STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145583	A. BUILDING _____ B. WING _____	C 10/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUSH OAK PARK HSP SKILLED CARE UNIT	**520 SOUTH MAPLE AVENUE OAK PARK, IL 60304**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Investigation 1590304 / IL74403 - No deficiency Incident Report Investigation IRI of 9/21/15 - IL80496 - Refer to F323	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to have a nurse aide have hold of a resident's contact guard assist device (gait belt) at all times while assisting a resident to transfer or ambulate, to prevent a resident from falling. This applies to one of three residents (R1) reviewed for falls in a sample of 4. Findings include: According to a electric medical record, R1 was 94 years old admitted to unit on 9/08/15, for physical rehabilitation post hip surgery. R1 was initially admitted after she fell at home. R1's fall risk assessment upon admission (9/08/15) to the unit was high risk. Minimum Data Set (MDS) assessment of 9/15/2015 R1 required extensive assistance of one person for ambulation.	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 Facility's Incident report of 9/29/2015 documented, On September 29, E6 (Certified Nursing Assistant, CNA) was assisting R1 in toileting. R1 walked with a walker, wearing non skid socks, gait belt intact, to the toilet. As R1 was maneuvering out of the restroom, her walker caught on the doorway causing her to lose balance and to fall backwards back into the restroom. E6 who was in the doorway of the restroom, holding the gait belt, was not able to maneuver past the walker to ease the patient to the floor. R1 landed on her left hip. Physician was made aware and X-Ray done showed, new spiral oblique fracture through the distal femoral meta diaphysis distal to the femoral stem of a left hip arthroplasty. On 9/28/2015 Physical Therapist wrote R1 needed Contact Guard Assist (CGA) for ambulation. On 9/28/2015, Occupational Therapist (E4) documented R1 needed minimal assistance for transfer to the toilet. On 10/2/2015 at 2:15, E4 said R1 needed one person to assist with ambulation by CGA. E4 said that CGA meant staff should hold on to the gait belt lightly for ambulation. On 10/2/2015 at 12:25PM, E6 (CNA) said R1 had a gait belt on, but she (E6) did not hold on to the gait belt because she focused on straightening the walker. She said she was in front of the walker. E6 said she should have been holding on the gait belt. When surveyor asked E6 to describe what happened she said she was in front of the walker and not holding on to the gait belt as she tried to straighten the walker. On 10/2/2015 at 12:45PM, R1 was in bed . She was awake and alert. According to R1, on the night when she fell, there were two CNAs (Certified Nursing Assistants) who were "	F 323		

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F 323	Continued From page 2 laughing and giggling and may not have been paying attention to me " . She said the CNAs were at the door of the restroom when she called them, " I got up from the toilet and started walking with the walker and the walker was twisted so I tried to straighten it out and I fell." The surveyor asked R1 if she was supposed to walk by herself. R1 said , " The girls were there and talking to each other. I felt they were not paying any attention to me, so I got up " . On 10/2/2015 at 2:15pm, Z1 (physician) said the PCT (also known as CNA) should have been there to assist the resident and use the devices that were ordered for the resident. Facility ' s policy on Falls dated 5/2011 noted, " Assure that the patient' s personal assistive devices- eyeglasses, hearing aids, braces, ambulatory aids, prosthetics are within reach and in use. ".	F 323		