STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007843	A. BUILDING: _____ B. WING _____	C 11/20/2024

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PALOS HEIGHTS REHABILITATION	13259 SOUTH CENTRAL AVENUE CRESTWOOD, IL 60418

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S 000	Initial Comments Facility Reported Incident Investigation of 9/28/24-IL180445	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210c) 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		

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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.

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.

These requirements were not met as evidenced by:

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Based on interview and record review the facility failed to follow the plan of care and provide three persons assist with activities of daily living care during bed mobility for a dependent resident. This affected one of three residents (R1) reviewed for avoidable accidents. This failure resulted in R1 falling out of bed when provided one person assist, V1 pushed the linen under R1's body, pushing R1 out of bed. R1 complained of pain, sent to the hospital diagnosed with non-displaced left, 11th rib fracture.

Findings include:

R1 face sheet shows diagnosis of generalized osteoarthritis, repeated falls, hereditary and idiopathic neuropathy, adult failure to thrive, morbid obesity, muscle weakness, difficulty in walking, unspecified lack of coordination, venous insufficiency, chronic pain, vitamin D deficiency. R1 MDS dated 9/30/24 section for cognitive pattern shows score of 15 (cognitively intact), section GG for functional status shows mobility-roll from left to right- 01 is entered (01-dependent, helper does all the effort, resident does none of the effort to complete the activity or the assistance of or more helpers is required for the resident to complete). Section K shows R1 is 67 inches in height and weigh 376 pounds.

Facility final report to the department dated 9/28/24 denotes in part date of occurrence 9/28/24, R1 observed laying on the floor by side of hospital bed in bedroom. R1 complained of pain to left shoulder and left knee. Pain medication offered by nurse and refused by R1. She is placed back in bed by facility staff. MD (Medical Doctor), family were made aware of findings and orders to send R1 to ED (Emergency

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Department) for further evaluation was received and carried. Upon further investigation, it has been determined that R1 experienced a fall while receiving ADL care from facility staff aide. R1 is alert, orient x four, verbal and able to tell writer what happened at time of fall. R1 stated "she slid out of bed while laying on her side receiving care from facility aide". Facility staff aide was interviewed: stated that R1 was receiving ADL care in bed, she was trying to change bed sheets when R1 slid out of bed. R1 complained of pain to left shoulder and left knee. Pain medication offered by Nurse and refused by R1. She (R1) is placed back in bed by facility staff. MD, family were made aware of findings to send R1 to the hospital for further evaluation was received and carried out. R1 noted with left eleventh rib non-displaced fracture in hospital, she (R1) returned to the facility with no new orders. R1's plan of care is updated, MD and family aware. This shall serve as the final report.

On 11/15/24 at 12:07pm observed sitting in her wheelchair, R1 observed alert to person, place, time, and situation. R1 said she was receiving ADL (Activity of Daily Living) care, she was on laying on her right side, R1 said when the aide pushed the linen, she rolled out of bed. R1 said she fell on the side of the bed between the wall and bed frame. R1 said the aide summons the Nurse, the Nurse assessed her. R1 said she was having pain. R1 said she was sent to the hospital and was diagnosed with left shoulder contusion, left rib fracture, and sprain left knee. R1 said the fall caused her to have a set back in function abilities. R1 said her shoulder is painful, to move, her right knee is better, and the bruising from the fractured ribs has resolved.

On 11/15/24 at 1:57pm V1 (CNA) she was R1

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aide on 9/28/24, V1 said she had provided R1 with ADL care and was changing R1's bed linen. V1 said R1 was laying on her right side facing the wall. V1 said she put the linen on the bed, and as her pushed the linen to get it under R1, R1 fell out of bed. V1 said R1 landed on the floor on the side of the bed. V1 said she summons the nurse right away. V1 said the Nurse and other staff picked R1 up from the floor.

On 11/15/24 at 3:20pm V5 (Restorative Nurse) said R1 requires two assists with bed mobility, V5 said R1 required 2 persons assist with bed mobility on 9/28/24. V5 said staff should review the care card prior to providing care. During follow up interview on 11/19/24 at 11:00am V5 said staff should provide the level of assistant that the resident has been assessed to need during care. V5 said this is for patient and staff safety, it helps reduce risk falling out of bed, reduce skin tears, and reduce risk for resident getting hurt. V5 said 2A on the baseline care plan means 2 persons assist.

On 11/15/24 at 3:00pm V2 (Director of Nursing) said he conducted the investigation for R1's incident of 9/28/24. V2 said R1 fell out of bed during care. V2 said R1 is 2-person assist with bed mobility now (11/15/24). V2 said when R1 fell out of bed on 9/28/24, R1 required three persons assist with bed mobility. V2 said V1 should have checked the resident care card prior to providing care, V2 said V1 should have asked the Nurse on duty what was R1 functional status with ADL care/ bed mobility prior to giving care to R1. V2 said the resident care card is placed in their closet and the aides should check the care card prior to proving care. V2 said R1 or any residents should not fall from bed during care.

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11/19/24 9:58am V4 (Restorative aide) said R1 was a three person assist with bed mobility on 9/28/24. V4 said all the staff including the aide are to check the care card before giving care to the resident.

On 11/19/24 at 11:29am V6 (Rehab Director) said on 9/28/24 R1 required max assist with bed mobility. V6 said staff provided 75% to 90% of support for bed mobility. V6 said staff assist with the turning left to right and should be there to hold R1 in place to keep R1 in that position.

R1 baseline care plan dated 9/24/24 shows ADL assistance, will receive ADL assistance as needed, 2A (2 assist) with bed mobility.

R1 post fall observation dated 9/28/24 at 12:14pm denotes in part fall to the floor, witnessed by (V1), what was resident doing prior to fall- in bed, what was resident trying to do just before they fell- turn to side, resident usual ambulatory status- mechanical lift, review contributing factors- amount of assistance in effect, evaluation; what appears to be the root cause of the fall-need more assistance.

Facility Activities of Daily Living policy with effective date of 2/2023 denotes in part our collaborative professional team, together with the resident and/ or resident representative: develop and implement interventions in accordance with the residents evaluated need, goals for care, and preference and will address the identified limitation in an ability to perform ADLs. Revise the approach to care as appropriate.

Facility policy Titled "Falls and falls risk, managing" with revised date 8/2008 denotes in part based on previous evaluation and current

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data, the staff will identify interventions related to the residents' specific risk and causes to try to prevent the resident from falling and try to minimize complications from falling.

R1 face sheet shows diagnosis of generalized osteoarthritis, repeated falls, hereditary and idiopathic neuropathy, adult failure to thrive, morbid obesity, muscle weakness, difficulty in walking, unspecified lack of coordination, venous insufficiency, chronic pain, vitamin D deficiency. R1 MDS dated 9/30/24 section for cognitive pattern shows score of 15 (cognitively intact), section GG for functional status shows mobility-roll from left to right- 01 is entered (01-dependent, helper does all the effort, resident does none of the effort to complete the activity or the assistance of or more helpers is required for the resident to complete). Section K shows R1 is 67 inches in height and weigh 376 pounds.

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when R1 slid out of bed. R1 complained of pain to left shoulder and left knee. Pain medication offered by Nurse and refused by R1. She (R1) is placed back in bed by facility staff. MD, family were made aware of findings to send R1 to the hospital for further evaluation was received and carried out. R1 noted with left eleventh rib non-displaced fracture in hospital, she (R1) returned to the facility with no new orders. R1's plan of care is updated, MD and family aware. This shall serve as the final report.

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On 11/19/24 at 11:29am V6 (Rehab Director) said

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on 9/28/24 R1 required max assist with bed mobility. V6 said staff provided 75% to 90% of support for bed mobility. V6 said staff assist with the turning left to right and should be there to hold R1 in place to keep R1 in that position.

R1 baseline care plan dated 9/24/24 shows ADL assistance, will receive ADL assistance as needed, 2A (2 assist) with bed mobility.

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Facility policy Titled "Falls and falls risk, managing" with revised date 8/2008 denotes in part based on previous evaluation and current data, the staff will identify interventions related to the residents' specific risk and causes to try to prevent the resident from falling and try to minimize complications from falling.

Facility policy titled baseline care plan with revised dated 10/19/24 denotes in part nursing

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S9999	Continued From page 10 homes are required to develop a baseline care plan within the first 48 hours of admission which provides instructions for the provision of effective and person-centered care to each resident. The facility staff must implement the interventions to assist the resident to achieve care plan goals and objectives. (B)	S9999		