febuary 2, 2014. R1's face sheet showed R1 has diagnoses that includes subdura hemorrhage, history of falls, vascular dementia, hypertension, depressive disorder and insomnia.

The two most recent MDS (Minimum Data Set) assessments dated February 24, 2015 and May 25, 2015 showed that R1 required supervision

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with one person physical assist for ambulation and eating. The MDSs also showed R1 scored 14 and 13 in cognition (cognitive intact).

However; during the past few months, R1 sustained three falls (3/25/2015, 6/14/2015 and 6/21/2015).

The incident reports showed the following R1's falls:
3/24/2015 at 12:40 A.M. showed "(R1) used the urinal and when he stood up, lost balance and fell and hit his head in the cabinet. The report also showed that R1 laceration to the back of his head was noted with minimal bleeding. The report showed R1 was sent out to the hospital and was diagnosed with head trauma and subdura hematoma. The hospital Computed Tomography) CT scan of the head dated 3/25/15 showed R1 with occipital laceration about 1-3/4 inches and 8 millimeter (mm) subdura hematoma.

6/14/2015 at 1:15 P.M. showed that "(R1) was waiting by the doors to the unit and was asked to back up and while he was backing up his shoes caught in the carpet and he fell to his knees. No injuries were noted with this fall. The post fall huddle dated 6/14/15 identified R1's fall risk assessment as 10 (High Risk). The post huddle fall also added that R1 to have a scheduled times to be taken out of the unit. This was not incorporated in R1's care plan.

6/21/2015 at 11:10 A.M. showed that "(R1) was observed on the floor with abrasion to occipital area and scant bleed. The report showed R1 was sent to the hospital. The hospital CT scan report dated 6/21/15 showed 'large acute and subacute subdura hematoma with maximal thickness 1.5cm with diffuse edema and midline shift to the

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S9999	Continued From page 4 right by 1.1cm" The "Fall and Accident/Incident Resident Management Review showed that R1's falls were reviewed with plan of care as follows: As the result of the 3/24/2015 fall, R1's care plan was updated as provide R1 with bed alarm for safety; therapy to pick R1 up for skills training; keep needed items within reach; maintain a clear pathway and to be sure R1's call light is within reach and encourage R1 to use it for assistance as needed. There was no further plan of care with specific intervention to prevent possible fall. As the result of the 6/14/2015 fall, the care plan showed to "re-educate R1 not to stand by the exit doors as people comes in and out of the unit. R1 scored 8 in fall risk assessment (high risk). There was no other plan of care or any modification with the current interventions to prevent further fall. There was nothing in the care plan to show that the facility plans to supervise R1 during ambulation. As the result of the 6/21/2015 fall, the plan of care was to provide R1 safety devices such as bed sensor alarm and chair sensor alarm for added safety. It also showed to ensure R1 is wearing appropriate footwear, non skid when ambulating or mobilizing in wheelchair." Facility records did not show how R1 sustained this fall. The nurse (E3) that took R1 for coffee break stated during interview she left R1 in the far east pod with no staff or other resident present. On 6/30/2015 at 12:40 P.M., E2 Director of Nursing (DON) stated R1 likes to go to the front lobby for coffee and ambulate around the unit. E2 provided recent care plan for fall prevention that	S9999		

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was reviewed by the facility staff with each falls on 3/24/2015, 6/14/2015, 6/22/2015 and at admission, quarterly. It was indicated in the care plan that R1 was a high risk for falls related to history of multiple falls, and adverse reactions related to meds. "On 3/24/2015: Provided with bed alarm for safety.....On 6/22/2015: Provided with safety devices such as bed sensor alarm and chair sensor alarm for added safety." The rest of interventions were non-specific and generalized care plan such as "clear pathway, keep needed items within reach, monitor medications for possible side effects, call light within reach, educate and remind for safety." There was no specific intervention and mention of supervision or assist to ambulate in the unit to ensure R1's safety of the identified problem of "R1 likes to go for a cup of coffee and ambulate around the unit".

E2 provided a unit notice to staff members that showed, " R1's name, room number and instruction that reads= 'coffee & off the unit schedule (with staff supervision) 7 days a week including weekends'. Morning shift -10:30AM and afternoon shift 3:30 PM and 7:30PM each with staff supervision."

The Daily nursing progress note dated June 21, 2015 10:30 A.M., showed R1 approached E3 (Nurse) to escort him to get coffee and stayed in the far east Avalon pod to drink his coffle. The note showed at 11:10 A.M., E3 went back to check on R1 and found him on the floor. The note showed E3 noted abrasion to the back of R1's head. The same progress note (the day of the fall) showed R1 independent with bed mobility, transfer, dressing personal hygiene and toileting and ambulation. The note further showed R1 was sent to the hospital for evaluation.

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Facility's admission log showed R1 was re-admitted to the facility on June 22, 2015.

The daily nursing progress notes dated June 23, 2015 showed R1 with extensive assist in bed mobility, transfer, toileting, dressing and personal hygiene R1 was noted on this chart to use wheelchair for ambulation/mobility. The subsequent daily nursing progress notes dated June 25, 2015 through June 30, 2015 showed R1 with total dependence in all areas of ADL.

The nurses note dated June 24, 2015 at 5P.M., showed R1 was fed with 60 percent of dinner while the nurses note of June 25, 2015 3-11 shift showed R1 was fed with 20 percent of meal.

On June 30, 2015 at 1:30P.M., E3(Nurse) stated on June 21, 2015, R1 asked her to escort him to get coffee. E3 stated she took R1 for the coffee and then left him in the far east Avalon pod to watch the television. E3 stated there was no staff or other resident present when she left R1 at the far east pod. When asked if E3 asked anyone to supervise R1, E3 stated no but that "she has to pass medications to other residents". E3 stated she never designate anyone else to supervise R1 at the pod because she felt R1 should be 'ok'; but unfortunately he was found on the floor upon returning to check on R1. The 'coffee and off unit schedule for R1 dated June 15, 2015 showed R1 coffee and off unit schedule with "staff supervision". E3 stated R1 has not being verbally responsive in the past few days.

R1's hospital CT scan record showed R1 had a large subdura hematoma. The facility's admission record showed R1 was re-admitted to the facility on June 22, 2015.

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The daily nursing progress note dated June 26, 2015 showed R1 was noted to be sluggish and put back to bed. The note showed the doctor was notified.
The evening note showed R1 with close eyes and non verbal. The daily nursing progress note dated June 27, 2015 showed R1 was evaluated by hospice care. The note also showed R1 was not verbally responsive, closed eyes, would not respond to his name. The note showed R1 was admitted to hospice as he has declined in activities of daily living and non-verbally responsive.

R1's physician order sheet (POS) dated June 27, 2015 showed, "discontinue all prior medications. Give comfort pack as directed. Admit to Vitas hospice today".

On June 30, 2015 at 10:30 A.M., tour of the Avalon unit was made with E2. R1 was observed in bed, eyes closed and would not respond to greetings. The far east pod was also observed to be located at the far east end of the unit. The far east pod is not immediately visible to someone passing in the hall way of east unit. The far east pod is also not visible from the nursing station.

The failure to revise R1's care plan to reflect R1's need of assistant with supervision and the failure to allow R1 to have un-supervised coffee break on June 21, 2015 resulted to R1's fall, subdura hematoma and his decline in ADL status and hospice placement.

On July 1, 2015 at 3:10 P.M., E6 Certified nursing assistant (CNA) stated she cared for R1 'today'. E6 stated R1 was not verbally responsive, did not eat or drink anything and had only one slightly wet diaper.

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S9999	Continued From page 8 On July 1, 2015 at 2:45pm, Z1 (Doctor) stated that R1 it was indicated through R1's progress notes that R1 is high risk for fall and that R1 should have been closely monitored and should not have been left alone given the fact that R1 is high risk for falls and this was documented in all doctor's progress notes. Z1 added that R1's fall on June 21, 2015 was a contributing factor to his decline in activities of daily living and been placed on hospice care. (A)	S9999		

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ILLINOIS DEPARTMENT OF PUBLIC HEALTH

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Imposed Plan of Correction

Brentwood North HC & Rehab
Complaint: 1513446/IL78264
Survey date: 7/01/15

300.1210a)
300.1210b)
300.1210d)6)
300.3240a)

Attachment B
Imposed Plan of Correction

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.

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. Restorative measures shall include, at a minimum, the following procedures:

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.* (Section 2-107 of the Act)

Compliance with the above Regulations will be accomplished by:

A. Resident assessments are to be reviewed to ensure that those residents who are at risk for falls have appropriate interventions and post fall assessments provide specific interventions to prevent further falls. Care plans are modified and updated.

B. Audits are to be conducted by responsible party to determine that post fall assessments and Plan of Care is updated.

C. Nursing staff is to be educated, as needed, on post fall interventions and modification of Care Plan.

D. Results of audits and training are to be document and reviewed by the facility. Quality Assurance Committee Monthly and for review and recommendations.

Completion date: 10 Days from Receipt of Notice