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S 000	Initial Comments Complaints: 1988892 / IL 118057 - F689 2080044 / IL 118862 - F686	S 000		
S9999	Final Observations 1) Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. 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	S9999	Attachment A Statement of Licensure Violations	

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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:

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Regulations were not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure that a resident identified at high risk for pressure ulcers, was adequately assessed by facility staff. This facility

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failure resulted in a delay in the identification of an alteration in skin integrity and the implementation of treatment, for one resident (R3), who was admitted to the hospital for the treatment of unstageable pressure ulcer to the sacral area.

Findings include:

R3 is 78 year old with diagnoses that includes Chronic Respiratory Failure, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, Paraplegia, Chronic Kidney Disease, Anemia, Dementia, Unspecified Chronic Gastritis.

On review of the Braden Scale pressure ulcer assessment tool dated 11/29/2019, it was documented that R3 was at moderate risk (score 14) for the development of pressure ulcers.

The Minimum Data Set (MDS) dated 12/6/2019, as documented in the section titled Functional Status, facility staff identified that R3 was totally dependent and required the assistance of two staff persons for physical assistance during transfers, bed mobility and toileting. On review of the section titled Skin Condition, facility staff documented that R3 had no ulcers, wounds or skin problems.

On review of the Progress Notes dated from 11/16/2019 to 12/22/2019, there was no documentation that R3 was identified to have any alterations in skin integrity. R3's Bath and Skin Report Sheet dated 11/4/2019, 11/13/2019, 11/20/2019, 11/28/2019, 12/4/2019, 12/19/2019, indicated that R3's skin was intact.

On review of the Bath and Skin report dated 12/23/2019, facility staff documented R3 was

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noted to have open wound. R3's Weekly Wound Evaluation dated 12/23/19, documented R3 had an Unstageable pressure ulcer to the sacrum measuring 3.0 cm (centimeter) x 3.0 cm 0.0 cm.

On review of the Progress note dated 1/2/2020, facility staff documented that R3 was admitted to a local hospital with diagnosis of severe anemia and sacral decubitus.

On review of the hospital record, it was documented in the Discharge Summary, that R3 was admitted from nursing home, secondary to worsening sacral wound.

On 1/22/2020 at 3:22 PM, V4 (Wound Care Nurse) stated, "If the skin is intact I don't do a skin assessment. I only do it when there is a wound." V4 further stated that a wound assessment would only be done when there is an issue with the skin.

On 1/22/2020 at 4:07 PM, V2 (Director of Nursing) stated, "The nurses do a skin assessment as noted on the Skin assessment on the MAR (Medication Administration Record). If there is any skin alteration, then they would tell her (V4 Wound Care Nurse). So on the day that they saw the wound on her (R3), V4 was made aware so she can do the documentation. V2 further stated, that R3 has history of a coccyx wound, which resolved years ago. CNAs (Certified Nursing Assistants) should check the skin at least every shift or when they shower or change the resident."

On 1/22/2020 at 3:40 PM, V15 (Wound Physician) stated, "It is possible that there would be manifestations on the skin before it develops to Unstageable pressure ulcer, you may see

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some signs such as redness. Staff needs to monitor the skin more closely especially if they have poor nutrition."

On 1/22/2020 at 9:46 AM, a wound treatment observation was conducted with V4 and wound measurements were obtained. On review of the Weekly Wound Evaluation dated 1/23/2020, facility staff documented that R3 has a Stage 4 pressure ulcer to the sacrum that measured 8.5 cm x 5.5 cm x 1.0 cm.

The Facility policy titled, "Risk and Skin Assessment" undated, stated in part but not limited to the following:
Procedure:
II. C. Skin check is completed on each shower day by nursing assistant staff.
1. Shower sheet maybe used to document skin check.
2. If an area is identified, the nurse is notified and the Stop and Watch Tool may be used to communicate this information.
D. The nursing assistant visually inspects the skin daily and with care.

(B)

2)

Statement of Licensure Violations:

300.610a)
300.1210b)
300.1210d)6)
300.3240a)

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S9999	Continued From page 5 Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. 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:	S9999		

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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 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Regulations were not met as evidenced by:

Based on interview and record review, the facility failed to implement interventions to ensure the safety of a resident with bilateral above the knee amputations of the lower extremities; and failed to follow the facility policy related to the identification of risk factors for fall prevention, for one resident (R2), who was sent to the hospital for a dislodged gastrostomy tube, as a result of a fall related incident and was determined to have sustained a fibula fracture of the right below the knee stump, as a result of the fall incident.

Findings include:

R2 is an 83 year old admitted in the facility on 11/22/2019, with diagnoses that include Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side; Acquired Absence of Left Leg Below Knee and Acquired Absence of Right Leg Below Knee.

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On review of the hospital records dated 11/24/19 to 11/27/19, the Discharge Summary indicated that R2, who previously had an amputation of the left leg, recently had surgery for leg amputation below knee, right on 11/01/19 and Esophagogastroduodenoscopy with PEG (Percutaneous Endoscopic Gastrostomy) on 11/18/19.

On review of the Fall Risk Assessment dated 11/22/19, facility staff documented R2 had a total score of 12-16, which indicated the resident was at High Risk for falls.

R2's Baseline Care Plan, on admission to the facility on 11/22/19 included:
E. Safety Goals and Interventions/Safety/Fall History
1. History of Falls: n/a (not applicable)
3. Interventions for Fall Prevention: n/a

On review of the progress note dated 11/22/19 at 3:53 PM, staff documented, "R2 was admitted to the facility with gastrostomy tube (Gtube) in place and intact. R2 had an admitting diagnoses of Altered Mental Status (AMS) and Below Knee Amputation (BKA). At 7:30 PM, R2 had a fall incident. R2 was observed on the floor by his bedside in a sitting position with no injuries noted." On review of the facility Incident Report dated 11/22/2019, R2 was assessed to be confused, impulsive, had decreased strength/endurance and safety awareness as predisposing physiological factors.

During an interview on 1/22/2020 at 3:10 PM, V9 (Licensed Practical Nurse, LPN) stated, that she was the admitting nurse when R2 was initially admitted in the facility. V9 verbalized, "He is alert, oriented to self. I did his admission. The hospital

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report didn't tell me that he is a high fall risk, only that he has bilateral amputation. So when he came, I did the assessment and I can see that one of the legs was done recently, the right leg. After he was put into bed, I went back to his room to do my assessment, then later, I left the room to get a Gtube pole. When I came back into the room, I found him on the floor, sitting by the bedside. There were no injuries noted upon assessment. He was not in any form of pain as I observed from his facial expression. I notified V10 (Nurse Practitioner, NP) regarding his fall and was just told to monitor him (R2). Upon admission, he was not assessed as high risk, but after the fall incident, he was now considered high risk." During the interview, V9 stated, "We use mechanical lift device for his transfers, make sure floor mats are placed on both sides of his bed, bed in lowest position, his call light should be within reach with prompt responses for call light requests and continuous monitoring." V9 further stated, "Maybe the bed is new to him, because in the hospital, the bed has side rails that he can hold onto while he moves himself in bed. He can still move while in bed. Maybe the cause of his fall was he rolled out from bed."

On review of an Incident Report dated 11/24/19, facility staff documented, "R2 had another unwitnessed fall incident from bed. He was again observed in a sitting position on the floor mat on the right side of his bed. There were no injuries noted neither pain or bleeding on the right BKA." It was also noted from the report that R2 requires staff assistance for all transfers and was noted to have cognitive deficits and impulsive behavior status post CVA (Cerebrovascular Accident). Facility staff also documented that R2's PEG tube was noted dislodged during this fall incident and the resident was transferred to a local hospital for

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PEG tube reinsertion.

R2's Fall Risk Care Plan dated 12/03/2019 included the following:
Approaches/Interventions:
Be sure call light is within reach and encourage it for assistance as needed. Respond promptly to all requests for assistance.
Anticipate and meet needs.
Complete Fall Risk Assessment per Facility protocol
11/22/19: Floor mats
11/25/19: Gather information on past falls and attempt to determine cause of falls. Anticipate and intervene to prevent future recurrence; bariatric low bed; floor mats (9 inch) and hospital evaluation.

During an interview on 1/22/2020 at 2:34 PM, V7 (Registered Nurse, RN) confirmed that R2 had a 2nd fall related incident. V7 stated, "On that day (11/24/2019), I was notified that patient was on the floor. I went to the room and noted him in a sitting position on the floor mat with his back leaning on the bed. Upon assessment, I asked him, "dolor?" (meaning pain) and he shook his head. I checked his vitals and all within normal limits. I inspected his whole body and extremities, no injuries were noted. I noticed that his Gtube was dislodged. I asked him what happened but he wouldn't say anything with regards to his Gtube. There was no bleeding noted on the Gtube site. Then, he was put into bed using the mechanical lift device. It was an unwitnessed fall, don't know how he fell. He was transferred to the hospital as ordered for further evaluation. He (R2) was still awake and alert, no pain was noted and reported. I don't know him (R2) enough, he was just admitted in the facility."

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On review of the hospital record, the emergency room department notes included documentation from the History and Physical dated 11/24/19, which stated R2 was transferred to the hospital due to concerns related to Gtube dislodgement and right BKA (below knee amputation) stump pain, after an unwitnessed fall in the facility. R2 had an X-ray of the right lower extremity stump, which concluded status post BKA and fracture of the mild aspect of the remaining fibula with the apex of the fracture site directed anteriorly.

V10 was interviewed on 1/22/20 at 3:58 PM regarding R2 and fall interventions. V10 stated, "I didn't see him at the time. It was reported to me that he had a fall incident on 11/22/19 with no injuries. Usually, if there are injuries noted after fall, we send residents to the hospital. If there is pain or discomfort, we do X-rays. If there is nothing serious, we do body checks and 72 hours monitoring post fall. Depending on the condition of the resident, like if he or she is not alert and has no self-awareness, they have to be monitored closely and implement interventions like low bed, call light within reach, identification of the risk factors that could lead to falls and lab work-ups to rule out infection. There should be a care plan that should be initiated at the time of admission. Any change in condition, care plan is formulated and or updated. He (R2) was admitted with AMS (Altered Mental Status) with bilateral amputation so safety is a big concern. In order to prevent falls, he should be secured while in bed. If he rolls out from bed, side rails can be put up. I have residents who roll when they sleep. The basic thing is to make the patient secure; fall precautions should be observed, do an update for any change in status and if there is any immediate concerns, send to the hospital. Upon admission, staff needs to do a head to toe

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assessment to identify risk factors leading to fall occurrences, it's on a case by case basis, therefore, interventions are tailored to patient's needs. Not all fall interventions are applicable to a specific resident, like for residents with AMS, they cannot use the call light. Staff needs to identify the real cause."

On 1/23/2020 at 10:05 AM, V2 (Director of Nursing) was interviewed regarding falls. V2 stated, "I head the Fall committee. We all meet weekly to discuss the fall incidents that happened in a week. But if there is a fall, we meet the next day unless it's a weekend. We meet to discuss in making sure the interventions implemented are appropriate. For newly admitted residents, the floor nurses are responsible for completing a fall risk review assessment. It gives you a number and the higher the number, the higher the resident is at risk for falls. If we know that prior to coming here that they are high risk for falls, we implement an intervention right away like floor mats, low bed especially if they are not ambulatory. However, in the event that the nurse considered them high risk upon admission, the nurse would implement appropriate interventions for the resident. Baseline care planning for safety is based on the information that the admitting nurse gathered during admission assessment. Over-all, thorough assessment should be performed on a newly admitted resident for individualized fall interventions. The baseline care planning was accomplished at the time the resident was admitted. The interventions are relayed to the staff through verbal communication from the nurse. In his (R2) baseline care plan for safety/falls,there should be interventions documented for fall prevention."

On 1/23/20 at 1:56 PM, V17 (LPN) stated, "I did

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his baseline care plan. The baseline care plan was done within the first hour of getting here and what happened was we have 48 hours to do a complete one. That might have been a mistake that I did but there were interventions in place like fall mats and low bed. There should be documented interventions for fall prevention in his baseline care plan. When he fell second time, I ordered a bariatric bed. He is a bit larger in size. He was placed on a regular bed. When he turns, he could not reposition himself, and he can roll out from bed. The bariatric bed is not available in the facility, it has to be ordered."

MDS (Minimum Data Set) dated 11/24/19, R2's weight was recorded as 211 pounds and has a height of 71 inches.

Facility's policy titled "Fall Prevention Protocol" dated 08/03/17 stated in part but not limited to the following:
Risk Assessment
III. Fall Prevention
A. Identify risk factors
B. Implement individualized approaches/interventions based upon resident risk
1. The Fall Prevention Strategies/Interventions list may be used to identify appropriate interventions
2. Approaches/interventions should focus on risk factors identified
V. Care Plan
A. Interdisciplinary care plan is implemented for residents at risk and may include
1. Interventions to prevent falls
3. Assistive devices as appropriate
5. Adaptive equipment
C. Evaluation of the interventions is completed
2. Post fall
3. Interventions are modified as indicated based

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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
S9999	Continued From page 13 upon evaluated efficacy of the interventions Facility's Fall Prevention Strategies/Interventions documented in part: Staff intervention - observe for potential interventions appropriate for the resident Facility's policy titled "Care Plan Policy and Procedures" dated 11/26/19 documented in part but not limited to the following: 5. New admissions will have a preliminary care plan initiated with actual and potential problems identified as the comprehensive care plan will continue to be developed in conjunction with the completion of the MDS (Minimum Data Set) Assessment. (B)	S9999		