

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005227	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/24/2018
NAME OF PROVIDER OR SUPPLIER LAKEVIEW REHAB & NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 735 WEST DIVERSEY CHICAGO, IL 60614		
(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 1882813/IL102283 - F689G	S 000			
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.690b) 300.690c) 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 300.690 Incidents and Accidents b) The facility shall notify the Department of	S9999			

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

06/14/18

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S9999	Continued From page 1 any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. 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 care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: d) Pursuant to subsection (a), general	S9999			

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S9999	Continued From page 2 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) This requirement was not MET as evidenced by: Based on interview and record review, 1) the facility failed to follow their fall prevention and management policy to include: development, implement and re-evaluate effectiveness of individualized fall prevention interventions; provide an assistive device to minimize the risk of falling; and provide supervision for a resident with repeated falls. 2) the facility failed to follow policy and notify the Illinois Department of Public Health (IDPH/State Agency) of a reportable incident after a resident sustained a right shoulder fracture after a fall, which applies to one resident (R1) reviewed for falls and incident reporting. These failures resulted in R1 sustaining a 10 centimeter laceration requiring sutures and another fall sustaining an acute right shoulder fracture. Findings include:	S9999			

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S9999	Continued From page 3 R1's initial MDS (Minimum Data Set) with Assessment Reference Date (ARD) of 12/28/2017 shows the following: -BIMS (Brief Interview Mental Status) = 14/15, Cognitively intact -Requires Extensive assistance and one person physical assist with bed mobility, transfers, walking in room, locomotion on unit, dressing, toilet use, and personal hygiene -Not steady, only able to stabilize with staff assistance for walking, moving on toilet, surface-to-surface transfer, and moving from seated to standing position -Impairment on one side for both upper and lower extremities -Always continent of urine and occasionally incontinent of bowel -Diagnoses not limited to: Urgency of urination, difficulty in walking, digestive surgery, personal history of poliomyelitis, generalized muscle weakness, [hemiplegia affecting right dominant side] (paralysis of one side of the body) and meningitis -No history of falls R1's Fall Risk Review dated 12/21/2017 shows: -History of falls within last six months: 3 or more falls -Exhibits loss of balance while standing, requires hands-on assistance to move from place to place, uses short discontinuous steps and/or shuffling steps, has lurching, swaying, or slapping gait, exhibits jerking or instability when making turns, uses an assistive device, decrease in muscle coordination -High risk for falls On 5/23/2018 at 10:14am, R1 stated: I've urinated on myself many times and I hurt my arm,	S9999		

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S9999	Continued From page 4 because I have to wait 20-30 minutes for staff when I press the call light. I can't hold in my pee for that long, and I don't want to wet myself. I fell one time trying to stand using a urinal and I fell another time when I was walking with my cane. I also fell other times waiting to go to the bathroom, but waiting too long and trying to do things myself. It's frustrating. On 5/23/2018 at 9:45am, V7 (Family member) stated: [R1] fell around 5-7 times, and he's falling too much at the nursing home. He had 12 sutures and a broken shoulder already. The facility knew that since he came in, he has had surgery and cannot be walking or doing things on his own. One time, I did place R1 in the room but no one would answer the call light, so I stepped outside to call staff for help because R1 needed to use the bathroom. The staff takes too long because they are busy and understaffed, that R1 couldn't hold in his urine and tried going to the bathroom himself. When R1 needs to go, he needs to go and can't wait 30 minutes or so for someone to answer the call light. On 5/23/2018 at 10:06am, V5 (LPN/Licensed Practical Nurse) stated, "If R1 doesn't wait, he will try to transfer himself. Sometimes he won't use the call light and we keep encouraging him to use the call light." On 5/23/2018 at 10:08am, V4 (Certified Nursing Assistant/CNA) stated: R1 is continent and he knows when he has to go, and will call for help. In January, R1 used to do things on his own and would walk with a cane and only needed supervision. R1 is on the falling star program, because he's had around 2 falls or so, but I don't know exactly why he fell. R1 needs monitoring, because if he feels he's been waiting too long for	S9999			

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S9999	Continued From page 5 the call light to be answered, then he will do things on his own. R1's progress notes show R1 had the following five unwitnessed falls: 1. [1/13/2018 4:30pm] Late Entry: NOD (nurse on duty) while assessing another resident heard a noise in the room immediately checked and found resident laying on his left side with his face down, Initial assessment done and found a 2-3 linear laceration on the left forehead just above the eyebrow, pressure dressing was applied..... R1 sent to local Emergency Department (ED) 2. 1/25/2018 at 8:21pm: Heard a thump coming from resident's room, saw resident on the floor next to wheelchair urinal on the floor, attempting to use urinal...Assisted with three staff without difficulty... 3. 3/24/2018 6:16pm: Late Entry: Resident sister was visiting and she wheeled res (resident) to the room and came to the nursing station to talk to staff quickly, when she returned to the room resident was on the floor in sitting position. Sister came and notified this writer that res was on the floor. This writer went to assessed res. When res was asked what happened he stated? He wanted to get up to use the bathroom and I slide off wheelchair. 4. 3/27/2018 9:24am: Writer received report from overnight nurse that resident had a fall this AM [7:29], upon assessment resident c/o (complained of) right [arm] pain 7/10 and was noted with a bruise to right hand. when asked what happened resident states "I was trying to get from my bed to the w/c (wheelchair) when I fell on the floor, now my arm hurts." 5. 5/12/2018 at 7:18pm: Resident observed in room laying on his right side between bed and nightstand. Resident verbalized trying to get to bed, had no strength fell forward, Resident stated	S9999			

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S9999	Continued From page 6 hitting back of his head right side.... MD called with orders to be send out for CT (computed tomography) scan R1's five incident reports show: 1. 1/13/2018 - Resident is independent with ambulation with cane... After interviewing the resident it was determined that as resident was ambulating, his leg got caught on his cane, causing him to lose balance and coordination and fall to the floor. Resident returned from local hospital, after receiving 7 stitches to lacerations site. Resident educated on safety precautions and verbalized understanding. Resident to be evaluated by therapy department. 2. 1/25/2018- Attempting to use urinal, lost balance, slid off and was noted sitting down As a result of the accident/incident, the plan of care has been updated to decrease potential for future falls: Encourage to use urinal safely if unsure ask for assistance, call light within reach encourage use, check if gait and transfer ability declining or improving 3. 3/24/2018 - Got up the wheelchair unassisted towards bathroom, lost balance. As a result of the accident/incident, the plan of care has been updated to decrease potential for future falls: -Resident instructed to ask for help, he is alert and able to use call light and alert to ask for help 4. 3/27/2018 - Got up unassisted, reaching for object As a result of the accident/incident, the plan of care has been updated to decrease potential for future falls: Remind to use call light and not to transfer self without assistance, pain management, x-ray to right arm, continue physical therapy IDT reviewed incident and analyzed root cause,	S9999			

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S9999	Continued From page 7 resident is instructed to ask for assistance as he can use call light, wheel self around and transfer with minimal assist. He can use urinal at bedside. Resident's x-ray right arm requires orthopedic evaluation, discussed with [V10/Attending Physician], no acute fracture noted. X-ray result reviewed by doctor and concluded that right hemiplegia and polio contributed to abnormal right arm X-ray. Recommend to send resident for evaluation at hospital. 3/28/2018 - Resident returned from hospital with no new intervention, right arm sling on and pain medication as needed. 5. 5/12/2018 - Resident failed to use call light for assistance, educate, continues refusal As a result of the accident/incident, the plan of care has been updated to decrease potential for future falls: falling star program and frequent rounding R1's hospital physician progress note dated 1/13/2018 at 9:45pm shows: 10 cm (centimeter) laceration on the left frontal scalp, repaired with sutures On 5/23/2018 at 11:14am, V6 (Physical Therapist) stated the following: Initial PT assessment was on 12/21/2017. R1 has history of having right hemiplegia, where his right arm cannot move at all, his arm just hangs there and he doesn't have much control at all. R1 first came in with a quad cane that has four prongs, and needed minimal staff with one person assist. R1 was discharged after six sessions (1/3/2018), and needed stand-by assistance at all times and was to ambulate with a hemi-walker. R1 was not safe to ambulate without supervision and was not stable with a quad cane. R1 was safer and more steady ambulating with a hemi-walker, because it has a wider base support. After R1 was	S9999			

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S9999	Continued From page 8 discharged from therapy, R1 started having decreased balance and increased falls, due to behavior and being a very impulsive person. R1 had a tendency to use the call light and wouldn't wait, so he would attempt to do things himself, which is not safe. We have one hemi-walker in the building, and restorative would come down to borrow it, when walking R1 and would return it. R1's x-ray results show: 1/26/2018- Right shoulder: No subluxation or dislocation, normal visualized humeral head 3/27/2018- Correlative films provided: 1/26/2018, Right shoulder, Impression: 1. There is acute fracture of the proximal humerus with slight impaction at the level of the neck 3/27/2018- Right humerus, Impression: 1. Fracture of the proximal humerus R1's Emergency Department discharge instructions dated 3/27/2018 shows: There is a fracture of the neck of the humerus. Wear the sling at all times. Follow-up with orthopedic surgery on 4/4/2018. R1's rehabilitation physician progress note dated 4/3/2018 shows: 1. Neuromuscular deconditioning 2. Activities of daily living dysfunction 3. Gait dysfunction 4. Falls 5. Right hemiplegia Functional status updates: Contact guard wheelchair mobility. Plan/recommendations/status: initial evaluation, plan and goals reviewed today. Patient has an appointment with orthopedic surgery on 4/4/2017 in regard to findings on x-ray. R1's medical record does not contain any documentation clarifying if R1's x-ray results was due to hemiplegia or polio as documented on the	S9999			

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S9999	Continued From page 9 incident report on 3/27/2017. On 5/24/2018 at 9:03am, V1 stated, I can't find any documentation about R1's x-ray being due to Polio or hemiparesis or why the injury was not reported to IDPH. On 5/24/2018 1:10pm V10 stated the following: I received a call in March that R1 had a fall and they left a message instead of paging me right away. Initially, R1 and V7 didn't want to go to the ER, so I ordered an x-ray. I saw a previous x-ray in 2015, and R1 did not have a fracture then. It does seem that R1 had an acute fracture, I can't say it's a chronic fracture because that was an event that R1 fell and had arm pain associated with the fall. R1 is able to give information, is very impulsive and has history of seizures, Polio and having many falls at home. R1 came to the facility for subacute rehab, and is doing well now considering. R1's primary care physician did note that R1 has an enlarged prostate, and has urinary frequency and urgency. R1's comprehensive care plan shows: -12/28/2017 - Transfer needs- Quad Cane, Educate resident on benefits and risk factors associated with non-compliance with use of adaptive equipment, transfer devices and refusal for restorative programming participation as indicated when refusals occur R1's care plan was not updated to reflect the use of hemi-walker when discharged from physical therapy on 1/3/2018. Falls were listed for 1/13/18 and 1/25/18 and interventions include education and evaluation by therapy department. Falls were listed for 3/24/2018 and 3/27/2018, and the same interventions included to ask for assistance and use of call light. R1's care plan does not address R1's diagnoses and complaints of	S9999			

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S9999	Continued From page 10 urinary urgency. R1's care plan was not updated after his fall on 5/12/2018. On 5/23/2018 at 1:39pm, V8 (Restorative Director) stated the following: the previous Director of Nursing was in charge of investigating falls, and we discussed falls as an interdisciplinary team (IDT) to assess what happened and what we will do to update the care plan. R1 fell the first time on 1/13, the interventions were a referral to the therapy department and educate on safety awareness. During that fall, R1 was using a cane that he brought from home. The hemi-walker was only used during therapy and restorative sessions. I would borrow the hemi-walker from therapy, because R1 is on an ambulating program. I just recently ordered a hemi-walker for R1, but it has not arrived yet. We provided R1 with a wheelchair instead so that R1 would not walk on his own. After R1 fell on 1/25, the intervention was to encourage the safe use of a urinal, to ask for assistance, and to check if there's a decline or improvement with gait. R1 fell again on 3/24, and interventions were to instruct to ask for assistance and encourage use of call light. R1 fell on 3/27, and interventions were to ask for assistance and encourage use of call light when transferring. R1 fell again on 5/12, but my signature isn't on the IDT report, so I wasn't aware of these new interventions and didn't update the care plan. On the incident report, it says to implement falling star program and another intervention I can't read, but R1 was already on the falling star program, which started in March 2018. We have the IDT meetings after every fall, but we don't have another meeting to follow up and re-evaluate effectiveness of interventions, which is something we can do and work on. R1 also was not on a toileting schedule	S9999			

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S9999	Continued From page 11 to address his urinary urgency. We should have included more supervision in the interventions, because R1 still keeps falling even though his room is near the nurse's station. I was not aware that R1 had a fracture on the shoulder, I was told it was from his history of Polio and hemiparesis. R1's MDS for significant change in status with ARD of 3/30/2018 shows: -BIMS (Brief Interview Mental Status) = 11/15, Moderate cognitive impairment -No rejection of care -Requires Extensive assistance and two plus person physical assist with bed mobility, transfers, walking in room and corridor, toilet use -Requires Extensive assistance and one person physical assist locomotion on and off unit and dressing -Impairment on one side for both upper and lower extremities -Mobility device: wheelchair -Not steady, only able to stabilize with staff assistance for walking, moving on toilet, surface-to-surface transfer, and moving from seated to standing position -Occasionally incontinent of bowel and urine -Number of falls since admission (most recent Assessment) - A. 2, two or more falls with no injury; B. 2, two or more falls with injury (except major); C. 0, No falls with major injury (bone fractures...) On 5/23/2018 at 4:08pm, V9 (MDS and Care Plan Coordinator) stated: the previous MDS Coordinator did a significant change MDS for R1 due to a decline and multiple falls. Based on the x-ray results and history of falls, R1's falls should have been coded as A. 2, two or more falls with no injury, B. 1, one fall with injury (except major) for the laceration, and C. 1, fall with major injury	S9999			

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S9999	Continued From page 12 for the shoulder fracture. The fall interventions should have been analyzed and investigating falls involves a lot of critical thinking. They are the same interventions for 3/24 and 3/27, but should have addressed toileting and supervision. The facility's policy and procedure titled, "Fall Prevention and Management" version 8/3/2017 reads: [Through] an interdisciplinary approach, this facility will provide fall prevention assessment, implement interventions to prevent falls as much as possible, and manage post-fall treatment. The facility will achieve these goals through: 1. An individualized fall risk assessment 2. Interventions that are implemented based upon the identified risk factors. 4. Reassessment of risk after a fall with modification and/or additional interventions as appropriate V. Care Plan A. Interdisciplinary care plan is implemented for residents at risk and may include 1. Interventions to prevent falls 3. Assistive devices as appropriate 4. Supervision as appropriate B. Evaluation of the interventions is completed 3. Interventions are modified as indicated based upon evaluated efficacy of the interventions VI. Documentation B. Fall risk and care plan are reviewed and updated 4. Revise or implement additional individualized interventions as appropriate 2) On 5/23/2018 at 12:26pm, V1 (Administrator) stated: [V11/previous Director of Nursing] reported to me that R2 had a fracture, but that it was an old fracture and that it didn't need to be reported to IDPH. V2 (Director of Nursing) and I	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005227	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/24/2018
NAME OF PROVIDER OR SUPPLIER LAKEVIEW REHAB & NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 735 WEST DIVERSEY CHICAGO, IL 60614		
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S9999	Continued From page 13 are just finding out now, that R2's x-ray results show an acute fracture. If I had this information back then, I would have reported it to IDPH. On 5/24/2018 at 9:03am, V1 stated, I can't find any documentation about R1's x-ray being due to Polio or hemiparesis or why the injury was not reported to IDPH. The facility's policy and procedure titled, "Fall Prevention and Management" version 8/3/2017 reads: V. Notification of the State when indicated A. If the fall results in a serious injury, the Illinois Department of Public Health is notified within 24 hours or as soon as possible B. The report is prepared and sent by the Director of Nursing or designee C. The full report of the investigation is sent to IDPH within five (5) days of the accident/incident (C)	S9999			