STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009757	A. BUILDING: _____ B. WING _____	01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERFRONT TERRACE	7750 SOUTH SHORE DRIVE CHICAGO, IL 60649

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S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 3001210d)6 300.1220b)3 300.3240a) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as	S9999		

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S9999	Continued From page 2 indicated by the resident's condition. The plan shall be reviewed at least every three months. 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 observation, interview and record review, the facility failed to ensure that fall prevention policy was followed for 2 residents (R1,R12) in the sample of 19 and 1 supplemental resident(R20). This failure resulted in R20 experiencing multiple falls resulting in hematoma to the head and a head laceration requiring hospitilization and 8 sutures. Findings Include: The facility's Fall Policy was reviewed. The policy states that residents are to be assessed after every fall. A Fall Committee will assess the effectiveness a resident's care plan as it relates to fall prevention. Tracking and trending of falls is to be done for each resident in order to discover the root cause of a resident's falls. Interventions are to be based on that cause. 1/29/2015 at 12:40pm, the facility fall policy was discussed with the Director of Nursing (DON/E3) and E5. E3 and E5 presented a log of falls for R12 and R20, but no documentation showing that a root cause for the falls were used to develop appropriate fall interventions for R12 and R20. During the 1/29/2015 interview at 11am with E5(Nurse), R20's fall care plan was discussed. E5 confirmed that before the 12/24/2014 fall, R20 was in a low bed (added 7/10/2014) with a bed	S9999		

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alarm (added 9/11/2014) and mats (added 7/10/2014). 12/24/2014, R20's fall care plan was updated with keeping the resident close to the nurse's station while up in recliner with chair alarm (added 7/17/2014). E5 was asked if the monitoring requested by Z2 and Z3 added to R20's care plan. E5 stated that Z2 and Z3's request was only for 72 hours and no adaptation was added to R20's care plan. After the fall of 12/27/2014, the staff increased telling R20 to ask for assistance. R20 has a care plan for cognitive impairment that was initiated, 4/29/2014. On her most recent Minimum Data Set (MDS) dated 12/26/2014, R20 was not given the Brief Interview for Mental Status (BIMs/Score = 00) because of the severity of her cognitive impairment. R20 cannot follow directions. R20's fall care plan contains interventions which R20 is incapable of doing based on her cognitive impairment. These interventions are safety training, education and calling for assistance. An individualized monitoring program was not initiated and put in place as apart of R20's fall care plan.

R20 has the following diagnosis which added to making R20 high risk of falls: Hypertension (HTN), Congestive Heart Failure (CHF), Dementia with Behaviors, Syncope with Falls and Altered Mental Status. Per Incident reports and Nurse's Notes, R20 has fallen 7/10/2014, 9/8/2014, 12/24/2014, 12/27/2014 and 1/20/2015. R20 sustained injuries when she fell, 7/10/2014, 9/8/2014, 12/27/2014 and 1/20/2015.

Nurse's Notes dated 12/24/2014 at 7:30pm, stated that R20 was found on the floor by staff. R20's Physician (Z2), Administration, and the Family were called. Vitals were taken. R20 was not injured. Z2 at 8pm, 12/24/2014, gave a telephone order to watch and monitor R20 at

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bedside for 72 hours. Monitoring was not updated in R20's care plan after this fall.

Nurse's Notes dated 12/27/2014 at 7pm, state that R20 was found on the floor by her bed by CNA (Certified Nursing Assistant/E16). A written statement in the Incident Report dated 12/27/2014, from E16 states that she heard the bed alarm go off in room 302 and found R20 on the floor mat next to R20's bed. Nurse's Notes state that R20 sustained a bruise to the right side of her forehead. No bleeding was observed. Z2's office was called at 7:15pm, Z3 (Physician) ordered application of a ice pack to the Hematoma and 72 hour monitoring. Monitoring was not updated in R20's care plan after this fall.

R1 was observed two days of the survey 01/26/15 and 01/27/15 in a recliner with back of chair reclined back seated at the entrance of room door (318) or in bed with G-Tube feeding in progress via pump. At no time during the observation period did R1 attempt to remove self from the recliner or bed. R1 remained quiet and immobile during the entire time. The resident requires extensive total care with activities of daily living (bed mobility, transferring surface to surface, toilet use and personal hygiene).

During record review of (incident/accident reports), it was determined R1 had multiple falls in July 2014 as follows:
- 07/05/2014 at 3:00pm on matt next to low bed
- 07/12/2014 at 8:00pm on matt next to low bed
- 07/25/2014 at 7:00pm on floor next to bed
- 07/28/2014 at 6:00pm on floor with G-Tube pole next to resident

Four episodes of falls (from a low bed onto matt in room) within a one month period of time, no

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S9999	Continued From page 5 injuries documented. R1's Fall Risk Screening Tool dated 05/22/2014 to 07/12/2014 indicated the resident is at risk for falls (scored from 19 to 20). "A score of 14 or greater means the resident is at risk for falls." In addition, R1 had six falls in a four month period time from August 2014 to December 2014 as follows: - 08/01/2014 at 7:10am face down on matt next to bed - 09/20/2014 at 1:20am on back on matt next to bed - 09/24/2014 at 6:30pm on the matt on the floor next to bed -11/04/2014 at 10:40pm on matt on floor next to bed -11/30/2014 at 9:15am on floor next to bed in room - 12/02/2014 at 6:40am on mattress on floor with small amount of blood on forehead. Although the "Unusual Occurrence Investigation Form" describe a left sided gash to the forehead, E5/nurse supervisor reports the wound was a small area. Interview with E5/nurse on 01/29/2015 at 1:30pm about the alleged gash to the forehead, E5's written statement is, "R1 had fall on 12/1/14, E15/nurse did do incident report and used term gash. Resident did have a small opening to forehead, however did not have gash, nothing with depth was noted with bleeding at time of fall. However, upon fall review area was healed on 12/2/14, no gash noted. E15/nurse did use inappropriate words for assessing resident." R1's Fall Risk Screening Tool dated 08/25/2014 to 12/02/2014 scored the resident from 18 to 23,	S9999		

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S9999	Continued From page 6 at risk for falls. Based on the 06/28/2014 and 12/26/2014 Minimum Data Set (MDS) Section C, Brief Interview for Mental Status (BIMS), R1 is scored as 03. A (BIMS) score is classified as being severely impaired, according to E14/social services director. On 01/29/2015 at 12noon when questioned about the score, E14's/social service director written statement is, "severely impaired cognition. R1 has impaired insight, judgement and decision making skills. Due to R1's cognitive impairments, pulling resident call light may not be something R1 thinks to do mentally. Instead R1 may occasionally call out. Due to resident's cognitive impairments R1 doesn't understand safety issues. Due to the resident not understanding safety, R1 may continue to roll himself out of R1's bed." The resident's care plan reviewed from 07/05/2014 to 12/02/2014 and there is a problem "at risk for falls related to past history of falls." Several of the interventions are as follows: place resident near nurses station when not in bed/activities, continue to encourage resident not to roll out of bed, staff will monitor every 2 hours for signs/symptoms of restlessness, staff will provide safety training and education as needed, follow up to ensure understanding, and monitor for behaviors with interventions to reduce risk for falls. R1 is severely cognitively impaired. E5/nurse supervisor interviewed 01/29/2015 at 1:30pm about how R1 is being monitored related to the multiple fall events. E5's/nurse written	S9999		

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S9999	Continued From page 7 statement is, "resident is being monitored every two hours and as needed, based on behavior. There is no rounding log used at this facility, however the facility does document in the kiosk behaviors and care concerning resident. Resident is not in a room close to nursing station because the facility will revisit with fall committee." (B)	S9999		