STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006779	A. BUILDING: _____ B. WING _____	C 06/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK LAWN RESPIRATORY & REHAB	9525 SOUTH MAYFIELD OAK LAWN, IL 60453

(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 FRI of 5/15/2022/IL147479, Complaint Investigations: 2293407/IL146429, 2294036/IL147222	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 300.610a) 300.1210b)4 300.1210d)3 300.3240a) 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 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. 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. 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) These Requirements were NOT MET as evidenced by: Based on interviews and records reviewed the facility failed to prevent an incident of staff to resident mental abuse by cutting the call light cord for a resident assessed to require extensive assistance. This affected 1 of 3 resident reviewed for mental abuse. This failure resulted in R8	S9999		

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S9999	Continued From page 2 feeling scared, repeating "I want my call light," and becoming anxious. Findings include: R8 is 58 years old with diagnosis including but not limited to Anxiety Disorder, Panic Dosorder, Chronic Obstructive Pulmonary Disease, Paranoid Schizophrenia, Bipolar Disorder, Essential Hypertension, Epilepsy, and Atherosclerotic Heart Disease. R8's cognitive assessment notes on 5/2/22 she as score of 15, intact. On 6/9/21 at 1:38PM R8 observed in her bed with a bright orange call light string next to her. R8 said "she always takes the call light from me." R8 was not able to give more description or details. On 6/10/21 at 9:51AM R8 told the surveyor when "they took my call light, I felt scared." R8 said she used the call light to call for help. On 6/9/22 at 1:55PM V1, Administrator, said I was called and told the CNAs cut R8's call light string. I was told the CNAs did not want to cooperate with giving a statement or leaving the facility. V1 said we had to threaten to file charges against them to leave the facility. V1 said she spoke to R8 and she said her call light string had been cut. V1 said I confirmed with the nurses and they said "everyone knew it was cut." V1 said on the Friday before this happened we had replaced all the call light strings with a solid orange colored string, when I saw the string after the allegation it had been cut and pieced together in a different color string. V1 said she went to interview R8 and she said she hates those two, but did not give a further statement. V1 said she was told about the allegation by V13, Licensed Practical Nurse	S9999		

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S9999	Continued From page 3	S9999		

(LPN). V1 said her investigation findings was that the CNAs (V3 and V4) did act inappropriately and they were terminated. V1 said we substantiated abuse.

On 6/9/22 at 2:08PM V12, Dietary Manager, said he was the manager on duty on 5/15/22. V12 said when V13, LPN, told him about the allegation he called V1. V12 said V1 told him to get statements from V3 and V4 and then they must leave the facility immediately. V12 said he spoke with V3 and V4 but they refused to give their statements. V12 said he went to speak with R8, but she did not speak with him. V12 said the nurse reported that V3 and V4 had been speaking in a loud voice to R8.

On 6/9/22 at 2:26PM V13, LPN, said V38 (LPN) told her that the CNAs were being inappropriate with a resident. V13 said she went to check if this was any kind of abuse. V13 said she spoke with V3 and V4 and asked for a statement but they refused to cooperate. V13 said I told them they have to leave and they refused.

On 6/10/22 at 2:13PM via phone interview, V38, LPN, said she was assigned to R8 on 5/15/22. V38 said V3, Certified Nursing Assistant (CNA), was R8's assigned CNA. V38 said she had been exchanging words with V3 about the care she expected for R8, including maintaining her head elevated while in the bed because R8 is on oxygen. V38 said she had instructed V3 to not be on the phone while on duty. V38 said she heard V3 say "this will be a fisting night." V38 said R8 had kept putting her call light on. V38 said she heard V3 say to R8 "dang, you got the light on, I am right here." V38 said she spoke with V3 about the comment made. V38 said she then went to provide care to R8's room mate then she heard

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S9999	Continued From page 4 R8 repeating "I want my call light, I want my call light." V38 said R8 was anxious and worked up. V38 said the call light is important to R8. V38 said she looked and saw that R8's call light string was in "pieces, it looked cut, and it was a clean cut." V38 said she was discussing the situation with V3 when V4, CNA, approached. V38 said she told V3 this is abuse and one of the CNAs said to R8 "Stop pulling this call light." V38 said she left the room and called the manager, the scheduler, and the administrator. V38 said in the meantime V3 and V4 became more outrageous. V38 said V4 told R8 "shut up, you doing too much." V38 said the situation was getting heated, the police had been called. V38 said V3 and V4 slammed a door in the police face. A review of the facility investigation incident date on 5/15/22 notes V3 and V4, both CNAs are staff involved. R8 stated both CNAs cut her call light, spoke to her inappropriately, and handled her inappropriately Agency nurse interviewed and agreed with the resident's statement. Administrator attempted to interview both CNAs and both refused to cooperate with the interview. Witness Resident Form date of incident from R8 states R8 alleged staff cut her call light, was very rude to her on purpose. She does not like the CNAs from Sunday. Review of R8's Functional Status Assessment dated 5/2/22 notes she requires extensive assistance from 2 persons for bed mobility, dressing, toilet use, and personal hygiene. Review of Employee Disciplinary Action Form for V3 and V4 dated 5/19/22 notes both V3 and V4 refused to leave the facility resulting in the facility having to request police assistance to remove	S9999		

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S9999	Continued From page 5 them. While leaving the facility V4 made a threatening statement towards the nurse supervisor, threatening to slap her. V3 and V4 were terminated, effective date 5/20/22. The facility Abuse Prevention Policy revised on 3/1/21 notes It is the policy of this facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and crime against a resident in the facility. (B) 2 of 2 Licensure 300.610a) 300.1210b) 300.1210c) 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. Section 300.1210 General Requirements for Nursing and Personal Care	S9999		

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S9999	Continued From page 6 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. These Requirements were NOT MET as evidenced by: Based on interviews and records reviewed the facility failed to develop a plan with interventions to prevent or reduce the risk of falling for 2 of 3 residents (R2/R1) reviewed for fall prevention protocols. This failure resulted in R2 falling from the bed being transported to the local hospital and treated for traumatic hemorrhage of the cebrum and R1 having at least 4 subsequent falls in a 2 month time frame. Findings include.	S9999		

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S9999	Continued From page 7	S9999		

Review of R2's admission fall risk review documents a score of 13. A score of 10 or above represents High risk for falls.
On 6/9/22 at 10:18 AM V48 (Family) states she stressed to the facility when R2 was admitted that he could not fall because R2 was on blood thinners. V48 states his nurse V6 (Nurse) she was at the facility when it opened and they would not let her stay the night. V48 states V6 called her at 5:30 AM on 4/11/2022. V48 states, she was awakened out of her sleep and she thought she heard V6 say R2 tried to stand on right leg. V48 states when she got to the facility, R2 was distraught and said" I want to get out of here and go home." R2 said they let him fall and he was on the floor for 4 hours in his feces. V48 states she immediately told the nurse that was there and called V6 on the phone and asked why he did not tell her that R2 fell. V48 states V6 stated that is why he called her to tell her.

V6 (nurse) documented the following note in R2's electronic medical record: 4/11/22 at 5:51 PM. Resident was observed with his right side lower to the floor and his weak left side and his lower extremities still in bed. Staff immediately lowered resident to the floor on a haul pad and transferred resident back to his bed.

On 6/10/22 at 11:01 AM V6 remembers R2. Had a "tendency move a lot." V6 states when he went to start medication around 5:00 am he found. R2's legs were in the bed, but his right side of body, head, and right shoulder off bed. His head was pointing downward but didn't touch the floor. V6 states he called wife and she said send R2 to the hospital. V6 states, he notified the doctor and the doctor said send R2 to hospital. V6 states he told the incoming nurse that morning

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S9999	Continued From page 8 that the doctor said send the resident to the hospital. On 6/9/2022 at 2:05Pm. V5 (LPN) states the wife was angry when she came in that morning. V5 states, she called the provider and told them exactly what the wife had told her, and the provider said send R2 to the hospital V5 (Nurse) charted the following in R2 electronic medical record: 4/11/2022 at 5:51 PM wife at bedside and states her husband said his head was on the floor along with his right side. On 6/17/2022 9:57 V2 (DON) states the definition of a fall is a change in plain, both assisted and unassisted. V2 states, "Charting is a legal document." V2 states staff should be charting the facts. R2's nursing progress note dated 4/11/2022 at 7:03 PM documents: Doctor at particular hospital phoned facility. admit diagnosis: Contusion with bleed. Review of hospital records from hospital dated 4/11/2022 documents the following: Visit Diagnosis: Fall, initial encounter (primary). Traumatic hemorrhage of cerebrum without loss of consciousness, unspecified laterality, initial encounter. History of present illness: This is a 58 yrs old male with PMH, of MI, CHF, CVA with residual L sided weakness & aphasia, HTN, CAD, DM, COPD, afib on Eliquis presents from Nursing home after a fall from his bed. Patient, initially complained of headache. Patient was taken to an [hospital] where Head CT was done showed petechial hemorrhage. Patient transferred to [hospital 2] for further work up of hemorrhage.	S9999		

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S9999	Continued From page 9 NUS consulted d/t IPH. Page 16: Documents: R2 was admitted to [hospital 2] on 4/11/22 from [Hospital 1] following unwitnessed fall at Skilled nursing facility, found to have acute traumatic R frontal IPH. Page 36 Documents the following: Recommendations: Right frontal IPH, likely secondary to trauma while on anticoagulation. R1 admitted to the facility on 3/3/2022. R1's Fall risk review dated 3/4/22 documents R2 as a high risk for fall with score of 14. R1 progress notes documents the following: 3/3/2022 at 8:25 pm by V6 (nurse): Resident called the staff stated "She wanted to use the bathroom but walk by herself to the bathroom. Staff informed resident that It is not safe for her to walk by herself that we can help her with the assistance of a wheelchair. Resident slid to the floor from her bed with staff assisting her to the floor. Complete body and pain assessment initiated with no injury noted resident refused to be transferred back to her bed with staff assistance stated, she preferred to sleep on the floor. Family member called with no response. MD made aware. Requested from facility all falls reports, investigation, root-cause-analysis and nothing was given for the 3/3/2022 fall. 3/4/2022 at 9:15 PM V6 (nurse): Resident was observed sitting by the side of her bed. Complete body and pain assessment initiated with no injury noted, skin w/d touch not c/o pain, verbalized at this time. Resident was immediately transferred back to her bed. MD called with no new order and family member notified.	S9999		

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S9999	Continued From page 10 Review or falls and Accident/incident resident management review (FARMR) for 3/4/22 and dated 3/7/22 does not document previous incident and there is nothing listed that may have contributed to the accident. No root cause documented. The interventions documented on this form bed in lowest position, floor mat, ask to wait for assistance. This FARMR form state care plan reviewed/updated. Care plan does not document bed in low position or floor mat. 4/2/2022 at 7:10 AM V30 (LPN): Resident observed in bed asleep at 12:30 AM Rounds made @1:50 AM, observed sitting on the floor. When resident questioned how she ended up on the floor, Resident stated. "I was on the bed and I reached for my blanket and I fell". Full body check done. No apparent injuries observed. Assisted of floor with hoyer lift back into bed. Encourage resident to ring call light and ask staff for assistance. Floor mat place on side of bed. FARMR assessment dated 4/4/22 for 4/2/22 incident. There is no root cause. Contributing factors are her diagnoses of Cognitive communication deficit and Bells Palsy. This FARMR documents to decrease future falls encourage to use call light and that Care plan was reviewed/updated. Review of resident's appears that encourage to use call light for assistance was there since 3/10/22. There is no apparent new interventions. 4/23/2022 at 6:50 AM V30 (LPN): Resident seen in bed awake at 4:00 AM during rounds. Rounds made 5:50AM, observed sitting on the floor mat. When writer questioned resident, how she ended up on the floor, the resident stated, "I was trying to walk to the washroom."	S9999		

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S9999	Continued From page 11 The FARMR form dated 4/24/2022 for 4/23/2022 incident documents: care plan reviewed/updated. Call light education. Floor mat to the right of bedside. Contributing factors are diagnoses of Cognitive communication deficit and not utilizing staff assistance. This FARMR documents to decrease future falls: call light education, Floor mat to right of the bedside. Care plan is not updated with any new interventions. On 6/17/2022 9:57 V2 (DON) states the definition of a fall is a change in plan, both assisted and unassisted. V2 states, "Charting is a legal document." V2 states staff should be charting the facts. On 6/10/22 at 1:30 PM V2 (DON) states there should be a post fall review of records and update care plan, put interventions in place. V2 states they do and investigation. Not called a root cause analysis. V2 states there should be documentation on care plan as to falls. Interventions should be on the care plan. Do post fall assessment. Review what is charted and talk to the staff. Facility's Fall risk policy documents the following: Fall prevention B. Implement individualized approaches/interventions based upon resident risk. 1. The fall prevention strategies/interventions list may be used to identify appropriate interventions. 2. Approaches/interventions should focus on risk factor identified. IV implement additional interventions to reduce risk. (B)	S9999		