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CHALET LIVING & REHAB	7350 NORTH SHERIDAN ROAD CHICAGO, IL 60626

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S 000	Initial Comments Annual Licensure Survey Investigation of Facility Reported Incident of January 27, 2024/IL169681	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b)4)5) 300.1210c) 300.1210d)3)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 meet the resident's medical, nursing, and mental	S9999		

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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.

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. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

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

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S9999	Continued From page 2 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: 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. 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 observation, interviews and record reviews, the facility failed to provide adequate supervision for 1 confused resident (R19) who is a high fall risk out of a sample of 36 residents reviewed for falls. This failure resulted in R19 sustaining a displaced bilateral nasal bone and anterior osseous nasal septal fracture. Findings Include: R19 was reviewed as a closed record. R19 was sent to the hospital on 2/19/24. R19's clinical record documents in part: R19 is a 77-year-old with the medical diagnosis of	S9999		

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metabolic encephalopathy, need for assistance with personal care, lack of coordination, abnormalities of gait and mobility, adult failure to thrive, adult failure to thrive, retention of urine, pleural effusion, myocardial infarction, fracture of nasal bones, subsequent encounter for fracture with routine healing, fall, subsequent encounter, secondary hypertension, chronic obstructive pulmonary disease, chronic kidney disease, stage 3a, retinopathy of prematurity, stage 2, unspecified eye, schizoaffective disorder, bipolar type, bipolar disorder, current episode mixed, moderate, major depressive disorder, spinal stenosis, schizophrenia, personal history of transient ischemic attack (TIA), and cerebral infarction, asthma, chronic obstructive pulmonary disease, and fusion of spine cervical region.

R19's Minimum Data Set (MDS) dated 1/29/24, Brief Interview score (8) indicates R19 is cognitively impaired.

R19's Fall Risk Evaluation dated 1/27/24, Section J form effective as of 4/25/23. Revised/Effective 11/14/23. documents in part the following for R19: Display a memory problem, and R19 is not able to walk even with the assistance and/or assistive device. R19 scored (15), indicates R19 is a high fall risk.

R19's Hospital After Visit Discharge Summary dated 1/27/24 documents in part:
Diagnosis-Fall initial encounter with displaced bilateral nasal bone and anterior osseous nasal septal fractures.

R19's care plan dated 11/21/2023, documents the following in part:
R19 is a high fall risk, the following falls noted.

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S9999	Continued From page 4 12/9/23 R19 went to the basement and fell of walker rollator, while trying to get a soda. Intervention: No fall intervention noted on fall care plan. 1/27/24 R19 was observed on the floor next to his bed with a bruise on his nose. R19 sent to hospital and diagnosis with a displaced bilateral nasal bone and anterior osseous nasal septal fracture. Intervention input on care plan on 1/29/24: R19 was moved to a closer room near the nursing station. 2/5/24 R19 Fell outside smoking on patio. Intervention input on care plan on 2/9/24: Schedule one to one smoking. 10/18/21 R19 is using protective head gear, soft helmet to prevent head injury due to recent fall as a result of a seizure. R19 is occasionally noncompliant with the usage. Encourage R19 to use helmet for safety measures 8/23/22. Replace helmet as needed. Staff to ensure helmet is on daily. Staff to redirect R19 when he removes helmet. R19 progress notes document in part: V29 (Licensed Practical Nurse) nurse note: On 12/9/23 at 11:57 PM, Incident Summary: Prior to fall incident R19 was last seen by this nurse (V29) in his room lying on his bed after dinner was served. Writer (V29) received call from receptionist that R19 was in the basement on the floor. Upon trying to go downstairs to basement to assess resident, R19 came upstairs with rollator. R19 states "I slipped off my rollator, while I was trying to buy a soda in the basement, but I did not hit my head". R19 was taken back to his room. Head to toe assessment done, no visible injuries	S9999		

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S9999	Continued From page 5 noted this time. R19 denies any pain currently. Able to move all extremities without difficulty. Physician made and family made aware. V23 (Licensed Practical Nurse) nurse note: On 1/18/2024 10:10 AM, Change of Condition (SBAR) Situation: 1. The change in condition, symptoms, or signs observed and evaluated is/are: R19 noted with period of confusion, AMS (altered mental status), and suspect Pneumonia. V25 (Nurse Practitioner) assess R19 with order to send R19 to the hospital. VS Taken BP (blood pressure) 116/83, T(temperature) 97.3, P (pulse) 77,02 SAT (oxygen saturation) 95% (room air), R (respiratory) 18. R19's family made aware by V25. Report given to hospital nurse and ambulance transport dispatch. (R19 was noted confused) V23 (Licensed Practical Nurse) nurse note: On 1/26/2024 at 9:18AM, Admit/Readmit Follow Up Note Note Text: R19 in his room in bed comfortable, who appears stable, alert, and oriented x 1-2 confuse at times this time, with no SOB (shortness of breath) and or any discomfort. Bed at the lowest position with call light in place. Vital signs taken and recorded. Plan of care ongoing. (R19 was noted confused) V42 (Restorative Nurse) Note: On 1/26/2024 at 1:35 PM, R19 noted with history of repeated falls, has poor balance and poor safety awareness, decrease functional mobility but, does not call for assistance from staff when it comes to complete ADL task. R19 is able to note the urge to void but has difficulty to go to toilet self. Endorsed to Therapy.	S9999		

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S9999	Continued From page 6 V24 (Licensed Practical Nurse) nurse note: On 1/27/24 at 11:54 AM, Incident Summary: Prior to the incident R19 was lying in the bed watching TV, while he was in bed, bed on the lowest position, call light placed within easy reach about 10 minutes later, the staff came to notify the writer (V24) that R19 was sitting on the floor with no witness. On assessment R19 noted with bruise on the top of his nose but was able to move all extremities with no pain, on enquiry R19 was unable to express himself, R19 was just mumbling words. Vital signs done as follows T:97.8, RR:20, PR:86, B/P:142/98 and 02 Sat:96% on room air. No loss of consciousness, R19 was able to get back in bed with a mechanical lift with the help of two staff. V25 (Nurse Practitioner) notified, V25 gave order to send the R19 to hospital emergency room for further evaluation. R19's family and V3 (Director of Nursing) made aware. V25 (Nurse Practitioner) note: On 1/29/2024 at (Medical Professional Progress Note) Reason: 1/27/2024, R19 was admitted to hospital for status post fall, with laceration and fracture. R19 was discharged same day with diagnosis of minimally displaced bilateral nasal bone and anterior osseous nasal septal fracture. R19's Incident Final Report dated 2/2/24 documents in part: -R19 is a 77-year-old male, alert, and oriented X2 with BIM score of 11 of out 15. On 1/27/24 at 10:12 AM, V24 noted R19 on the floor in a sitting position in his room. Note a bruise on the bridge of the nose. R19 was not able to tell what happened. There is no change in mental status from baseline. Prior to incident R19 was lying in bed watching TV. The bed was at its lowest position and call light in reach. R19 sent to	S9999		

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hospital for evaluation and diagnosis of open fracture of nasal bone.
(R19's Minimum Data Set (MDS) dated 1/29/24, Brief Interview score (8) indicates R19 is cognitively impaired. R19's progress notes documented change/decline in mental status on 1/18/24, and 1/26/24 prior to fall on 1/27/24).

On 2/21/24 at 1:22 PM, V24 (Licensed Practical Nurse) stated, "I was R19's nurse on 1/27/24 when he fell. Ever since R19 was positive for Covid on 1/1/24 he had a decline in his mental status. R19 was very confused, weak, unsteady on his feet and could not walk anymore. R19 needed close monitoring and supervision. Due to R19 being so confused prior to his fall on 1/27/24, R19 had a bed and wheelchair alarm, low bed, and mats on the floor next to his bed, and call light in reach. However, R19 was so confused he did not know how to place on his call light for assistance. Nursing staff had to monitor R19 very closely. Prior to R19's fall on 1/27/24, I saw him in bed resting watching TV. I went down the hall passing medications to other residents. Approximately 30 to 40 minutes later I heard his bed alarm sound off. By the time I got to R19's room, he was on the floor mat next to his bed trying to get himself up off the floor very confused, he could not tell me what happened, which was his normal mental status for a several weeks. I called for assistance, completed body assessment, vital signs and noted a cut open area on his nose that was starting to bleed and bruise. R19 was not wearing a helmet. I have not seen any helmet R19 was to wear. I cleaned up R19 nose, and he was lifted off the floor with several staff and the use of the mechanical lift. I notified V25, V3, and R19 family of incident and the order from V25 to send R19 to the hospital for evaluation. After that fall, R19 room was moved

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closer to the nursing station for close monitoring and supervision. R19 use to be a smoker, but to him being so confused, R19 was not going outside to smoke anymore."

On 2/21/2 at 11:27 AM, V27 (Certified Nursing Assistant/CNA) stated, "I was R19's CNA when he fell on 1/27/24. R19 was very confused, on 1/27/24, after breakfast, R19 was wet and needed to be cleaned up and changed. I changed R19's under brief and linen, he continued to rest in bed. Around an hour later, V24 called out for assistance, because R19 was on the floor. R19 was lying down on the floor next to his bed trying to get up off the floor. No there was no floor mats in R19 room or next to his bed. V24 and I used the mechanical lift to assist R19 back into the bed. R19 did not have on a helmet, I never seen R19 with a helmet on his head or in his room, I do not know anything about a helmet."

On 2/21/24 at 2:54 PM, V26 (Licensed Practical Nurse) stated, "I was R19's nurse when he fell on 2/5/24. R19 is confused and hard to redirect. R19 has a bed and wheelchair alarm and need extensive assistance the ADL care. R19 kept getting out of bed and his wheelchair, but he was so confused, he did not know to place on his call light. R19 need close monitoring and supervision. On 2/5/24, I was passing out medications and V49 (Security/Smoke Monitor) pushed R19 to me. V49 said R19 was downstairs smoking on the patio and slipped out his wheelchair onto the ground. V49 assisted R19 back into his wheelchair and brought him to me. I assessed R19, no injures was noted. I phoned V25, V3 and R19's family to notify all regarding fall. I do not know how R19 got into his wheelchair and down to the smoke patio. I was passing medications out to other residents. I cannot provide one to one

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monitoring to R19. Fall interventions for R19 is wheelchair/bed alarm, low bed, call light in reach and floor mats. R19 does not wear a helmet, and I have not seen any helmet on R19 or in his room."

On 2/21/24 at 3:30 PM, V30 (CNA) stated, "I was R19 CNA on 2/5/24 when he fell. I checked on R19 and he was in bed sleeping. I went to assist another resident. I was told by V26 that R19 went downstairs to smoke and fell on the outside patio. R19 is very confused sometimes he is not coherent, a high fall risk and disorientated. R19 needs close monitoring and supervision. Most of the time R19 is not re-directable. R19 fall interventions are wheelchair/bed alarm, low bed, and side rails. I have not seen any floor mats or a helmet. I did not know R19 needs to wear a safety helmet. I have never saw any helmet in his room or on his head. I had to assist my other residents and could not continuously monitor R19, he needs one to one monitoring."

On 2/21/24 at 1:36 PM, V49 (Security/Smoke Monitor) stated, "R19 was outside on the smoke patio smoking when he got up and slipped out of his wheelchair. R19 was trying to get up off the ground, so I assisted him back into his wheelchair and took him to his nurse V26."

On 2/21/24 at 2:24 PM, V25 (Nurse Practitioner) stated, "I no longer work for the facility since 2/12/24. I was R19's nurse practitioner and very familiar with him. R19 tested positive for covid around the end of December 2023, that when there was a rapid noticeable decline with R19's mental and medical status. R19 was hospitalized twice after covid, not eating, or drinking, and had several falls. I recommended to nursing

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administration for R19 to have side rails, floor mats, and someone to sit with R19. The facility did place side rails on the bed; however, I never saw any floor mats. The fall dated 1/27/24 when R19 fell out the bed, the injury was avoidable. R19 would not have sustained a displaced bilateral nasal bone and anterior osseous nasal septal fracture if the floor mats were down next to the bed. R19 was not walking anymore since December 2023, the floor mats would not have been contraindicated. R19's fall on 2/5/24 was avoidable. Due to the fact if R19 was adequately supervised, he would not have been able to go down and outside to the smoke patio and fell, without the staff knowing he was off the nursing floor. I have never seen R19 with a safety helmet on his head or in his room."

On 2/21/24 at 11:28 AM, V28 (Psychotropic/Fall Nurse) stated, "I investigate the falls and develop fall interventions for each fall that happens in the facility. If a fall occurs on the weekend or when I am off work the fall intervention is not developed or placed int the care plan until I return to work. A fall intervention is developed and placed in the care plan to prevent another fall from occurring. R19 has a total of 10 falls since his admission (8/31/17). The most recent falls in 2023 and 2024 were on 12/9/23, 1/27/24, and 2/5/24. On 12/9/23 R19 had used his rolling walker and went to the basement to buy a soda out the machine. R19 was sitting on the rolling walker and leaned over to get the soda and fell onto the floor. There is no fall intervention entered in the fall care plan for 12/9/23, I am not sure what happened, I thought I entered the fall intervention. On 1/27/24 R19 was observed on the floor next to his bed with a bruise on his nosed. R19 sent to hospital and diagnosis with a displaced bilateral nasal bone and anterior osseous nasal septal fracture. The

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fall intervention was moved R19 to a closer room near the nursing station, I placed in the fall intervention in the care plan on 1/29/24 due to the fall was on a Saturday. On 2/5/24, R19 Fell outside smoking on patio. The fall intervention was to schedule R19 one to one for smoking. I entered the fall intervention in the care plan on 2/9/24, I do not remember why I was late assessing R19's fall and developing a fall intervention. When a fall intervention is not developed soon as possible it leaves the resident susceptible to another fall, due to no fall intervention in place for the nursing staff to review to prevent another fall for occurring."

R19 was readmitted back to the facility on 2/21/24 evening.

On 2/22/24 at 11:22 AM, surveyor and V23 observed R19 in bed. R19' bed was in high position approximately 3 1/2 feet high, up to V23's waist. No floor mats, and safety helmet noted. V23 (Licensed Practical nurse) stated, "The hospice nurse recently left. R19's bed should not be this high, and I will call for floor mats."

On 2/22/24 at 12:18 PM, V3 (Director of Nursing) stated, "R19 is confused, and a high fall risk. Fall interventions for R19 are floor mats, low bed, bed alarm, and moved him close to nurse station. R19 need close monitoring, that is why he was move close to the nurse station. V28 is the facility fall nurse. V23 investigates, develop fall interventions, and update the resident care plan. A fall intervention needs to be place in the care plan soon as possible, so nursing staff is able to review the plan of care, to assist with prevention further falls."

Policy- Fall Occurrence dated 7/17/23 document

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CHALET LIVING & REHAB	7350 NORTH SHERIDAN ROAD CHICAGO, IL 60626

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S9999	Continued From page 12 in part: -It is the policy of the facility to ensure that residents are assessed for risk for falls, that interventions are put in place, and interventions are re-evaluated and revised as necessary. -The nurse may immediately start interventions to address falls in the unit, even prior to the falls coordinator investigation. -The fall coordinator will add the intervention in the resident's care plan. -The interventions will be re-evaluated and revised as necessary. "B"	S9999		