STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005227	A. BUILDING: _____ B. WING _____	C 05/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW REHAB & NURSING CENTER	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 Complaint Investigation 2182960/IL133441	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b)5) 300.1210c) 300.1210d)6) 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: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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,	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. Based on interview and record review, the facility failed to implement effective fall prevention interventions for one of three residents (R6), reviewed for falls. This failure resulted in R6 experiencing an unwitnessed fall and sustaining a right intertrochanteric femur fracture (hip fracture), requiring surgical intervention, and acute subarachnoid hemorrhage (bleeding in space between brain and surrounding membrane). Findings include: R6's medical record (Face Sheet) notes resident is an 85 year old admitted to the facility on 04.01.2021 with diagnoses including but not limited to: Cerebral Infarction, Dysphagia Following Cerebral Infarction, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, Attention and Concentration Deficit Following Cerebral Infarction, Unspecified Abnormalities of Gait and Mobility, Unspecified Lack of Coordination and Weakness. MDS (Minimum Data Set, 4.8.21) documents severely cognitively impaired with worsening of current behavior symptoms. R6 requires extensive assist of two for bed mobility and transfer; is totally dependent with assist of one for locomotion on unit; only able to steady self with staff assistance when moving from seated to	S9999		

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S9999	Continued From page 2 standing position/moving on and off toilet/surface-surface transfer (transfer between bed and chair). Resident has limited range of motion effecting both upper and lower extremities on both sides and is frequently incontinent of urine and stool. R6's Admission Fall Assessment (04.01.2021) documents R6 receives medication that affects awareness, judgement or safety; has altered level of consciousness that fluctuates; balance problem while standing/walking and history of stroke that places R6 at high risk for falls. R6's fall risk score was assessed as "16". Per document, a score of "10" or above represents high risk (for falls). Facility's Final Incident Report of 04.15.2021 documents R6 was observed on floor next to bathroom door, unable to recall how the fall occurred. Resident was sent to (local hospital) and admitted with right femur fracture and subarachnoid hemorrhage. R6's hospital record (04.09.2021-04.22.2021-Progress Notes) confirms R6 was admitted to the hospital after falling at the facility on 04.09.2021. Resident sustained a right intertrochanteric femur fracture (hip fracture) requiring surgical intervention and acute subarachnoid hemorrhage (bleeding in space between brain and surrounding membrane). 05.06.2021 at 2:32 PM, V10 (LPN-Licensed Practical Nurse) described R6 as a "fall risk" due to resident's unsteady gait and frequently getting up without staff assistance. V10 said, "She (R6) wouldn't stay in bed. She got up at least 10 times during the shift. I tried to check on her every 15 to	S9999		

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S9999	Continued From page 3 30 minutes, but I had other things to do and couldn't always check on her. I told the staff to keep an eye on her, of course, we can't do that all the time. I told the CNA (Certified Nursing Assistant) to watch her. He was feeding another resident when she (R6) fell. He should have gone back after he was done feeding that resident." V10 was unable to tell this writer which CNA was instructed to supervise R6 or what fall prevention interventions were in place prior to R6's fall. V10 responded, "I did not read the care plan, I was too busy that day." 05.06.2021 at 3:44 PM, V23 (CNA) said "I never took care of her (R6) before. That was the first time I saw her. No one asked me to watch her. V15 (CNA) said to me, "I was trying to avoid this all day (resident's fall), trying to prevent this from happening. She was taking care of R6." 05.06.2021 at 4:47 PM, V15 (CNA) denied taking care of R6. "There was someone on the floor. I didn't know it was her. I wasn't assigned to take care of her." 05.06.2021 at 6:02 PM, V22 (CNA) said, "I don't remember anything." V20 (CNA) was not availble for interview. 05.07.2021 at 9:15 AM, V2 (Director of Nursing) said that she expects CNAs to follow nurses' directions. R6's "Fall Risk" care plan (dated 04.08.2021) documents R6 is at risk for falls related to: Cognitive Impairments, Decreased Safety Awareness, Requires ADL (Activities of Daily Living) assistance for Transfers and Mobility, Incontinence, Decreased Strength and	S9999		

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S9999	Continued From page 4 Endurance and, diagnosis of CVA (Cerebral Vascular Accident) with possible Hemiparesis or Hemiplegia. Approaches/Interventions include: Call light within reach, encourage to use for assistance as needed; respond promptly to all requests for assistance. Anticipate and meet needs. The facility did not implement fall risk approaches/interventions. 05.07.2021 at 7:49 AM V21 (Family Member) said, "They were one of the only facilities that would take (R6) because of her behavior. She wouldn't follow commands (instructions/directions). She had a sitter when she was in the hospital. She was tied down at the hospital (described wrist restraints) after they got rid of the sitter." R6's hospital record(Progress Notes 3.21.2021, 03.29.2021) document R6 required a sitter and restraints (A)	S9999		