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OAK LAWN RESPIRATORY & REHAB	9525 SOUTH MAYFIELD OAK LAWN, IL 60453

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S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)2) 300.1220b)6) 300.1220b)8) 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 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	S9999	Attachment A Statement of Licensure Violations	

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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.
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.
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 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status,

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sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.
6) Developing and maintaining nursing service objectives, standards of nursing practice, written policies and procedures, and written job descriptions for each level of nursing personnel.
8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and restorative/rehabilitative nursing techniques through out-of-facility or in-facility training programs. This person may conduct these programs personally or see that they are carried out.

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 requirements and not met as evidenced by:

Based on observation, interviews and records reviewed facility failed to perform comprehensive fall assessment and initiate immediate interventions to prevent falls on a newly admitted high risk resident (R3).
This failure resulted in R3 sustaining a fall incident with severe head injuries requiring hospital and surgical interventions. Facility also failed to implement care planned fall prevention interventions on 6 high risk for falls residents

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S9999	Continued From page 3 (R13, R7, R10, R12, R5 and R8). This applies to 7 of 13 residents reviewed for falls in the sample of 13. R3 admitted to facility 01/15/15 from the hospital with diagnosis to include Obstructive Hydrocephalus, Brain Cancer with a ventricular peritoneal shunt (VP shunt), placement. R3's 01/16/15 fall incident report includes: On 12/08/14, R3 had a occipital craniotomy, tumor resection for cerebral mass with obstructive hydrocephalus complicated by hemorrhage and on 12/15/14, R3 had a VP shunt placement. R3's 01/07/15 hospital discharge records (that accompanied R3 to facility on admission), include: - 01/14/15 and 01/15/15 "Transition of care report's" document "High Fall Risk", awake and alert but forgetful at times. Ambulates in room with assistance. - 01/15/15 "Nursing Summary Patient Data Report," include High Risk for falls, use gait belt, bed/chair exit alarms, fall precaution signage posted and hourly rounding implemented. R3 has history of falls within past 3 months, fell during previous hospitalization 12/13/14. - Nursing progress notes of intermittent confusion, restlessness and forgetfulness. - physician progress notes include; 01/13/15, intermittently confused and hallucinating. Personality disorder possibly related to premorbid condition or somehow related to brain metastases (mets), and hydrocephalus. R3 has stage 4 squamous cell carcinoma of the lung with met's to the brain. Cerebellar 4th ventricular skull tumor post craniectomy and VP shunt in 12/2014. On 01/12/15 drainage noted from	S9999		

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surgical incision and Cat Scan of brain completed. R3's 01/12/15 Cat Scan of brain showed fluid collection at suboccipital craniectomy site with focus of gas.
- 12/30/14 rehabilitation conference summary document: very impulsive, poor safety awareness, requires supervision, cues and a sitter.

R3's 01/15/15 "Facility admission/re-admission department notification assessment," states, high risk for falls, needs a low bed, placement as close to nursing station as possible, frequent checks and falling star.
R3's 01/15/15 Fall assessment include high risk for falls but fails to include recommendations for individualized fall precaution interventions.

R3's 01/15/15 admission nursing assessment includes; requires extensive assistance with ambulation, has unsteady gait. Requires extensive assistance with activities of daily living (ADL's).

R3's "Admission Care Plan," includes Fall Risk, use mobility alarm and floor mats.

R3's 01/16/15 fall incident report includes:
On 01/16/15 at approximately 2:35AM, a loud noise heard from R3's room. R3's room mate in hall stating her room mate was on the floor. R3 found lying face down on the floor in the middle of her room. R3 was initially verbally responding to questions but the became unresponsive. 911 called and R3 sent to the hospital. R3 admitted to hospital with diagnosis of subdural hematoma. The precautions in place at time of fall were low bed and proper footage, no alarms or floor mats in place.

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R3's 01/16/15 hospital records include:
R3 admitted to emergency room after being found down and unresponsive at nursing facility. Upon admit to emergency department, R3 found to have a large subdural hematoma with a midline shift, new parenchymal bleeds compared to prior cat scan (01/12/15). R3 was unresponsive with unequal pupils that were unreactive to light and positive babinski. R3 was sent from emergency department directly to surgery for an emergency left frontal temporoparetal craniotomy with evacuation of subdural hematoma.
Post surgery, R3 never re-gained consciousness and required artificial life support until 01/21/15 expiration.

During staff interviews 01/10/15 and 01/11/15, the following information obtained:

- During 02/10/15, 9:30AM telephone interview, E4 (nurse), stated, R3 was admitted to facility 01/15/15 on the evening shift. E4 completed R3's admission assessments and assessed R3 to be delusional. E4 also said, during report from the hospital nurse, E4 was told R3 was a fall risk. E4 said if a resident is a fall risk, facility staff monitor the resident every 15 minutes, keep the resident close to nursing station, apply bed alarms, floor mats and keep call light in reach of resident. E4 also said bed alarms are usually kept in the medication rooms but on 01/15/15, there were no alarms available for R3. E4 said "I'm sure I notified the night shift nurse that R3 was a fall risk and I believe I documented such in facilities 24 hour nurse report."
E4 also stated that bed alarms are locked up in the restorative office and not accessible on evening and night shifts.

Facilities 01/15/15, first floor 24 hour nurses

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S9999	Continued From page 6 report does not include documentation of R3 being a fall risk. - During 02/10/15, 3:05PM telephone interview, E10 (nurse aide), stated she was R3's 01/15/15 evening shift (3PM- 11PM), nurse aide. E10 also stated R3 was not on fall precautions but when toileted was "woozy." E10 also stated, R3 had no bed alarms, floor mats or falling star postings in place 01/15/15. E10 said residents that are fall risks are provided bed bolsters, chair and bed alarms and provided constant supervision. - During 02/11/15, 11:29AM telephone interview, E13 (nurse), stated, E13 was R3's 01/15/15 11PM through 01/16/15 7AM, night shift nurse. E13 said she received a brief report regarding R3 being a possible fall risk. R3 was alert and responsive and did not have any bed alarms or floor mats in place at the time of her fall incident. E13 validated information documented on R3's 01/16/15 fall incident report. E13 stated, on 01/15/15 there were no bed alarms or floor mats available to apply on R3. E13 also stated "I was terminated from facility for failing to contact management in an attempt to obtain bed alarm and floor mat for R3 prior to the fall incident. E13's personal file include documentation stating, on 01/21/15 E13 was placed on a 3 day suspension pending investigation of a residents fall incident. E13 was then terminated for failing to follow facility documentation protocol. - During 02/10/15, 2:45pm telephone interview, E11 (nurse aide), said, on 01/15/15 night shift, R3 was not using any bed alarms, fall risk postings or floor mats. E11 also said that she was unaware that R3 was a fall risk.	S9999		

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During 02/10/15, 10:15AM interview, E5 (restorative nurse), stated when a resident is identified high risk for falls, nursing staff are to utilize the "Fall Prevention Kits", kept in the medication rooms. E5 said the fall prevention kits include sensor pad alarms, batteries, tab alarms, non-skid pads, a use call light sign and a "Falling Star" symbol. E5 also stated there is a fall prevention kit on the first floor and the second floor in the medication rooms. E5 said these kits are checked and refilled daily on day shift by restorative staff.

On 02/10/15 at 10:20AM, one fall prevention kit observed in each of the 2 medication rooms. The fall prevention kits observed to include one sensor pad alarm, one tab alarm, batteries, one use your call light posting and star shaped symbols. No floor mats observed in the medication room.

Facilities 01/15/15 Admission Report documents 4 residents admitted.

During 02/10/15 individual interviews E12, E8, E18 and E7 (nurses), all stated if a resident is identified as a high risk for falls, staff are to apply bed alarms, low bed, floor mats, falling star posting at bedside and increased monitoring with frequent rounding's.
Licensed Practical Nurses E6, E8 and E12 were not aware of facility's "Fall Prevention Kit's."

Facilities "Falling Star Program" policy and procedure include:
- Residents are assessed on admission to facility for fall risk.
- Residents assessed to be fall risk, are to have a "falling star" symbol placed by the residents room,

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on their name plate and on the residents mobility device.
- A plan of care will be initiated utilizing fall prevention strategies to reduce or eliminate each residents fall risk.
- Safety movement devices will be used as an integral tool to prevent unassisted ambulation.

Facilities "Falling star program" protocol does not list the specific fall prevention strategies staff are to initiate.

During 02/11/15, 10:20AM telephone interview, Z1 (R3's attending physician), stated he was unaware of facilities fall precaution protocols other than using low beds and sometimes side rails on beds.

On 02/10/15, between 10:15AM and 11:55AM, R10, R5, R13, R8, R12 and R7 (facility identified high risk for fall residents), observed as follows:

- R10 up in a wheel chair in his room, using oxygen per nasal cannula that was tautly extended from head of bed to dresser beyond the foot of his bed. No staff were present in the room with R10. R10 had a sensor pad alarm on his wheel chair but not connected to alarm sounding box. No alarm box present on R10's mobility device (wheel chair). R10 had a falling star symbol over the head of his bed.
R10's 01/16/15 fall assessment includes high risk for falls.
R10's current fall care plan documents intervention to use sensor alarms in bed and chair at all times.
R10's diagnoses include encephalopathy, anxiety, weakness, dementia with behavior disturbances.
R10's 01/10/15 MDS include unable to perform brief interview mental status assessment,

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requires extensive assistance with bed mobility, transfers, ambulation, dressing, toileting and hygiene.

R10 had 2 recent unwitnessed fall incidents in his room:
- 11/13/14 at 3:45AM, found on the floor. R10 was attempting to sit on the side of his bed without staff assistance.
- 01/16/15 at 9:40AM, found on the floor at bedside with skin tears to the face and anterior left lower leg. R10 was confused. R10's 01/16/15 incident report does not document bed alarms were in place at the time of the fall. R10 was receiving anti-coagulants at the time of his fall.

R10 was re-admitted to facility from hospital 01/15/15, same day as R3 admitted.

- R5 in bed with a falling star symbol over head of bed and without any bed alarms in place. E7 present at time of this observation and E7 stated R5 should have bed alarms in place at all times.
R5's 01/15/15 fall assessment includes high risk for falls.
R5's 01/15/15 MDS include severe cognitive impairment and requires extensive assistance with bed mobility, transfers, ambulation, toileting, dressing and hygiene.
R5's current fall care plan include need to utilize bed alarms.

On 12/05/14 at 8:33AM, R5 had an un-witnessed fall from bed. R5's 12/05/14 incident report includes R5 is only oriented to self, confused and with memory impairments.

- R13 in bed, turning himself over toward side rails without any bed alarms in place.

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R13's 02/08/15 fall assessment documents high risk for falls.
R13's 01/16/15 minimum data set assessment (MDS), include severe cognitive deficits, is totally dependent and requires extensive assistance with bed mobility, dressing, toileting, transfers, hygiene and ambulation.
R13's current fall care plan includes interventions to utilize bed alarms.

- R8 in bed awake, alert and non-verbal. R8 had no falling star symbol or use call light sign posted. R8 had no floor mats or bed alarms in place.
E9 (nurse aide), present at time of this observation and E9 stated R8 should have bed alarms and floor mats.
R8's 02/08/15 fall assessment documents not a high risk for falls but R8's current care plan and facilities high risk for fall list, state R8 is high risk for falls.
R8's 01/06/15 MDS, include severe cognitive deficits, is totally dependent and requires extensive assistance with bed mobility, dressing, toileting, transfer, hygiene and ambulation.

- R12 in bed pulling himself up and over onto his right side rail. R12 had no bed alarms in place. R12 had a falling star symbol over head of bed.
R12's 01/11/15 fall assessment document high risk for falls and inability to stand independently.
R12's 02/04/15 MDS document severe cognitive deficits, requires extensive assistance with bed mobility, transfers, toileting, ambulation, dressing and hygiene.
R12's current fall care plan include requires sensor pad alarms to the bed.

- R7 in bed without any bed alarms or floor mats present. E9 stated R7 should have bed alarms in place.

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S9999	Continued From page 11 R7 identified by facility on high risk for fall list. (A)	S9999		

Imposed Licensure POC

Oaklawn Respiratory and Rehabilitation Center
9525 S. Mayfield
Oaklawn, Illinois 60453

Combined Plan of Correction and Allegation of Compliance

The following plan of correction constitutes the facilities allegation of compliance such that all alleged deficiencies cited have been and will be corrected by the date or dates indicated. The statements made on the plan of correction are not an admission to, and does not constitute an agreement with alleged deficiencies herein. We respectfully submit that these deficiencies do not exist. To remain in compliance with all State and Federal regulations, the facility has taken or will take the actions set forth in the following plan of correction.

300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6)
F323 300.1220b)2) 300.1220b)6) 300.1220b)8) 300.3240a)

Corrective action for residents affected:
R3 no longer resides within the facility. No further interventions can be completed for R3
R8 no longer resides within the facility. No further interventions can be completed for R8
R13, R7, R10, R12, R5 have been reassessed for fall risk. Care plans have been updated as appropriate.

How other residents will continue to be identified:
All residents at risk for falls could be affected by the alleged deficient practice.

System revision:
Nursing staff have been inserviced regarding fall prevention program, assessment, and interventions.

New admission inquiries will be reviewed to ensure that appropriate fall interventions are put into place at the time of admission.

Fall Interventions supplies provided for staff to initiate off hours have been made available at all times.

How the facility will monitor system:
The DON/Designee will monitor that fall interventions are in place 3X/week for the first month and weekly thereafter. The DON/Designee will ensure that inquiries are reviewed for fall interventions 3X/week for the first month and weekly thereafter. All identified trends will be reviewed by the QA committee and a plan will be discussed and implemented until resolution.

Date of completion: February 27, 2015

accepted

Attachment B
Imposed Plan of Correction