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
	IL6014633	A. BUILDING: ____ B. WING ____	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INVERNESS REHAB	**1800 W COLONIAL PARKWAY INVERNESS, IL 60067**

(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 Annual Licensure Survey Complaint Investigation 2494300/IL173842	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2) 300.615e) 300.615f) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act) f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender. This REQUIREMENT is NOT MET as evidenced by:	S9999		

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/26/24

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Based on interview and record review, the facility failed to follow its policy on conducting background checks for four (R52, R103, R105 and R106,) of 10 residents reviewed for admission screening. This failure has the potential to affect 117 residents currently residing in the facility.

Findings include:

Per census report, there are 117 residents currently residing in the facility.

R52 is a 75 year old, female, admitted in the facility on 06/15/24 with diagnosis of Unspecified Fracture of Shaft of Humerus, left Arm, Subsequent Encounter for Fracture with Routine Healing. R52's Criminal History Information Response Process (CHIRP) was done on 06/17/2024, two days after admission.

R103 is 78 year old, male, initially admitted in the facility on 01/05/24 with diagnosis of Unspecified Dementia, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety. There was no documentation that R103's CHIRP was checked, nor his name checked under State Sex offender website and Department of Corrections.

R105 is a 69 year old, female, admitted in the facility on 06/24/24 with diagnosis of Sepsis, Unspecified Organism. There was no record that her name was checked under Illinois Department of Corrections upon admission.

R106 is a 58 year old, female, admitted in the facility on 03/01/24 with diagnoses of Anorexia; Adult Failure to Thrive and Major Depressive

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Disorder, Recurrent, Unspecified. Her CHIRP was done on 03/05/24, which was four days after admission. R106's name was checked in the Illinois Department of Corrections, State Sex offender website on 07/09/24, which was four months after she was admitted. R106 is an identified offender for criminal offenses and had history of incarceration.

On 07/09/24 at 3:05 PM, V1 (Administrator) was asked regarding background checks on residents. V1 stated, "For new admissions regarding background checks, the team is notified that we have to check with National and State sex offender websites and the department of corrections. We have to do those prior to admission. CHIRP is done within 24 hours of admission. We want to make sure if there is a hit for sex offenders so we could provide a private room."

V20 (Medical Director) was also asked on 07/10/24 at 4:27 PM regarding background checks. V20 verbalized, "Regarding screening of new residents, they should be screened prior to admission to facility for background checks and at sex offender websites. We want to make sure they are not a danger to other residents and other staff."

Facility's policy titled, "Abuse Prevention Policy", dated 9/28/23 documented in part but not limited to the following:
Procedures:
II. Pre-Admission Screening of Potential Residents
This facility shall check the criminal history background on any resident seeking admission to the facility in order to identify previous criminal convictions.

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This facility will:
Request Criminal History Background Check within 24 hours after admission of a new resident
Check for the resident's name on the Illinois Sex Offender Registration Website
Check for the resident's name on the Illinois Department of Corrections sex registrant search page
While the background or fingerprint checks, and/or Identified Offender Report and Recommendations are pending, the facility shall take all steps necessary to ensure the safety of residents.

Facility's policy titled, "Admission of Identified Offender", dated 5/3/22, stated in part but not limited to the following:
Guidelines:
1. Screened on Sex offender website.
2. Criminal History record information requested.
4. Facility must review screenings and all supporting documentation to determine if the placement is appropriate.

(B)

Statement of Licensure Violations (2 of 2)

300.610 a)
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

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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 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.

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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 observation, interview and record review, the facility failed to implement effective fall interventions and adequate supervision for a dependent resident assessed as a high risk for falls with diagnoses of Parkinson's disease and Dementia. This failure affected one (R99) of three residents reviewed for falls in the sample of 44. This failure resulted in (R99) experiencing repeated falls that resulted in hospitalizations, sustaining lacerations on two occasions, with one laceration requiring three sutures.

Findings include:

R99 is a 78-year-old resident admitted to the facility on 08/01/2023 with diagnoses including but not limited to: Parkinson's disease, dementia, depression, ataxic gait, cognitive communication deficit, urgency of urination and visual hallucinations.

On 07/08/24 at 12:44 PM surveyor observed R99 dining in reclining chair with no concerns. R99 had an approximate quarter size yellowish purple bruise to right outer eye area.

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On 07/08/24 at 2:59 PM surveyor observed R99 sitting in TV (television) area with drink on table within reach. Surveyor requested to have staff bring resident to room for interview. Floor mat noted in room. Resident confused, does not want to talk with surveyor without staff present. When staff present resident stated, he is not the one I need to talk to. Surveyor observed an approximate quarter size yellowish purple bruise to right outer eye area.

On 07/09/24 at 11:33 PM R99 is not in his room. R99 noted sleeping in reclining chair with seat cushion in place in front of nursing station by TV area. Surveyor observed an approximate quarter size yellowish purple bruise to right outer eye area.

On 07/09/24 at 2:11 PM R99 is observed in reclining chair sleeping in TV area. R99 appeared comfortable. Surveyor observed an approximate quarter size yellowish purple bruise to right outer eye area. V16 (Registered Nurse - RN) stated, R99 has a laceration to back of the head, but due to resident sleeping surveyor unable to observe back of head. Surveyor observed large bruise to right hand area. V16 stated, he believes that was from a blood draw.

MDS (Minimum Data Set) dated 05/07/2024 shows R99's BIMS (Brief Interview for Mental Status) score of 7 which means severe cognitive impairment. MDS dated 5/7/2024 shows resident requires Substantial/maximal assistance for the following areas: toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear, sit to stand position, chair to bed transfer, toilet transfer and tub/shower transfer. Resident requires partial/moderate assistance

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with oral hygiene, upper body dressing, personal hygiene, rolling left and right, sit to lying, lying to sitting on the side of bed, and walking 10 feet.

Fall risk assessments dated 2/26/24, 5/23/24, 5/29/24, 6/8/24, 6/28/24 and 07/06/2024, R99 is categorized high risk for fall.

Incident report/root cause analysis dated 2/25/24, R99 sustained 1-2 cm (centimeters) x less than 0.0 cm skin tear with minimal bleeding noted to lateral left parietal region behind left ear from unwitnessed fall. Predisposing environmental factors - wheelchair unlocked.

Incident report/root cause analysis dated 5/22/24 R99 was noted on the floor in his room leaning up against wall. Writer noted bleeding on right side of his head. First aid immediately rendered and cold compress applied. CNA (certified nursing assistant) stayed with resident. Writer called 911 and resident was transferred to ER for evaluation. Predisposing factors: footwear and none. Predisposing physiological factors: cognitive factors - confusion/disorientation, cognitive factors- impaired memory, neuromuscular factors - gait imbalance, cognitive factors - impaired decision. Predisposing situation factors: ambulating without assist.

Skin assessment dated 5/22/24 documents: 3 sutures noted to right lateral forehead. Denied pain or discomfort. With orders to apply dry dressing every 3 days and to remove sutures in 7 days per MD (medical doctor) & hospice order

Hospital discharge instructions dated 5/23/24 document that reason for visit was fall and diagnosis was subarachnoid hemorrhage. This form also documents items done on this visit

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were laceration repair and wound/incision care. Imaging done on this visit were CT (computed tomography) brain without contrast and CT spine cervical without contrast.

Progress note dated 05/23/2024 at 02:43 AM documents: Writer noted copious amounts of blood on the floor next to R99 and there was blood dripping from the right side of his head.

Progress note dated 5/23/24 at 2:31 PM documents: Resident arrived back from ER, noted w/(with)skin impairment to right lateral forehead. Sutures intact. No bleeding noted. Denied pain or discomfort. MD made aware, Tx (treatment) and orders in place. Dry dressing applied. V19 (family member/power of attorney) and hospice updated.

Hospital discharge paperwork dated 05/24/24 documents: This is a 78-year-old male with past medical history as below, who was seen in this ED 24 hours ago for fall diagnosed with small subarachnoid hemorrhage, ultimately discharged back to hospice who presents to ED again for another reported witnessed fall. This report also documents, discussed that there needs to be an improved plan of care for this patient. They understood the plan. CT Brain without contrast impression 1. No acute intracranial abnormality. 2. Chronic findings as above. Narrative findings: There is no hemorrhage, mass effect, midline shift or hydrocephalus.

Incident report/root cause analysis dated 6/28/24 writer was notified by visitors that resident was on the floor at nurse's station. Writer observed resident sitting on the floor next to (geriatric) chair. Predisposing physiological factors: behavioral factors - agitation/combative,

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behavioral factors - restless/anxious, bowel/bladder elimination - incontinence, cognitive factors - confusion/disorientation and behavioral factors - resistive. No apparent injury.

Incident report/root cause analysis dated 07/06/24 writer's attention was called by staff that resident is on the floor and immediately proceeded to the room and observed resident sitting on the side of the bed that is on low position, alert conscious and verbally responsive with not visible injury noted initially. Resident sustained laceration to back of head. Predisposing physiological factors: cognitive factors - confusion/disorientation, neuromuscular factors - gait imbalance.

Progress note dated 07/06/24 at 07:39 AM documents: Resident had a fall and had a laceration on the back of the head about ¾ of an inch with minimal bleeding. Placed a call to sister/POA unable to answer call left voicemail about the incident. Spoke to hospice and they stated they will have a nurse come to see the patient. MD notified.

Care plan dated 08/01/23 documents:
Focus: R99 is at risk for falls related to Parkinson's, dementia, impaired cognition, anxiety, depression, visual deficits, history of fall, impaired balance, and psychotropic medication use. Prefers his independence and does things on his own. With episodes of impulsivity, agitation, and restlessness. Will attempt to ambulate without an assistive device.
Goal: Prevent serious fall related injury
Interventions:
Offer to assist R99 with getting snacks as he allows.
Make frequent purposeful rounds when R99 is in

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room and offer toileting assistance as needed.
Place R99 at nurse's station for closer supervision when unable to sleep during the night.
Ensure proper positioning in reclining chair and adjust positioning as needed towards back of seat.
High risk for falls - FALLING STAR
ANTICIPATE and MEET R99's needs. Redirect him if he is agitated.
Be sure his CALL LIGHT is within reach and encourage the resident to use it for assistance as needed.
Check his ENVIRONMENT for clutter or trip hazards and area is well lit.
Encourage NONSKID FOOTWEAR as needed.
Fall RISK evaluation.
Keep BED IN LOWEST POSITION acceptable by the resident when the resident is in bed.
Remind to REQUEST ASSISTANCE when getting up if needed.
REPORT to PHYSICIAN any untoward side effects associated with the resident's MEDICATION use.
Refer to hospice for therapy evaluation.
Remind R99 to lock his wheelchair brakes prior to attempting transfers out of his wheelchair and to request staff assistance as needed with ambulation from the dining room.
Remind R99 to request staff assistance with toileting needs.

On 07/09/24 at 2:07 PM Interview with V17 (Certified Nursing Assistant - CNA). V17 stated, I have worked with R99 before. He is a fall risk. We put the mattress when he is in bed but sometimes, he tries to jump it. I can't think of anything else we do to help prevent falls for R99. R99 can be aggressive and combative. I have not been here when he has fallen. Sometimes we

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have seen R99 on the mat. I think he falls because he is confused. He used to make is bed and walk around and now is confused.

On 07/09/24 at 1:57 PM Interview with V18 (CNA). V18 stated, I have taken care of R99 before. He is a fall risk. We have a large floor mat to go on one side of the bed when he is in the bed. No other things I can think of. He has fallen when I was working. Dementia caused the fall that time.

On 07/09/24 at 2:00 PM Interview with V16 (Registered Nurse - RN). V16 stated, R99 is a high fall risk. We change the bed to the lowest bed, frequent checks, bring to nurses' station/TV area. When he starts to get up, we try to bring him where we can see him. V19 (family member) doesn't want him in nurses' station. I think his cognitive issues are causing the falls. He wants to do the same things he used to be able to do like walking around. We discussed with V2, director of nursing 2 days ago to put him back to a 6am wake up depending on sleep the night before. He is combative at times and will hold the wrists of the staff and twist. He has a bruise on right eye and laceration to back of head. I was here for the laceration to back of head. I went in his room on July 6, 2024. He was sitting on the foot part of the bed. He fell and hit his head on the post. He was bleeding very minimal. This incident caused a laceration to back of head. The hospice nurse had wanted to change Seroquel dose, but sister did not want to agree to that. I believe the bruise was caused by him hitting himself accidentally as he was being combative with staff during care.

On 07/09/24 at 3:03 PM Interview with V21 Licensed Practical Nurse (LPN). V21 stated, I have taken care of R99 before. On 6/28/24 day

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R99 was at nursing station in reclining chair. I had just went to 900 hall for a minute to pass medication. I was actually talking to another resident in the hallway when I was notified by visiting family member of another resident that R99 was on the floor next to his geriatric chair. He is not 1:1 We were keeping him at nursing station to keep a better eye on him. I had just checked on him probably 10-15 minutes prior and he was sitting calm in the chair. He is a high fall risk. We kept bed in low position and locked and fall mat in place. While in reclining chair we try to keep an eye on him as much as possible between myself and CNA's. If he is anxious, we try to see what is causing it. We offer snacks, fluids toileting. In my opinion I feel like he is sundowning more in evenings and that is causing him to have more falls. If we offer to take to bathroom, he will go but then gets aggressive, paranoid, combative very quickly. I try to encourage to have CNA check and change him 2x or more during the shift especially if he is getting restless. If we keep him clean and dry, he tends to be more calm but taking him for peri care is when we struggle.

On 07/09/24 at 3:15 PM Interview with V22 (LPN). V22 stated, I have worked with R99 before. On 5/23/24 it was around the start of shift, so my CNA who I do not recall who it was, was doing rounds and immediately called me. R99 had floor mat in place but he crawls on that and is able to stand up. He has a reclining chair. He has a low bed and that was in place. He had his call light within reach. He has been instructed multiple times on call light use but appears unable to be able to use call light. He is always checked on frequently like every 15-20 minutes just to make sure he is safe. I think his increased confusion, restlessness, anxiousness, and incontinence is

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	IL6014633	A. BUILDING: ______ B. WING ______	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INVERNESS REHAB	1800 W COLONIAL PARKWAY INVERNESS, IL 60067

(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
S9999	Continued From page 13	S9999		

causing his falls. He is so unpredictable so it is very hard to put anything in place to decrease falls except to increase medications, but family will not agree to that.

On 07/09/24 at 1:24 PM Interview with V2 Director of Nursing (DON). V2 stated, R99 he is under hospice care and very active. He really doesn't know his limitations. He attempts unsafe transfers, He has Parkinson's, history of hallucinations. This very last fall he rolled out of bed, and we decided to put in place to be put in his chair as soon as he is awake as he allows. And toileting and have his needs met. He is very active, and he bumps his hands and I think that is why he is having bruising. He is aggressive at times. He is also not aware of safety issues.

Fall policy labeled: Fall Prevention Program AA Healthcare dated 2/12/2024 provided to surveyor by V2, DON on 07/09/2024 states:
Policy:
The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents.
Procedure:
1. A Fall Prevention program will be implemented and maintained to assure the safety of all residents admitted to the facility. The program will be inclusive of measures which determine the individual needs of each resident by assessing the risk of falls, and implementation of appropriate staff interventions to assure adequate supervision is provided, and that assistive devices are utilized when necessary. Fall Incident Reports will be reviewed, and quality issues identified to assure the on-going effectiveness of the prevention program.

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S9999	Continued From page 14	S9999		

4. The DON or designee will be responsible for implementing and communicating resident-specific recommendations from the Fall Risk Committee to the nursing staff assigned to the resident. The nursing staff will be responsible for assuring the recommendations are followed through.
7. Fall prevention strategies will be utilized for all residents at risk for falls including individualized interventions in accordance with the assessed needs of each resident. Fall alarms may be utilized to alert staff to resident attempts to rise without assistance unless they prevent the resident from rising or pose an increased risk for falls.

(B)