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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN LAKELAND REHAB & HCC	820 WEST LAWRENCE CHICAGO, IL 60640

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S 000	Initial Comments Complaint Investigations: 2484079/IL173549	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)3)6) 300.1220b)6)7) 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 300.1010 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	S9999		

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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. Restorative measures shall include, at a minimum, the following procedures:

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.

Section 300.1220 Supervision of Nursing

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Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

6) Developing and maintaining nursing service objectives, standards of nursing practice, written policies and procedures, and written job descriptions for each level of nursing personnel.

7) Coordinating the care and services provided to residents in the nursing facility.

These requirments were not met as evidenced by:

Based on interview and record review the facility failed to identify a change in condition for one resident (R5), failed to follow the facility's Head Injuries policy and failed to call 911 after a fall with head injury that resulted in resident (R5) expiring due to intracranial hemorrhage with midline shift related to the fall. This failure affected one resident (R5) of four residents reviewed for resident injury.

Findings include:

R5's Physician Order Summary (POS) with active orders as of 4/08/2024 documents, in part, send to (local) Hospital for evaluation post fall. POS also documents Metoprolol Tartrate Oral Tablet 25 mg (milligrams) every 12 hours.

R5's Medication Administration Audit Record (MAAR) documents that R5's ordered Metoprolol Tartrate Oral Tablet 25mg was given on 4/08/2024 at 8:06pm.

R5 has a diagnosis of, but not limited to,

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Hemiplegia and Hemiparesis following Cerebral Infarction, Visuospatial Deficit and Spatial Neglect, Acute Respiratory Failure with Hypercapnia, Acute on Chronic Diastolic Heart Failure, Tracheostomy, Dysphagia, Hypertensive Heart Disease with Heart Failure.

R5's Brief Interview of Mental Status (BIMS) dated 4/8/2024 documents, BIMS score not assessed.

On 5/29/2024 at 1:13pm V3 (Licensed Practical Nurse-LPN) stated at about 5:30pm on 4/08/2024 R5 fell face forward from the bed and V10 (Certified Nursing Assistant-CNA) made her aware that R5 fell out of the bed) by yelling out at the time R5 was falling.

On 5/29/2024 at 3:30pm V10 (CNA) stated on 4/08/2024 at around 5:00pm I (V10) was bringing R5 her dinner tray and as I stepped one foot into the room I (V10) observed R5 sitting at foot of the bed, at the top of the fold (foot of bed was elevated), as R5 was literally falling forward from the bed onto the floor. R5 was wearing her glasses and hit her face on the floor with a very hard with a loud thud and her glasses remained in place but were broken (right arm flew off). V10 stated R5 hit her face and head (right side) onto the floor with a very loud thud, the loudest thud I had ever heard from a fall.

R5's progress notes dated 4/08/2024 at 6:28pm by V12 (Assistant Director of Nursing-ADON) documents, in part, R5 was witnessed losing balance and falling forward on the floor striking her head above her right eye, R5 was wearing glasses at the time causing an abrasion to her temple with scant bleeding. A 2cm (centimeter) hematoma was noted on R5's right temple with a

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1cm abrasion, VS (vital signs) taken and WNL (within normal limits). NP (Nurse Practitioner-V22) notified via phone to send out for evaluation and ambulance called with ETA (estimated time of arrival) of 60 minutes.

R5's Blood Pressure on 4/08/2024 at 5:38pm and 5:40pm was 167/109.

R5's Neurological Flow Sheet dated 4/08/2024 at 5:46pm documents, in part, LOC (Level of Consciousness) responds to name, and touch, Hand Grasps: right/left weak, Vital Signs: 97.5, 85, 20, 166/100. At 6:17pm documents, in part, LOC: responds to name and touch, hand grasps weak bilaterally, blood pressure 181/102. At 6:31pm documents, in part, LOC: responds to name and touch, hand grasps weak bilaterally, blood pressure 154/94. 7:01pm documents, in part, LOC: responds to name and touch, hand grasps: right weak, left strong, blood pressure 177/98. At 7:30pm documents, in part, LOC: responds to name, touch, light pain, deep pain, hand grasps: right weak, left strong, blood pressure 161/90.

R5's Admission initial assessment on 4/02/2024 documents, Blood pressure of 138/85, Right and left pupil size to be normal (size and shape) hand grasps (upper extremities and hand grasps) to be left strong and right weak.

R5's Vitals from (Electronic Health Record System) documents a blood pressure of 134/87 at 10:15am on 4/08/2024, 155/89 on 4/07/2024 at 9:41am, and 129/85 on 4/07/2024 at 8:51am. All other blood pressure were below 132/82 from 4/03/2024-4/06/2024.

Ambulance run sheet dated 4/08/2024

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documents, in part, dispatch notified at 5:51pm for Advance Life Support services.

Progress note dated 4/08/2024 at 8:30pm documents, in part, Ambulance (company) contacted to follow up on resident's transportation, ambulance is on the way and will be here shortly per dispatch.

On 5/29/2024 at 1:13pm V3 (LPN) stated R5's orientation status was a 1-2 and we called the ambulance service and not 911 because R5 was stable, verbally responsive, vitals were within normal range and R5 did not appear to be in any distress.

On 5/30/2024 at 9:14am V17 (Physician) stated the nurse should do a mental and body assessment and call 911 and that a nursing home could not manage a fall with head trauma. V17 also stated a change in mental can be immediate or delayed and the reason why we would send them out 911 for further testing so that the hospital handle and manage. The hospital is capable of doing tests to determine if there is internal bleeding.

On 5/30/2024 at 3:00pm V12 (ADON) stated R5's orientation status was that she was awake and oriented 1-2 (to self and place) and based on the nurse's assessment we would have called the regular ambulance service to send R5 out for evaluation. V12 also stated irregular vital signs, pupil irregularity, pain or signs of head injury would been a reason to call 911.

On 5/31/2024 at 12:21pm via phone V22 (Nurse Practitioner-NP) stated any resident who has a head injury (or hit that is above the neck i.e., head, face, neck) witnessed or witnessed should

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be sent to the hospital via 911. At 3:33pm V22 (NP) stated he was told that R5 fell on R5's face and she should have been sent out via 911 and in his V22's (NP) professional opinion I (V22) don't want to single this situation out but all falls with a head injury should be sent out 911 because I (V22) can't see internal bleeding and I (911) would rather error on the side of caution and send them out via 911.

On 5/31/2024 at 1:40pm via phone V13 (LPN) stated she did not speak to V22 (NP), V12 (Assistant Director of Nursing-ADON) called V22 (NP), but she (V13-LPN) does not recall being told to call 911. V13 (LPN) stated she took R5 neuro checks every 15 minutes, then every 30 minutes and there were no changes in LOC (level of consciousness) in speech, swelling (hematoma) and vital signs.

On 5/31/2024 at 3:07pm V20 (RN) stated R5 had swelling on the right side of the head and R5's vitals were within normal range. V20 stated abnormal blood pressure is above 140's but R5's trended a little bit higher. V20 also state I would call 911 if there is a change of condition.

On 6/05/2024 at 10:11am V23 (Lead Paramedic) stated facility staff did not know how critical R5 was when we (V23 and the partner) arrived. V23 stated he (V23) noticed R5's blood pressure read 226/110 on the facility's vitals monitor, legs twitching and the big (size of baseball) hematoma (a solid swelling of clotted blood within the tissues) that was very prominent on R5's head; R5 was unstable, unresponsive and breathing fast. V23 stated that when they arrived R5 was connected to the facility's vitals monitor and her blood pressure read high, so we confirmed R5's blood pressure with our own equipment. V23

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stated that they (V23 and his partner) were not made aware of anything (R5's status). V23 stated that the call came in as a BLS (Basic Life Support) call because it was reported as a fall, but after his assessment he had to call his superiors to get the call updated to ALS (Advance Life Support) due to R5 being unstable, hypertensive with a big hematoma on the head and having altered Consciousness-unresponsive. V23 stated that facility staff wanted them (paramedic staff) to take R5 to local hospital (hospital, doctor is affiliated with) and that the nurse (V20-RN) told him (V23) that the resident was awake about 15 minutes prior to them arriving and she was able to give the resident her medication. V23 stated when he (V23) saw how high R5's blood pressure was I started to question what was really going on and felt that the medications were given to cover the facility. V23 stated that he tried to advocate for R5 to be transferred to a hospital that had trauma center due to her symptoms but was told to take her to the closest hospital. R5 was taken to the closest hospital but later transferred to the hospital he was advocating for due to her symptoms and that hospital being a trauma center.

On 6/05/2024 at 3:58pm V12 (Assistant Director of Nursing-ADON) stated R5's vitals (blood pressure 167/109) indicated that she was hypertensive after the fall and R5's baseline is 130-140 over 90 from previous blood pressure that was taken on 4/07/2024. R5 had a hematoma that was about 2 cm and circular in size. V12 stated that a blood pressure of 170/100 would warrant a call to 911 for R5 to be sent out. V12 also said, yes, the elevated blood pressure of 181/102 would have warranted a phone call to the doctor and yes, this is considered a change in condition. V12 also stated a hematoma could be

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an indicator of internal bleeding along with an increase in size of the hematoma and R5's blood pressure, hematoma and hand grasps did not warrant a call to 911 because the ambulance was already scheduled to pick her up.

R5's Ambulance run sheet documents, in part, on scene at 8:54pm with Altered Consciousness Unresponsive and at 9:05pm R5's blood pressure was 226/110, respirations 22. Right and left pupils' size was 6mm and non-reactive. Upon arrival on scene patient was found laying in bed, 70-year-old female, only alert to painful stimuli by attempting to open her eyes and localizing to pain. Ambulance run sheet also documents R5 has a 3-inch diameter hematoma to her right eyebrow and temple and upon assessment patient was found hypertensive and AMS (Altered Mental Status). Crew repositioned the patient and suctioned due to patient started having gurgled respiration.

R5's Death Certificate dated 4/15/2024 documents cause of death complications from subdural hemorrhage and fall.

Policy dated 09/2020 titled Head Injuries, documents, in part, residents who exhibit signs and symptoms of head injury will be assessed and treated immediately and call paramedics (911) and transfer to hospital if indicated.

Job Description titled for Staff Nurse (Registered Nurse/License Practical Nurse) with a date of 1/2015 documents, in part, responsible to provide direct nursing care to the customer, objective is to ensure the highest degree of quality care is maintained at all time, assume all nursing procedures and protocols are followed in accordance with established policies and notify

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S9999	Continued From page 9 the customer's attending physician and family when there is a change in the customer's condition. (AA)	S9999		