Illinois Department of Public Health

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 05/19/2023

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 Investigations: 2383946/IL159752 2383357/IL159033 2383622/IL159360	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 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. 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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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.

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.

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These requirements were not met as evidenced by:

Based on observation, interview, and record review, facility failed to follow their policy to ensure fall prevention interventions in the care plan are updated and followed for 1 (R1) out of 3 residents reviewed for accident and prevention. This failure led to R1 falling and hitting her head against the wall twice in a month where both falls resulted in a subdural hematoma in her head.

Findings include:

On 05/16/2023 at 11:00 AM, surveyor observed R1 sitting in wheelchair in the dining room. R1 stood up by herself and pushed her wheelchair back. CNA helped R1 to sit back down.

On 05/17/2023 at 10:07 AM, surveyor observed R1 sleeping in her bed with no supervision.

On 05/16/2023 at 12:10 PM, V3 (Restorative Director) stated, that V3 is the falls coordinator and that she updates the care plan. V3 stated she is familiar with R1. Fall risk assessment are done quarterly, annually, at admissions and after a fall. After the assessments are done the fall risk care plan are done. V3 stated that R1 has had two falls. V3 stated that any time a resident falls, she updates the care plan with the date of the fall and any updated interventions.

V3 stated, "Today R1 was irritated, she is pushing herself around, and there is no telling what she might do. She (R1) needs to have eyes on her at all times. For R1's fall on April 10th, 2023, we did the incident report on 04/12/2023. She fell at 6:10

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PM. R1 was in bed and in an upright position. At 6:10, R1 was found in the bathroom on the floor with her head against the floor. When she (R1) fell, it was an unwitnessed fall." V3 stated R1 was unable to state what happened. V3 stated, R1 was sent to hospital when the Doctor ordered R1 to be sent out to the hospital and that's where they found the (R1's) hematoma. V3 stated. "So, when she (R1) fell she was by herself. At that time, we didn't have anyone watching her (R1). All falls can be prevented. After the fall on 04/01/2023 we put her on 1 on 1. One on one intervention is not added in the care plan. We were going to put it in there but the interdisciplinary team decided not to because we don't have the staff for it."

On 05/16/2023 at 1:28 PM, V2 (Director of Nursing) stated, upon admission there is a nursing assessment form, skin and body check, baseline care plan, fall risk assessment. Whoever does the fall risk assessment, determines whether the resident is a high fall risk or a moderate fall risk.

V2 stated, "If it is not documented, then it is not done. We can't put someone on 1 to 1 supervision all the time because we do not have the staff for it. But we started frequently monitoring R1. The intervention we added after her first fall on 02/2023 was taking her to bathroom before meals because we noticed a pattern that she would tend to get up right when she is about to eat. R1 was placed 1 on 1 after her second fall on 04/01/2023 for a short while and once we continued to notice a pattern that she would get up around meal times we enforced the intervention of taking her to the bathroom right when the food got to her and after she eats. That 1 on 1 intervention was never added on R1's

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S9999	Continued From page 4 care plan. I want someone to always keep an eye. I don't know if it is documented that V8 (Agency Certified Nursing Assistant) toileted R1 on 04/10/2023 when she got her dinner meal tray." 05/17/2023 at 1:15 PM, V7 (Registered Nurse) stated she was the nurse for R1 when R1 fell on 4/10/2023 in the bathroom. V7 stated that she checked on R1 at 5:00 pm and at 6:00 PM she heard a big sound in her (R1's) room. When V7 and a CNA ran in there, they found R1 laying on the bathroom floor with her head against the wall. V7 stated V6 was the CNA who gave R1 her dinner tray on 04/10/2023 prior to her fall. On 05/17/2023 at 1:30 PM, V4 (R1's primary doctor) stated, most falls will be prevented if staff are checking on the residents frequently and seeing if there is a pattern when resident is getting up out of wheelchair or bed. Interventions such as going to the bathroom before or after meals can help prevent falls. Interventions in care plan are to be followed. On 05/18/2023 at 11:40 AM, surveyor observed R1 laying in her bed. Surveyor also observed V7 (Registered Nurse) sitting at the 3rd floor nurse station with her back to R1's room talking on the phone through her Bluetooth headphones. Surveyor also noticed a call light going off on the 3rd floor with no nurses attending to the call light. On 05/18/2023 at 12:52 PM, surveyor observed R1 eating lunch on her bed in her room. V9 (3rd floor Certified Nursing Assistant) stated that she is R1's CNA for today. V9 stated the last time she took R1 to the bathroom was this morning and not when her lunch was brought up.	S9999		

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Reviewed R1's falls record:
1. Fall on 2/8/2023
2. Fall on 4/1/2023 resulted in hematoma to the head, evidenced by CT
3. Fall on 4/10/2023 led to hematoma in the head, evidenced by CT.

R1's hospital record on 4/1/2023 documents in part: CT scan findings - complex acute on subacute left sided subdural hematoma measuring up to approximately 2.2 cm.

R1's hospital record on 04/10/2023 documents in part: CT of head: CT findings - Left cerebral convexity acute on chronic subdural hematoma measuring up to 1.6 cm. 4 mm rightward midline shift. 2. Small acute subdural hematoma over the right posterior temporal lobe measures 3 mm in maximal thickness. CT of the head shows acute on chronic subdural hematoma with small amount of midline shift. Discharge instructions - Patient will require 24/7 supervision at discharge. Patient would benefit from subacute rehab.

Facility's final investigation report for R1's fall on 4/10/2023 documents in part: Statement from V7 stated she saw resident at approximately 5:00 PM and resident was in bed with no complaints. At approximately 6:10 PM, R1 was noted on the floor in her bathroom. She was unable to verbalize what happened. Statement from V8 (Agency certified nursing assistant) states, "I toileted R1 approximately 2 hours before her dinner." Conclusion: R1 was transferred to an acute care setting for further evaluation post fall and was admitted for subdural hematoma. R1 returned to the facility on 4/12/2023 with no changes to plan of care.

R1's care plan documents in part: On 2/8/2023,

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R1 placed on toileting program with focus on toileting before meals. offer assistance with toileting before lunch. Added 4/1/23, when patient in bed monitor for positioning and ensure patient in center in bed for comfort. Added 4/10/23, place resident on toileting program with focus on toileting before meals. No new interventions documented.

R1's progress notes by V7 (4/10/2023) documents in part: At 6.10pm the resident was observed in the bathroom in a sitting position with head against the wall. Resident unable to state what happened or when the incident occurred. Physical assessment completed. Immediate fall intervention of mat was initiated and put into place. V10 (R1's Nurse Practitioner) covering for V4 (R1's PCP) notified. New orders to transfer residents to outside hospital received.

R1's progress note on 4/1/2023 documents in part: Prior to the fall writer assisted resident back to bed approximately two minutes before fall occurred. Patient confirms hitting her head. Order received to transfer resident to outside hospital for CT-scan.

R1's MDS Section C (3/3/2023) documents in part: R1's BIMS score is 5. R1 is not cognitively intact.

R1's MDS section G (3/3/2023) documents in part: R1 needs oversight, supervision and cuing when eating. R1 is also an extensive assist for transfer and walking. R1 requires two person assist for transfer and walking.

Facility's fall policy (undated) documents in part: All falls will have a site investigation by appropriate staff in an effort to define the "root

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S9999	Continued From page 7 cause" of the fall. This will help provide information to enable staff to roll out interventions to prevent another similar occurrence. Each fall needs a new intervention rolled out. Based on the results of the fall, the resident' care plan will be addressed to ensure that any needed points of focus have measurable goals with appropriate interventions in place. (B)	S9999		