STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000467	A. BUILDING: _____ B. WING _____	C 09/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWOOD REHABILITATION CENTER	21020 KOSTNER AVENUE MATTESON, IL 60443

(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	Final Observations LICENSURE FINDINGS 300.1210a) 300.1210b) 300.1210d)6) 300.3240a) 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.	S9999		

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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.

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 follow their policy and provide adequate supervision for 4 of 6 residents (R1,R3,R4,R6) reviewed for falls in the sample of 8. This failure resulted in R1 falling from the wheelchair, sustaining a laceration to the head and bleeding in the brain.

Findings include:

On 9/23/14 at 11am, R3 sat leaning forward in the wheelchair with a chair alarm in place in the hallway across from the nurse station on side 1. There were no staff members in the hallway for 6 minutes. R3 had a fall on 8/8/14.
On 9/23/14 at 11:15am, R6 sat up in the wheelchair with a chair alarm in place in the hallway across from the nurse station on side 2.

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E3(Nurse) was at the desk but left several times within a 5 minute period. There was no one else at the nurse station when E3 left. At 11:20am, E3 stated R6 is brought out to the nurse's station because staff does not like to leave her unattended. The chair alarm will sound if R6 moves around or tries to get out of the chair. On 9/23/14 at 11:25am, R4 sat in a wheelchair with a chair alarm attached, across from the nurse station on side 3. R4 had a fall on 9/4/14. E4(Nurse) stated R4 gets up when she's not supposed to, so staff does not leave her alone, R4 is brought to sit in her wheelchair out at the nurse's station.

Closed record documents R1 was assessed as a high risk for falls on admission due to previous falls at home. Minimum Data Set (MDS) 8/6/14 documents R1 had a fall with major injury prior to admission to the facility and was not appropriate for the mental status interview due to cognitive deficits. R1 does not have a fall care plan. Nurse Notes for 8/2/14, 8/3/14, 8/4/14, and 8/6/14, R1 was brought out to the nurse's station on the 11pm-7am shift for close monitoring due to the bed alarm being activated by the resident. On 8/6/14 at 6:50am, R1 fell from the wheelchair while sitting at the nurse's station. Fall Investigation 8/6/14 documents staff was in other rooms or down at the end of the hallways, not near R1. R1 was transferred to the hospital and was diagnosed with a laceration to the head and bleeding on the brain. Hospital radiology report 8/6/14 documents an acute on chronic right subdural hematoma measuring 7 millimeters(mm) in width causing a 5 mm midline shift. Emergency Room History 8/6/14, R1 was alert and oriented to person, which is a normal assessment for her. R1's Glasgow Coma Scale (GCS) 8/6/14, which assesses neurological

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response, score R1 13 out of 15. R1 opened her eyes spontaneously, verbal response was confused, and motor response localized pain. Physician Certification 8/6/14 documents qualified clinical personnel or service unavailable; hospital resources unavailable; R1 needs to be transferred to another hospital to receive appropriate medical treatment. Nurse Certification 8/6/14, R1 is being transferred to a trauma hospital due to bleeding in the brain and possible surgical intervention by a neurosurgeon. No return phone calls from messages left on 9/23/14 for Z4(Emergency Room Physician), Z5(Trauma Surgeon, and Z6(Neurosurgeon). Transfer Emergency Room Records 8/6/14 document R1 now has a GCS of 7 out of 15, shallow breathing, and low oxygenation. R1 does not open her eyes, does not respond verbally, and still localizes pain. History and Physical 8/6/14 on arrival R1 breathing is compromised due to the altered mental status. R1 was placed on a ventilator to help her breathe; due to the poor prognosis, family withdrew life support and placed R1 on hospice.

On 9/23/14 at 1:40pm, E6(Nurse) stated R1 had a chair alarm. E6 heard the alarm and turned to see R1 on the ground. E6 stated R1 gets restless at night. She brings R1 out to the nurse's station to "keep an eye on her" and prevent falls.
On 9/24/14 at 1pm, E5(Restorative Nurse) stated residents assessed as high risk for falls have interventions of chair and bed alarms, low beds, floor mats, supervision, don't leave resident alone in the room, and bring them out to the nurse's station to monitor. E5 stated supervision means have more people watch the resident.
On 9/24/14 at 1:10pm, E2(Director of Nursing) stated the residents are assessed for fall risk on admission, interventions are put into place, and a

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care plan is initiated. Staff moved R1 to the nurse's station at night to monitor her more closely, R1 was getting out of bed, staff wanted to prevent a fall from the bed. E2 stated there isn't as much staff at night, so they put R1 out at the nurse's station to watch her. E2 confirmed that R1 did not have a care plan for falls and did not have floor mats ordered.
On 9/24/14 at 1:25pm, Z2(Trauma Surgeon) stated R1 had a new area of bleeding in the brain over the old area. This new area caused the brain to be pushed over to the side, creating pressure inside the skull. It was this pressure that caused R1's condition to deteriorate during the transfer from the first hospital. Z2 stated this injury is associated with R1's head trauma from the fall.
On 9/25/14 at 1:20pm, Z1(Physician) stated that it would have been better if someone was there to watch R1. An intervention could be to have someone stay at the desk to watch those residents that are put there.

Fall Reduction Policy - The program will include measures which determine the individual needs of each resident by assessing the risk of falls, and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. All assigned nursing personnel are responsible for ensuring ongoing precaution are put into place and consistently maintained.
Post Fall Investigation policy - Any new information and/or interventions will be reflected on the resident's care plan at the conclusion of the investigation.
Comprehensive Care Plans policy - A preliminary plan is developed upon the resident's admission.

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S9999	Final Observations	S9999		

LICENSURE FINDINGS

300.1210a)
300.1210b)
~~300.1210b)3)~~ deleted per comments
300.1210d)6)
300.3240a)

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

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S9999	Continued From page 1 care needs of the resident. 3) All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary. 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 REGULATIONS WERE NOT MET AS EVIDENCED BY: Based on observation, interview and record review, the facility failed to follow their policy and provide adequate supervision for 4 of 6 residents (R1,R3,R4,R6) reviewed for falls in the sample of 8. This failure resulted in R1 falling from the	S9999		

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wheelchair, sustaining a laceration to the head and bleeding in the brain.

Findings include:

On 9/23/14 at 11am, R3 sat leaning forward in the wheelchair with a chair alarm in place in the hallway across from the nurse station on side 1. There were no staff members in the hallway for 6 minutes. R3 had a fall on 8/8/14.
On 9/23/14 at 11:15am, R6 sat up in the wheelchair with a chair alarm in place in the hallway across from the nurse station on side 2. E3(Nurse) was at the desk but left several times within a 5 minute period. There was no one else at the nurse station when E3 left. At 11:20am, E3 stated R6 is brought out to the nurse's station because staff does not like to leave her unattended. The chair alarm will sound if R6 moves around or tries to get out of the chair.
On 9/23/14 at 11:25am, R4 sat in a wheelchair with a chair alarm attached, across from the nurse station on side 3. R4 had a fall on 9/4/14. E4(Nurse) stated R4 gets up when she's not supposed to, so staff does not leave her alone, R4 is brought to sit in her wheelchair out at the nurse's station.

Closed record documents R1 was assessed as a high risk for falls on admission due to previous falls at home. Minimum Data Set (MDS) 8/6/14 documents R1 had a fall with major injury prior to admission to the facility and was not appropriate for the mental status interview due to cognitive deficits. R1 does not have a fall care plan. Nurse Notes for 8/2/14, 8/3/14, 8/4/14, and 8/6/14, R1 was brought out to the nurse's station on the 11pm-7am shift for close monitoring due to the bed alarm being activated by the resident. On 8/6/14 at 6:50am, R1 fell from the wheelchair

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S9999	Continued From page 3 while sitting at the nurse's station. Fall Investigation 8/6/14 documents staff was in other rooms or down at the end of the hallways, not near R1. R1 was transferred to the hospital and was diagnosed with a laceration to the head and bleeding on the brain. Hospital radiology report 8/6/14 documents an acute on chronic right subdural hematoma measuring 7 millimeters(mm) in width causing a 5 mm midline shift. Emergency Room History 8/6/14, R1 was alert and oriented to person, which is a normal assessment for her. R1's Glasgow Coma Scale (GCS) 8/6/14, which assesses neurological response, score R1 13 out of 15. R1 opened her eyes spontaneously, verbal response was confused, and motor response localized pain. Physician Certification 8/6/14 documents qualified clinical personnel or service unavailable; hospital resources unavailable; R1 needs to be transferred to another hospital to receive appropriate medical treatment. Nurse Certification 8/6/14, R1 is being transferred to a trauma hospital due to bleeding in the brain and possible surgical intervention by a neurosurgeon. No return phone calls from messages left on 9/23/14 for Z4(Emergency Room Physician), Z5(Trauma Surgeon, and Z6(Neurosurgeon). Transfer Emergency Room Records 8/6/14 document R1 now has a GCS of 7 out of 15, shallow breathing, and low oxygenation. R1 does not open her eyes, does not respond verbally, and still localizes pain. History and Physical 8/6/14 on arrival R1 breathing is compromised due to the altered mental status. R1 was placed on a ventilator to help her breathe; due to the poor prognosis, family withdrew life support and placed R1 on hospice. On 9/23/14 at 1:40pm, E6(Nurse) stated R1 had a chair alarm. E6 heard the alarm and turned to	S9999		

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S9999	Continued From page 4 see R1 on the ground. E6 stated R1 gets restless at night. She brings R1 out to the nurse's station to "keep an eye on her" and prevent falls. On 9/24/14 at 1pm, E5(Restorative Nurse) stated residents assessed as high risk for falls have interventions of chair and bed alarms, low beds, floor mats, supervision, don't leave resident alone in the room, and bring them out to the nurse's station to monitor. E5 stated supervision means have more people watch the resident. On 9/24/14 at 1:10pm, E2(Director of Nursing) stated the residents are assessed for fall risk on admission, interventions are put into place, and a care plan is initiated. Staff moved R1 to the nurse's station at night to monitor her more closely, R1 was getting out of bed, staff wanted to prevent a fall from the bed. E2 stated there isn't as much staff at night, so they put R1 out at the nurse's station to watch her. E2 confirmed that R1 did not have a care plan for falls and did not have floor mats ordered. On 9/24/14 at 1:25pm, Z2(Trauma Surgeon) stated R1 had a new area of bleeding in the brain over the old area. This new area caused the brain to be pushed over to the side, creating pressure inside the skull. It was this pressure that caused R1's condition to deteriorate during the transfer from the first hospital. Z2 stated this injury is associated with R1's head trauma from the fall. On 9/25/14 at 1:20pm, Z1(Physician) stated that it would have been better if someone was there to watch R1. An intervention could be to have someone stay at the desk to watch those residents that are put there. Fall Reduction Policy - The program will include measures which determine the individual needs of each resident by assessing the risk of falls, and implementation of appropriate interventions to provide necessary supervision and assistive	S9999		

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S9999	Continued From page 5 devices are utilized as necessary. All assigned nursing personnel are responsible for ensuring ongoing precaution are put into place and consistently maintained. Post Fall Investigation policy - Any new information and/or interventions will be reflected on the resident's care plan at the conclusion of the investigation. Comprehensive Care Plans policy - A preliminary plan is developed upon the resident's admission.	S9999		