STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008304	A. BUILDING: _____ B. WING _____	C 10/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TERRACE OF MCHENRY REHAB	803 ROYAL DRIVE MCHENRY, IL 60050

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S 000	Initial Comments Incident Report Investigation (FRI) to Incident of October 13,2021/ IL139479	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 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 plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. 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: 3)Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These requirements were not met evidencded by: Based on interview, and record review, the facility	S9999		

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failed to ensure a safe transport of a resident via wheel chair by not ensuring foot rest were in place for three of three residents (R1, R3, R4) reviewed for safety in the sample of four. This failure resulted in R1 sustaining a fall with injuries including a nasal fracture which required five sutures. R1 was transferred to the local emergency room (ER).

The findings include:

1. R1's Order Summary Report shows R1 was admitted to the facility on 8/29/19 with diagnoses including: syncope and collapse, insomnia, long term use of aspirin, chronic pain, and dementia.

R1's MDS (Minimum Data Set) dated 10/1/21, shows R1 is not cognitively intact. R1 requires extensive two person assist with transferring and requires extensive one person assistance with locomotion. R1 has a limited range of motion on both of her lower extremities. R1 is dependent on staff to put on and taking off her footwear. R1 requires substantial/maximal assistance with the manual wheel chair.

R1's Fall Risk Assessment dated 9/30/21 shows R1 is at risk for falls.

R1's Care Plan initiated 8/30/19 shows, "R1 is at risk for falls due to poor safety awareness and cognitive deficit due to diagnosis of dementia, use of high risk medications, incontinence. R1 is noted to be unsafe with wheelchair cushion including with dycem applied due to leaning forward in wheel chair. R1 lacks trunk control. Bilateral leg rests applied for transporting resident (added to care plan 10/14/21)."

R1's Nurses Notes dated 6/29/21, shows R1

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S9999	Continued From page 3	S9999		

requires extensive staff assist with completion of ADLs (Activities of Daily Living). R1 utilizes a wheelchair propelled by staff for locomotion.

R1's Post Occurrence Documentation note dated 10/13/21, shows, "RA (Resident Aide) informed nurse of R1's fall. Resident observed sitting on her bottom in front of her wheelchair with her feet crossed in her room. Resident alert, observed with top of nose bleeding. Skin tear 1.5 cm (centimeters) X 0.4 cm on nose. Staff member verbalized resident was being pushed in wheelchair and R1 leaned forward and fell to the floor hitting her nose on the floor. Order received to send resident to the ER for evaluation and treat."

R1's Nurses note dated 10/13/21 shows, "R1 returned from local hospital and placed in her bed. Five sutures noted to bridge of nose with slight redness surrounding. Tylenol given for pain. Resident sitting upright in bed awaiting dinner. Discharge papers received and orders entered. CT (cat scan) shows fracture to tip of the bridge of her nose."

On 10/25/21 at 11:14 AM, V2 DON (Director of Nursing) said foot rests on wheel chairs for resident's that do not self propel are a fall prevention, and intervention for wheel chair safety. V2 said, V3 Resident Aide (RA) was transporting R1 via the wheel chair to take R1 to the dining room for lunch. V2 said, R1 has history of leaning forward while in her wheel chair. V2 said, while V3 was pushing R1 in her wheel chair, R1 leaned forward and fell. R1 was sent out to the hospital for evaluation and a fracture was found in R1's nose. V2 said, when R1 fell, she landed on her face. V2 said, after R1's fall, staff was educated to hold R1 upright via her shoulder

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and to make sure R1 has foot rests on with every transport. V2 said, R1 did not have foot rests on her wheel chair prior to this fall and they are a new fall prevention intervention. V2 said, during R1's fall investigation, the facility implemented that residents that cannot self propel in the wheel chair to have foot rests on. the wheelchair. V2 said, foot rests on wheel chairs are a part of safety. V2 said, the facility did a house wide audit to see if residents that needed foot rests had foot rests available.

On 10/25/21 at 11:47 AM, V3 Resident Aide with V1 Administrator as a translator said, she was taking R1 into the dining room for lunch when R1 leaned forward and fell out of the wheel chair. V3 said, when R1 fell, R1 hit her face on the floor. V3 said, R1 did not have foot rests on her wheel chair. V3 said, R1 was bleeding from her nose. V3 said, she has received education from the facility to make sure every resident has leg rests on the wheel chair and resident is positioned well in the wheel chair.

On 10/25/21 at 2:24 PM, V6 CNA said, R1 is a total care resident. V6 said, R1 is not able to use her feet while she is in her wheel chair and R1 is not able to follow directions.

2. On 10/25/2021 at 9:55 AM, V7 Activity Aide was pushing R3 in her wheel chair throughout the facility. R3's legs were hanging down.

On 10/25/21 at 2:15 PM, V5 CNA said, R3 should have foot rests on her wheel chair. V5 said, R3 is not able to use her feet while she is in the wheel chair. V5 said, foot rests are used for wheel chair safety and fall prevention interventions.

On 10/25/21 at 1:21 PM, V2 said, R3 had foot

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rests on her wheel chair when she was first admitted to the facility. V2 said, R3 went to the hospital and when R3 came back to the facility, her wheel chair was changed. V2 said, R3 should have foot rests on her wheel chair when she is being pushed for a long time.

On 10/25/21 at 12:00 PM, R3 said, she does not have foot rests for her wheel chair, but she would like to have foot rests for her wheel chair.

R3's Care Plan initiated 9/18/21 shows, "R3 is at risk for falls due to diagnoses hemiplegia, diabetes mellitus, chronic kidney disease, spinal stenosis, dysphagia, history of falling, and lack of coordination. Encourage appropriate use of wheel chair."

R3's Fall Risk Assessment dated 10/22/21, shows R3 is at risk for falls.

R3's MDS dated 9/24/21 shows, R3 is cognitively intact. R3 requires total assistance with two people for transferring and requires total assistance of one person with locomotion on the unit. R3 has an impairment in functional range of motion to both of her lower extremities.

3. On 10/25/21 at 9:46 AM, V7 was pushing R4 down the hall towards R4's room. R4 did not have foot rests on her wheel chair. R4 was holding her legs up slightly above the ground while V7 was pushing her wheel chair.

R4's Fall Risk Assessment dated 8/3/21, shows that R4 is at risk for falls.

R4's Care Plan initiated 5/12/19 shows, "Staff to ensure that resident's leg is placed properly in the leg rest." Care Plan initiated 12/31/18, "R4 is at

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S9999	Continued From page 6 risk for falls related to ADL deficit, cognitive deficit related to Alzheimer's disease." R4's MDS dated 8/4/21, shows R4 is not cognitively intact. R4 requires total assistance from two staff members with transferring and requires total assistance with one person for locomotion on the unit. On 10/25/21 at 12:05 PM, V4 CNA said, fall prevention interventions include locking the wheel chair, making sure the resident is sitting straight and using foot rests in the wheel chair. On 10/25/21 at 1:21 PM, V2 DON said, R4 should have foot rests on her wheel chair while transporting. The facility's Fall Management Program policy dated 8/2020 shows, "The facility is committed to minimizing resident falls and/or injury so as to maximize each resident's physical, mental and psychosocial well being. 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 resident at risk for falls, plan for preventative strategies and facilitate a safe environment." " B"	S9999		