STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010086	A. BUILDING: _____ B. WING _____	C 12/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF PALOS HILLS	10426 SOUTH ROBERTS PALOS HILLS, IL 60465

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S 000	Initial Comments 1897403/IL107281 -- F684G, F689G, cited.	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)6) 300.3240a) 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: 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

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 interviews and record reviews, this facility 1) failed to ensure adequate supervision to prevent an accident for (R5) and 2) failed to meet professional standards of quality care for one resident (R5) reviewed for a fall with injuries and timeliness of transport to the hospital. This failure resulted in sustaining significant injuries requiring hospitalization and a delay of 2 hours and 25 minutes in R5 receiving intensive monitoring and hospital-level treatment for an acute change in condition after a fall.

Findings include:

Review of the medical record notes R5 with diagnoses including: end stage kidney disease, dementia, anxiety disorder, and generalized muscle weakness, stroke with right sided Hemiplegia (paralysis on one side of body), rheumatoid heart disease, congestive heart failure, high blood pressure, and diabetes.

On 12/7/18 at 2:50pm, V7 CNA (certified nurse aide) stated that R5 was total dependence on staff for ADLs (activities of daily living). V7 stated that V7 had another CNA assist V7 with R5's care due to R5's inability to participate in care.

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S9999	Continued From page 2	S9999		

On 12/11/18 at 1:00pm, V2 DON (director of nursing) stated that after reviewing R5's medical record, R5 fell out of bed while receiving care by V11 CNA at 7:00pm on 11/10. V2 stated that at 7:30pm, EMS (emergency medical services) arrived to transport R5 to the hospital. This surveyor reviewed the EMS run sheet for 11/10/18 with V2. V2 acknowledged that EMS was not contacted by staff until 9:25pm. V2 was not able to articulate why EMS was not contacted for 2 hours 25 minutes or what, if any, care was provided to R5 during that time.

On 12/12/18 at 1:40pm, V15 LPN (licensed practical nurse) stated that V15 was called about 9:15pm by V12 LPN to see if V15 could sit with R5 while V12 called physician and paramedics. V15 stated that V12 did not inform V15 of what time R5 fell just that R5 fell while receiving care.

On 12/12/18 at 2:30pm, V16 CNA stated that a CNA came and got V16 to help lift R5 into bed. V16 stated that V11 CNA, V12 LPN, and another CNA were in room when V16 arrived. V16 stated that a mechanical lift device was used to transfer R5 back into bed.

V11 and V12 are no longer employed at this facility and were unavailable to speak with regarding this incident.

Review of R5's EMS (emergency medical services) run sheet, dated 11/10/18, notes EMS was contacted at 9:25pm to transport R5 to hospital due to bleeding from mouth. EMS arrived at this facility at 9:27pm. Crew knocked on facility door for approximately 5 minutes with no answer. The door the crew was knocking on is the designated door requested by this facility for EMS crew to enter. Crew waited several

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S9999	Continued From page 3	S9999		

minutes until a staff member escorted EMS crew around the building to a door on the west side. Crew waited an additional 1-2 minutes before accessing this facility. R5's room was on the opposite side of where crew entered. Upon EMS arrival to R5, R5 was found lying in bed, responsive to painful stimuli. Blood was observed coming from R5's mouth. R5 had a contusion around left eye. Blood was observed on the floor. R5's family relayed to EMS crew that the staff told them that R5 fell and was placed back in bed. No nurse was found on scene. CNA staff could not provide information of the incident to the crew. R5 was placed on cot and loaded into ambulance where ALS (advanced life support) continued.

Review of R5's hospital record, dated 11/10/18 at 9:50pm, R5 was taken emergently for a head CT (computed tomography) scan which noted an acute subdural hematoma with a 2mm (millimeter) shift of the midline towards the right. In the emergency department, R5's speech was incomprehensible and with decreased level of consciousness. At 11:30pm, R5 was transferred via ALS ambulance to a higher level of care for further treatment.

Review of R5's medical record, dated 11/10/18 at 7:00pm, notes while receiving care, R5 was repositioned to the left side by V11 CNA (certified nurse aide), V11 looked away, R5 fell to floor. V11 called V12 LPN (licensed practical nurse) to room to assess R5, body assessment done. V12 noted hematoma to left eye, ice pack applied, and bleeding from nostril, pressure applied to nasal area. Vital signs taken blood pressure 154/64, heart rate 84 beats/minute, respirations 20/minute, temperature 97.2 degrees Fahrenheit, and oxygen saturation 95%. Neurological checks

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S9999	Continued From page 4	S9999		

in place. R5 had no complaints of pain. R5's physician paged and family contacted made aware per family request 911 call immediately. R5 continues to be monitored by staff on duty.

Review of R5's MDS (minimum data set), dated 10/3/18, notes R5 required extensive assistance by two or more staff for physical assistance with bed mobility (turning/repositioning). R5 was totally dependent on two or more staff for toileting/incontinence care.

Review of R5's falls care plan, dated 9/1/18, notes R5 is at high risk for falls related to impaired mobility and dementia. R5 has limited range of motion to both upper and lower extremities. R5 is dependent on staff for all aspects of care. R5 is non-ambulatory and has poor trunk control. R5 requires two person assistance with ADLs (activities of daily living). Interventions identified include: anticipate and meet R5's care and safety needs and follow facility fall protocol.

Review of R5's range of motion screen, dated 10/17/18, notes R5 has severely limited mobility of left arm and no joint mobility of right arm, right leg, or left leg.

(A)