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
	IL6005714	A. BUILDING: ______ B. WING ______	C 11/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN LONG GROVE REHAB &HC CTR	BOX 2308 RFD HICKS ROAD LONG GROVE, IL 60047

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S9999	Final Observations	S9999		

Statement of Licensure Violations:

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

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 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

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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.

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.

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 Requirements are not met as evidenced by:

Based on interview and record review, the facility failed to revise a plan of care after a fall to prevent additional falls and conduct a post fall

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assessment to rule out a head and neck injury prior to rolling and moving a resident after a suspected head injury. This failure resulted in direct care staff moving and rolling R1 after a head injury and R1 sustaining an acute cervical fracture after a fall incident on 11-12-14.

The findings include:

The facility's incident report dated 11/12/2014 showed R1 is an 84 year old with multiple diagnoses which include Dementia, Alzheimer's Disease, Aortic Valve Stenosis, Anxiety and Agitation. R1 was originally admitted to the facility on 01/03/2014.

The facility's incident report showed R1 had three falls for period of 10 months. The incident report showed the details of the fall incidents:

1) On 9/8/2014 at 1:00 P.M., (R1) observed lying on the floor on his back. Per kitchen staff member, "(R1) was walking in the hallway close to his room and fell on the floor." R1 was sent to the hospital due to the fall. R1 sustained a subarachnoid hemorrhage precipitated by the fall incident.
2) On 9/26/2014 at 7:35 A.M.; R1 was found lying on the floor. R1 was sent to the hospital precipitated by this fall.
3) On 11/12/2014 at 10:35 A.M.; R1 was found lying on the floor in an empty resident room. R1 was found lying with his face down. R1 was found by Z1 (R1's family member), E4 (CNA-Certified Nurse Aide) and E10 (Activity Aide). R1 was sent to the emergency room via 911. The hospital CT (Computerized Tomography) of the cervical spine result dated 11/12/2014 at 11: 58 A.M. reflects the following

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document: " (R1) admitting diagnoses: fall; reason of CT procedure was neck pain after fall: indication was neck pain and injury. The findings: Bilateral C2 acute laminar fracture. There is resultant severe anterior subluxation of C2 and C3 by almost 1.5 cm. The Impression: Severe bilateral C2 fracture with anterior C2-C3 subluxation."

On 11/17/2014 at 10:00 A.M., E2 (Director of Nursing) and E14 (Nurse Consultant) provided all existing which included resolved and current care plan of R1. The care plan provided was reviewed together with E2. There was no revision of care plan to prevent further fall when R1 had a fall incident on 9/26/2014. Furthermore, there were no specific revised fall interventions when R1 was readmitted back to facility on 11/7/2014. E2 stated she had made an interim care plan dated 11/7/2014. The interim care plan interventions were nonspecific and lacked analysis if the fall interventions prior to R1 being sent to hospital on 10/19/2014 hospital were still applicable. The current care plan dated 9/14/2014 with target goal date of 01/01/2015 showed that R1 was at high risk for fall and one intervention to prevent fall was for R1 to have a sensor monitoring alarm while in bed.

During the investigation, the sensor monitoring alarm was not implemented when R1 had a fall on 11/12/2014 according to interviews held with E3 (LPN), E4 (CNA), E7 (CNA), E6 (CNA) and E8 (CNA).

On 11/17/2014 at 3:00 P.M., E1(Administrator) and E2(Director of Nursing) stated that there was no specific fall care plan since R1 was only readmitted on 11/7/2014 and the care plan was not due yet.

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The facility policy for "Fall Risk Assessment Policy" dated 3/2012 showed that:
"...a resident who scores 12 or greater will have individualized High Risk interventions implemented"
"...With fall, the care plan interventions will be reviewed for effectiveness and modified as appropriate to reduce hazards and risk to the residents."

The fall assessment dated 9/14/2014 showed R1 scored 21; on 10/1/2014, scored 22 and 11/7/2014, scored 22. These results were all indicative of high risk for falls.

The fall assessment policy was not followed when R1 had a score of 22 on 11/7/2014 and the plan of care showed no specific high risk fall interventions. The policy was also not followed when R1 had a fall on 9/26/2014 and there was no revision of the care plan.

On 11/7/2014 at 12:03 P.M., E4 (CNA) stated that together with E10 (CNA) and Z1 (R1's family member), on 11/12/2014 at around 10:35 A.M., R1 was found lying on the floor in patient room (former R1's room). The room was closed when R1 was found on the floor, E4 added. E4 also stated that they searched 2 other patient rooms before finally finding R1. E4 also added that R1 was lying on the floor next to bed and that there was no sensor monitoring alarm attached to the bed in room the patient was found.

On 11/17/2014 at 2:10 P.M., E8 (CNA) stated that R1 did not have a sensor monitoring alarm in place when R1 was in bed in room the night before the fall incident of 11/12/2014. E8 also stated that R1 had a sensor alarm in room

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S9999	Continued From page 5 patient's present room, but not in room where patient was located on 11/12/14. On 11/17/2014 at 11:20 A.M., E7 (CNA) stated that R1 had no sensor monitoring alarm when in bed in the morning of the fall incident on 11/12/2014. E7 also stated that she saw R1 on 11/12/2014 around 8:20 A.M. to 8:30 A.M. E7 further stated that R1 was agitated and was in an angry tone of voice when he told E7 "Get out of here, leave me alone." E7 further stated that she left R1 alone in room (The patient's former room) and did not return to check R1. E7 also stated that she did not inform E3 (Licensed Practical Nurse- assigned to R1) regarding R1's agitation. On 11/17/2014 at 11:35 A.M., E3 stated that she saw R1 at around 8:15 A.M. to 8:30 A.M. on 11/12/2014. E3 stated that R1 refused his medications and was resistive to care. E3 further added that R1 told her to "Get out of here; I don't need it (medications)". E3 stated that R1 had no sensor monitoring alarm when found in bed in room (Not the patient's assigned room). E3 also stated that R1 had a sensor monitoring alarm in room (R1's room) and used to have 1:1 supervision before R1 was sent out to the hospital on 10/19/2014. As E3 further stated, R1 was sent out to a mental/behavioral hospital due to aggressive behavior and R1 was returned to the facility on 11/7/2014. E3 also added that she did not check R1 again until the fall incident at 10:35 A.M. E3 also added that E7 did not inform her that R1 was agitated. E3 further stated that increase and close supervision could have been provided to R1 if she would have known about R1's agitation. E3 had added that she saw R1 lying on the floor on a supine position perpendicular to bed and window. E3 assessed R1 by checking blood pressure, pulse and	S9999		

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temperature. E3 added that R1 complained of headache but did not assess R1 for possible head injuries. E3 also stated that R1 was only noted with redness on bilateral knees and right side of the upper torso.

On 11/17/2014 at 12:41 P.M., E6 (CNA) stated that when he arrived in room at around 10:35 A.M on 11/12/2014, R1 was lying on the floor perpendicular to bed and window. E6 added that R1's face was touching the floor and was blocking R1's nose and mouth and therefore R1 had difficulty in breathing. E6 further stated that he took a bed linen from the bed, crunched it up and placed it on R1's forehead so R1's nose and mouth was not touching the floor.

On 11/17/2014, E5 (LPN, Restorative Nurse) stated that on 11/12/2014 at 10:35 A.M., he saw R1 on the floor in a prone position and R1's face was touching the floor. E5 also stated that R1 had a crunched out cloth material on his forehead and that R1 had difficulty breathing. Then E5 added, together with E6, R1 was rolled over to a supine position. E5 also stated that during the turn, E5 supported R1's head and neck by placing his hands behind R1's ears, back of head and neck while E6 was supporting R1's lower extremities. E6 also stated that R1 did not require oxygen administration after the change of position. E5 also added that R1 complained of pain, however, E5 did not assess for possible neck/head injury before R1 was rolled over.

On 11/17/2014 at 2:20 P.M., Z2 (R1's Attending Physician) stated that R1's C2 and C3 cervical fracture could have been caused from an impact. Z2 further added that if it was a non witnessed fall, an assessment to rule out possible neck and head injury should have been done. Then Z2

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S9999	Continued From page 7 added, R1 should not have been rolled over, not unless there was traction to immobilized R1's head/neck. Z2 further added that staff should have just removed the bed linen/cloth material that was obstructing R1's airway and should have just waited for the paramedics. On 11/17/2014 at 4:00 P.M., during the daily status meeting, E1 (Administrator), E2 (Director of Nursing) and E14 (Nurse Consultant) had all stated that the facility does not have a policy and procedure regarding care that would include assessment and changing a resident's position immediately after the fall incident. On 11/17/2014 at 9:30 A.M., Z1 stated that R1 was placed on hospice care after the fall incident. (B)	S9999		