STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003008	A. BUILDING: _____ B. WING _____	C 05/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF BERWYN, THE	3601 SOUTH HARLEM AVENUE BERWYN, IL 60402

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S 000	Initial Comments Facility Reported Incident Investigation Incident of 04/09/22/IL145769 - F689	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 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. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. This requirement is not met as evidenced by: Based on interview and record review that facility failed to implement effective fall prevention interventions to include monitoring/supervision to prevent or reduce the risk of falling for a resident	S9999		

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S9999	Continued From page 2 identified to be high risk for falls. This affected 1 of 3 residents (R2) reviewed for falls This failure resulted in R2 falling in the dining room when staff was not looking, and R2 required hospitalization for a new brain bleed. Findings Include: R2 is a 78 year old with the following diagnosis: traumatic hemorrhage of the cerebrum, unsteadiness on feet, abnormalities of gait and mobility, hemiplegia following a cerebral infarction, and history of falls. R2 admitted to the facility on 4/6/22. A Nursing note dated 4/9/22 documents at 9:35 AM, V8 found R2 on the floor flat on R2's back in the dining room, crying, saying R2's head hurt. R2 was unable to give a description of what happened prior to the fall. R2 is at baseline cognitive status. There was a new order to send R2 out of emergency room for evaluation. V8 contacted the hospital later that day and learned R2 was admitted to a different hospital in the neuro intensive care unit with a diagnosis of new intracranial hemorrhage. The Fall Event dated 4/9/22 documents at 9:35 AM, V8 found R2 on the floor in the dining room saying, "my head hurts". V8 asked R2 what happened and R2 was unable to answer per baseline. There was a new order to send R2 to the ER for an evaluation. At the time of the fall R2 is alert and oriented to self only. The predisposing physiological factors are documented as confused, cognitive impairment, and impaired memory. The predisposing situation factor is documented as ambulating without assistance. The Facility Incident Report dated 4/15/22	S9999		

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S9999	Continued From page 3 documents R2 was noted on the floor in the dining room lying on R2's back next to R2's chair. R2 was unable to tell what happened, when asked if anything hurt R2 reported R2's head hurt. No visible injuries were noted and R2 was sent to the emergency room for an evaluation. Later that day the facility was notified by the hospital that R2 was admitted due to intracranial hemorrhage. The care plan will be updated once R2 returns to the facility. The Hospital Records dated 4/9/22 documents R2 presented to the emergency room with an unwitnessed fall at the nursing home. There is no visible trauma. Per the paramedics R2 was found on the floor. The physical exam shows R2's pupils are equal, constricted but responsive to light. The CT of the head shows a previously diagnosed left arteriovenous malformation brain bleed. There is a new area of 1.7 cm acute hemorrhage adjacent to the superior margin left brain bleed edema. A left to right midline shift measures approximately 0.5 cm. Previously measured 0.3 to 0.4 cm. Neurosurgery was consulted for new brain bleed. R2 will be transferred to a different hospital for a higher level of care. R2's diagnoses are fall and intracranial hemorrhage. On 5/5/22 at 2:40 PM, V4 (CNA), stated "R2 couldn't talk and R2 stumbles a lot. That's what R2's wife told me. She also told me that the other nursing homes where R2 was at R2 was falling a lot. R2 was a former police officer so R2 would have a behavior of getting up and trying to "search for an offender." Sometimes R2 would have the strength to stand all the way up but R2 would immediately sit back down because R2 couldn't stand that long. R2 was in a Geri chair. It was around 830 or 930 and I was sitting with R2	S9999		

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S9999	Continued From page 4	S9999		

in the dining room. I was sitting right next to him. R2 was telling me that R2 was arresting someone. I heard another resident screaming down the hall that she wanted to get up. I turned and I told the nurse that I was going to start getting other people up for breakfast and I left the dining room. The nurse knew I was leaving. When I was coming out of that room people were telling me that R2 had fell. R2 was a High fall risk. R2 was high risk because R2 always tried to get up but R2 couldn't walk and R2's cognition was not there. R2 couldn't follow any directions from us. The only one that could get R2 to listen was R2's wife. For High fall risk people we do a lot of activities and watch TV in the dining room, eat snacks, and just keep them busy. If they keep trying to stand up and aren't listening and then we usually have two people try to walk up and down the halls with them to burn some energy. We couldn't leave R2 unattended. R2 was too much of a fall risk because R2 was so unsteady and couldn't listen."

On 5/5/22 at 3:19 PM, V7 (Fall Coordinator) stated, "From my interviews I found out R2 was in the dining room and was being watched by the CNA (V4). The CNA got up and R2 was then watched by the nurse (V8). I was told the nurse looked down for a second and when V8 turned back around R2 was on the floor. I don't know if R2 was getting up himself or if R2 fell over the side of the chair. I know the nurse said she asked R2 one time to sit back down in the chair. She was prepping medications for another resident. R2 was High fall risk when R2 first came in because of R2's medical diagnosis and unsteady gait. We put in place a low bed, locking his furniture, and having his belongings near him. His orientation was off and on. During the time of the fall, R2 was confused. R2 did have a previous

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brain bleed and the hospital was trying to figure out if there was a new one or not. High fall risk residents are rounded on every two hours, and if we find out they fall while we are still monitoring them then we put on a bed or chair alarm. These kinds of residents should not be left unattended. That is why they are a fall risk. R2 was very impulsive due to R2's diagnosis of a brain mass."

On 5/5/22 at 3:39PM, V8 (Nurse) stated, "R2 was a High fall risk. R2 had a one to one assist and was put in the dining room. The CNA left to go take care of someone else and told me to watch R2. I moved my med cart over closer to R2 to watch R2. No, I was not right next to R2. I turned my head to give meds to another resident and when I turned back around R2 was on the ground. I didn't see how R2 fell. R2 kept trying to stand up that morning and R2 was really confused. R2 could follow some directions that were basic. R2 kept trying to get up to go home. No, I never went closer to R2 when R2 was getting up. R2 had a very unsteady gait. R2 was a high fall risk because of R2's unsteady gait. The High fall risk residents usually have a one to one or someone within closer reach so we can keep an eye them at all times. These type of residents we should never leave unattended."

On 5/6/22 at 10:40AM, V9 (Director of Rehab) stated, "R2 was completely dependent on function, very impulsive, and needed max queuing to complete a task. R2 could do things like stand up or transfer or walk but it was very hard for R2 to follow directions. R2 was in a Geri chair because it was safer than R2 being in a wheelchair. In those type of chairs the legs can go up and the patient can lean back so there was a safety concern with R2 being in a regular wheelchair. In a regular wheelchair, R2 could just

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S9999	Continued From page 6 stand up and take steps by R2's self but in the Geri chair if the leg part was up then R2 could take longer to stand up before someone noticed R2. A lot of times in therapy we would see R2 getting up before R2 was given any direction. We educated R2 all the time but we didn't notice R2 carrying any of the education over. R2 could physically stand up and maybe take a couple steps but R2 was very unsteady. This made R2 a High fall risk. R2 lacked severe safety awareness. R2 was a one to one during therapy because R2 needed someone to be so close to R2." On 5/6/22 at 2:30 PM, V11 (Primary Physician) stated, " I know R2 had a history of a hemorrhagic stroke. R2 did have a brain bleed before the fall. This is why R2 had a baseline of being very confused. R2 having a stroke increases R2's risk of falls. These residents are usually not left unattended. I was called and was told the nurse was giving meds or something to another resident and when V8 turned back around R2 was on the floor. R2 was very confused so I can see that happening. For residents like R2, you need to do more closely monitoring but we can't keep an eye them 24 hours a day. The brain bleed R2 had previously was from the hemorrhaging stroke. If they found new ones on the CT scans at the hospital those could have been from the fall or they could possibly be a new hemorrhagic stroke. It's hard to tell." The Admission Hospital Records dated 3/21/22 documents R2 presented to the hospital with frequent falls and recently diagnosed brain bleed prior to this admission. Multiple falls have occurred at the nursing home R2 was staying at. The CT scan showed two left occipital arteriovenous malformations with surrounding	S9999		

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S9999	Continued From page 7	S9999		

edema. R2 is alert and oriented times 0 and does not follow commands. While in the hospital on 4/6/22, R2 attempted to get up and struck R2's head on the side rail of the bed with experienced transit loss of consciousness for about 30 seconds. An emergency CT scan of the head was ordered and did not show any acute intracranial hemorrhage. R2 was ready for discharge at this time.

The Nursing - Admission/Readmission Assessment dated 4/6/22 documents the fall risk score as a five for R2 (low risk). R2 is documented as being alert but confused and a barrier to education is cognitive impairment. R2's response to training is documented as needing practice and/or reinforcement.

The Care Plan dated 4/7/22 documents R2 is at high risk for falls related to hypo/hyper glycemia , seizure disorder, use of antipsychotic medication, and use of cardiovascular medication's. The following interventions were documented on 4/7/22: keep all needed items within reach, keypad in the lowest position for safety, keep furniture in locked position during transfers and nursing care, and make sure the call light is within reach and encourage use for assistance when needed. The intervention put in place after the fall is documented on 4/19/22 and is bed/chair alarm.

The Fall Risk Evaluation dated 4/9/22 documents a score of a 17. Anything that is an 8 or above means the resident is at high risk for falls. R2 is documented as being a High fall risk due to medications, unsteady gait, and having a memory problem.

The Care Plan dated 4/10/22 documents R2 as an adult with impaired cognitive function, poor

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S9999	Continued From page 8 environmental awareness, and has difficulty with decision making tasks, responsibilities, and reality. R2 was unable to recall the year, month, day of the week, and is not able to recall the words in the assessment. It is best to provide R2 with cueing, prompts, and reminders when R2 becomes distracted and to return our tools focus to completing the task at hand. The care plan does not document any interventions or plan for R2's impulsive behavior or lack of safety awareness. An Admission summary dated 4/19/22 documents R2 was admitted to the facility from the hospital after a fall causing a brain bleed. R2 is an extremely high fall risk and will need a bed alarm. A Nurse Practitioner note dated 4/20/22 documents R2 suffered a fall at the facility and was readmitted to the hospital on 4/9/22. R2 is diagnosed with a new intracranial hemorrhage adjacent to known ateriovenous malformation. R2 underwent a diagnostic cerebral angiogram with coil/nBCA embo of the left middle cerebral artery branches x 2 on 4/10/22. Once R2 was stabilized, he was discharged back to the facility for further care. The Minimum Data Set (MDS) dated 4/26/22 documents the Brief Interview for Mental Status score as a 3 (severe cognitive impairment). Section G of the MDS documents R2 needs extensive two person physical assist with transfers, R2 needs extensive one person physical assist with bed mobility, total dependence one person physical assist with locomotion on unit and walking in room activity only occurred once or twice. R2's balance is documented as not steady, only able to stabilize	S9999		

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S9999	Continued From page 9 with staff assistance when moving from a seated to a standing position, walking, and service to service transfers. The Policy titled, "Fall Occurrence," dated 7/28/21 documents, "Policy Statement: It is the policy of the facility to ensure that residents are assessed for risk for falls and interventions are put in place to prevent them from falling. Procedure: ... 2. Those identified for high risk for falls will be provided interventions to prevent falls." (A)	S9999		