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	IL6007843	A. BUILDING: _____ B. WING _____	C 09/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALOS HEIGHTS REHABILITATION	13259 SOUTH CENTRAL AVENUE CRESTWOOD, IL 60418

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S 000	Initial Comments Complaint Investigation 2295692/IL149242 2295551/IL149048 2297006/IL150788	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2) 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 300.1810f)1) 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.	S9999		

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S9999	Continued From page 2 Section 300.1810 Resident Record Requirements f) An ongoing resident record including progression toward and regression from established resident goals shall be maintained. 1) The progress record shall indicate significant changes in the resident's condition. Any significant change shall be recorded upon occurrence by the staff person observing the change. These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to identify and assess acute changes in condition to include and determine complaints of severe leg pain and assess and identify acute mental or neurological changes that required activation of 911. These failures affected 2 of 4 residents (R1, R7,) reviewed quality of care related to acute changes in condition. These failures resulted in R1 complaining of severe leg pain for 2 days and then treated for dislocation of the right hip replacement. R7 had displayed changes in mental status for undocumented period of time, R7 was admitted and treated at the local hospital for acute intracranial hemorrhage. Findings include: 1. R1 Review of R1's medical record notes, R1 was admitted to this facility on 1/29/22 for orthopedic aftercare of right femur fracture. R1 had a right total hip arthroplasty while in the hospital. Review of R1's physical therapy documentation	S9999		

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S9999	Continued From page 3 notes the following: On 2/7/22, V22 (Physical Therapy Aide/PTA) placed 1.5-pound weights on R1's lower legs while R1 was lying in supine position with instructions on isotonic and isometric exercises to increase range of motion, mobility, flexibility, muscle strength, and endurance. Afterwards, R1 performed gait training with a rolling walker, 9 feet to 14 feet minimum assistance, with decreased stride length, toeing off, a significant leg length discrepancy and an antalgic gait (a limp caused by pain in lower legs). On 2/8/22, V23 (Physical Therapist/PT) noted: R1 complained of right hip pain, 8 out of 10 post medication. R1 requires constant redirection due to increased anxiety and easily gets distracted. R1 instructed to increase foot clearance and step length. Rest breaks taken due to complaints of fatigue and pain. On 2/9, therapy session spent consulting with R1's nurse about R1's bulging right hip, swelling, increased back pain, and pain traveling down R1's leg to R1's toes, describing pain as lightning. R1 observed internally rotating right foot. On 9/15/22 at 11:00am, V5 (Director of Rehabilitation Services) vaguely recalls R1. After reviewing R1's physical therapy documentation, V5 stated that weights are applied to a resident's legs when doing exercises to improve the resident's stability. V5 stated that 1 1/2 pounds weights were used during R1's therapy session on 2/7. V5 stated that the therapist noted R1 was distracted during session, needed redirecting. V5 stated that the therapist also noted a leg discrepancy-right leg shorter than left; R1 was unable to do much in therapy due to pain.	S9999		

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S9999	Continued From page 4	S9999		

On 9/15/22, V8 (Nurse) stated that on 2/9/22 R1's right hip was very swollen. V8 stated that she ordered a right hip x-ray. V8 does not recall if x-ray was urgent or not. V8 denied contacting the outside diagnostic imaging company and receiving an estimated time of arrival for x-ray to be done. V8 stated that V8 endorsed to next shift.

On 9/15/22 at 3:00pm, V2 (Director of Nursing/DON) stated that the nurse is expected to call the outside diagnostic imaging company with all X-ray orders. V2 stated that the outside diagnostic imaging company will provide the nurse with a confirmation number with an estimated time of arrival at this facility to perform X-ray. When asked if it is appropriate for a resident who had been admitted to this facility for care after a right total hip arthroplasty to wait 10 hours for an X-ray of the right hip that was observed bulging, swollen, and with increased pain, V2 declined to answer. V2 stated that V2 would assess the resident and determine best course of action.

Review of R1's right hip X-ray results, dated 2/10/22 at 1:06am, notes R1 with dislocation of right total hip replacement with the femoral head displaced superiorly.

Review of R1's hospital record, dated 2/10/22 at 4:25am, notes the emergency room physician attempted to reduce R1's right hip dislocation, but was unsuccessful. R1 was taken to the operating room. A second attempt to close reduce R1's right hip dislocation was unsuccessful. R1 required surgical intervention, a right total hip revision, to obtain proper alignment of R1's right hip. Review of R1's physical therapy evaluation,

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S9999	Continued From page 5 dated 1/29/22, notes R1's activity tolerance, sitting and standing, is 0-15 minutes. Range of motion to right leg: completes up to 25% of normal range. Strength of left leg is 3 out of 5. Strength of right leg is 2 out of 5. Physical therapy recommended 5 times a week for 4 weeks. Review of this facility's change in a resident's condition or status policy, revised 03/2019, notes the nurse will notify the resident's attending physician when there has been a discovery of injuries of an unknown source, significant change in the resident's physical condition, need to transfer the resident to a hospital. The nurse will record in the resident's medical record information relative to the changes in the resident's medical condition or status. 2. R7 R7 was admitted to the facility on 2/7/22 with diagnoses of acute and chronic respiratory failure with hypoxia, pulmonary hypertension, heart failure, chronic ischemic heart disease and nausea. On 9/16/22 at 1:27PM, V16 (Certified Nursing Assistant/CNA) said R7's baseline was alert, oriented and able to express needs. V16 said she observed R7 having difficulty talking and R7 was unable to communicate what she wanted to say. R7 was confused and not herself. V16 unable to recall time of events but reported it to V10 (nurse). On 9/16/22 at 12:08PM, V10 (Nurse) said she recalls staff reporting R7 was not herself at some point during her shift. V10 said R7 was not talking a lot. V10 was unable to recall the time or vital	S9999		

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S9999	Continued From page 6 signs at time of assessment. V10 said she does not recall if she called the doctor or if she just called private ambulance. V10 said she called an ambulance due to vomiting and checked on the resident two additional times prior to the ambulance arrival. V10 said she did not call 911 because R7 did not need to go out immediately. V10 said she documented events and vitals but unsure why they are not recorded in R7's medical record. (A) Statement of Licensure Violations (2 of 2) 300.610a) 300.1210b) 300.1210d)6) 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.	S9999		

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S9999	Continued From page 7 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. 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. These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to follow fall prevention protocols and remove tripping hazards to prevent the risk of falling and failed to implement fall prevention recommendations. These failures affected 2 of 3 (R3, R8) residents reviewed for falls and fall prevention. This failure resulted in R3 tripping and falling to the floor sustaining a closed fracture of the left side rib. Findings Include:	S9999		

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S9999	Continued From page 8 Facility reported incident dated on 6/27/22 documented that R3 reported pain to R3's left side with increased pain and tenderness during movement. R3 reported a fall in the bathroom, R3 hit R3's side on the toilet and that R3 crawled back to the bed. Diagnostics revealed mildly displaced 11th rib fracture. R3's notes reviewed and documented on 6/23/22 by V29 (Nurse) reads in part: R3 discovered on the floor at bedside, not sure if R3 fell or just laid on the floor, abrasion noted to right elbow. On 9/16/22 at 1pm, V11 (Restorative Nurse) stated "Restorative aide reported to me that R3 is having pain on R3's left side where the left rib area was at. I went to see R3. My assessment was, R3 was in pain and could not move because there was more pain when moving. Pain only with movement. I asked R3 what happened. R3 reported R3 was out with the son couple of days ago, then the sister of R3 walked in and I asked if R3 was out of the building with R3's son and the sister said "NO". Sister then reported to me that R3 had fallen on the 23rd. the sister of the resident reported that the sister received a call from the nurse on the 23rd about the fall incident of R3. I talked to R3 on how did he fall and R3 said he was in the bathroom, lost balance and hit his side on the toilet. R3 stated "I crawled back to my bed." I asked if R3 called after the fall and R3 said R3 yelled out and the nurse came to check on R3." On 9/16/22 at 1:45pm, V17 (Restorative Aide) stated "I asked if R3 is in pain and if he had a fall, when and where did R3's fall happened. R3 stated "In the bathroom and I think it was the other day. I may have tripped and lost my balance".	S9999		

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S9999	Continued From page 9 Hospital record of 6/27/22 reviewed and CT abdomen pelvis with IV contrast was done and it shows minimally displaced posterior left 11th rib fracture. R3 is at risk for fall due to weakness, impaired balance and dementia with a revision date of 8/11/22. Goal for R3 is to be free of falls. Interventions: Increased staff supervision with intensity based on resident need. Provide individualized toileting interventions based on needs/pattern. R3 was assessed on 3/23/22, Physical Therapist and discharged summary: Balance Dynamic Standing as" Minimal assist to maintain, dynamic cannot move trunk without loss of balance. Walk 10 feet and 50 feet with two turns: Helper assist only prior to or following the activity. Walk 150: Supervision or touching assistance-helper provides verbal cues or touching steadying assistance as resident completes activity or intermittently. Walking 10 feet uneven surfaces: not attempted due to medical condition or safety concerns. Risk for fall: R3 will demonstrate improved balance to 41/56 as evidence by Berg Balance test result with improvement in safe transfer and gait. Status: Goal not met on 3/23/22. Explanation: reached highest functional level. End of goal status as of 3/23/22: Goal not met R3 medium fall risk as evidence by Berg Balance test result. Analysis of functional outcome/Clinical impression: R3 continues to demonstrate right	S9999		

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S9999	Continued From page 10 foot drop and R3 dragging right foot with R3 able to correct with verbal cues given. Precautions but not limited to falls. On 9/14/22 at 2pm, observation of R3's room conducted and noted duct tape on the floor by the doorway, bedroom to washroom transition. On 9/16/22 at 11am, R3's room recheck and the same duct tape on the floor was observed. Doorway floor bedroom to washroom transition. On 9/16/22 at 1130am, V3 (Maintenance Director) stated "I communicated this concern with the V1 (Administrator) and the management team first time it was observed by a surveyor during this survey on 6/14/22. I mentioned to them that in order for me to fix the floor issue, the resident in the room must be moved to another room. It would have been more of a trip hazard if the duct tape is not there, however having the duct tape is still a hazard. The floor needs to be fixed in order to make the area safe and not a hazard. I have everything/items to fix the floor, I am just waiting for the facility to move the resident who is present now in R3's former room". Fall and Fall Risk Management with a revision date of 3/2019 reads in part: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Policy interpretation and implementation: According to the MDS, fall is defined as: Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered	S9999		

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S9999	Continued From page 11 to have occurred. Fall Risk Factors: Environmental factors that contribute to the risk of fall include: Obstacle in the floor path. Resident conditions that may contribute to the risk of falls include: Lower extremity weakness. R8 was admitted to the facility on 8/26/22 with diagnoses of unsteadiness on feet, history of falling, lack of coordination and anemia. R8's brief interview for mental status dated 9/2/22 documents a score of 15/15, which indicates cognitively intact. R8 minimum data set section G, documents under bed mobility, Resident requires extensive assistance with one-person physical help. R8's nutritional assessment dated 8/29/22 documents a weight of 235 pounds. On 9/14/22 at 1:53PM, R8's mattress was observed hanging over the frame of her bed and was not flush to the bed frame. R8 had no positioning rails observed on bed. R8 post fall observation dated 9/14/22 documents an observation date of 9/5/22, staff relayed that R8 had slid between the mattress and wall, lodging herself. Staff carefully lowered her to the floor and used mechanical lift to return her to bed. The mattress was changed out; there were no further incidents or injury. What appears to be the root cause for this fall is that mattress did not fit the bed. Initial intervention documents: mattress changed. Additional information documents: assessed R8's bed mattress and still needs change and positioning rails on bed; informed maintenance. R8 Progress Notes dated 9/4/22 documents: Resident was observed in bed, alert and able to make needs known. CNA was doing ADL care	S9999		

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S9999	Continued From page 12 while resident was lying in bed on an air mattress and when turning to the side, the resident turned and got stuck between the bed and wall. R8 Therapy Notes dated 9/6/22 under notes: Patient on an extra-large air mattress and agreeable to bed positioning device to increase bed mobility On 9/15/22 at 2:46PM, V11(Restorative Nurse) said it was recommended for R8's mattress to be changed following an incident on 9/4/22. V11 said the mattress was too big for the frame and was not changed until 9/14/22. V11 said she was unaware of therapy recommendations for positioning rails for R8. (B)	S9999		