

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145527	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER Brandel Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 2155 Pflingsten Road Northbrook, IL 60062	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>41156</p> <p>Based on interview and record review the facility failed to develop an effective plan with interventions to prevent falls and falls with injury for a resident identified as high risk for falls, severe cognitive impairment and assessed with decreased safety awareness. This affected one of three residents R1 reviewed for falls and fall prevention. This failure resulted in R1 having multiple falls resulting in a non-displaced hip fracture 5.11.24, and another fall and fracture on 6.5.24</p> <p>Findings Include:</p> <p>R1 admitted in the facility on 5/6/24 and with diagnoses but not limited to History of Falling, Restless Leg Syndrome, Depressive Disorder, and Dementia.</p> <p>Assessed as High Risk for fall upon admission, assessment date 5/7/24.</p> <p>Facility Reported Incident dated 5/11/24, reads in part: R1 is supervised with walking with lack of safety awareness as R1 ambulates at a fast pace. On May 11, 2024, R1's wife and personal caregiver were visiting R1. Wife asked R1 to take a walk. Then R1, wife and caregiver proceeded to walk in the hallway without asking for supervision. Upon walking in the hallway, R1 fell . R1 was experiencing pain, and was sent out to hospital, admitted with non-displaced fracture of right femur. Upon interviewing wife, wife does not know how R1 fell . The caregiver stated that R1 lost his balance. There were no staff member to witness this fall.</p> <p>Hospital record dated 5/17/24, reads in part: Orthopedic surgery was consulted and recommending non operative management and admission for further care.</p> <p>On 8/13/24 at 2pm, V2 (DON) stated that R1 has poor safety awareness. Wife visited with wife's caregiver and decided to walk R1 without asking for staff to assist. Walked R1 with walker and no wheelchair with them. Staff was not present at the time of the fall, it was just R1's wife and the caregiver. Educated wife and caregiver not to walk R1 without staff assistance for resident safety. R1 had right femur nondisplaced fracture. No surgical intervention needed.</p> <p>(continued on next page)</p>		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145527
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Facility Reported Incident dated 6/6/24, reads in part: On 6/6/24, R1 experienced an unwitnessed fall in the dining area, R1 complained right hip pain. R1 transported to ER for further evaluation. R1 was in the dining area due to wandering. Incontinence care provided as routine care. R1 is confused and needs reminders all the time. R1 sustained a non-displaced intertrochanteric fracture of the right femur and questionable tiny avulsion fracture of the right talar dome, which likely represent the residual of an old trauma. R1 received on 6/7/24 right transfemoral nailing/pinning surgery. R1 was discharge to facility on 6/9/24.</p> <p>On 8/14/24 at 2:30PM verified with V1 (Administrator) that the incident happened on 6/5/24 at 8:30PM, and that it was reported to IDPH on 6/6/24.</p> <p>Hospital record dated 6/6/24, reads in part: right hip x-ray shows non-displaced intertrochanteric fracture. Right ankle x-ray shows questionable tiny avulsion fracture of the right talar dome.</p> <p>Hospital record with date of service of 6/9/24, reads in part: R1 presented to the hospital with right hip fracture and underwent Open Reduction Internal Fixation (ORIF). Found to have a nondisplaced fracture of the right greater trochanter on 5/12/24 which was deemed non-op at the time. Now with nondisplaced intertrochanteric fracture of the right femur and questionable tiny avulsion fracture identified along the medial aspect of the right talar dome.</p> <p>On 8/13/24 at 2:215PM, V6 (nurse assigned on 6/5/24) stated R1 had a fall around 8pm in dining room. V6's med cart parked close by in the dining room. It happened so fast, I picked up something on the floor and found R1 on the floor. Heard a noise and observed R1 laying on the floor. Other residents was in the dining room also. There was no CNA in the dining room when R1 fell . The CNA that was in the dining prior to the fall, was assisting another CNA who called for help with a resident in another room having behavior. Assessed R1 and complaint of right hip pain. Called MD and with order for STAT x-ray. X-ray result came back around 6am and relayed to MD to send R1 to ER for further evaluation. V6 was not close to R1 and per V6, staff such as CNAs alternates to watch the resident in the dining room. To staff never leave the dining room, and must be physically present and close enough to monitor and redirect resident.</p> <p>R1 had another fall in the facility dated 5/27/24 at 10:15AM, reads in part: R1 was observed laying on the floor on his back, his legs were close to his dresser, there was no witness to this fall. R1 stated he slightly hit his head. R1 not on anticoagulant. Neuro check started.</p> <p>On 8/14/24 at 11:53AM. V8 (Assigned Nurse for the fall incident of 5/27/24) stated that R1 already up on wheelchair. Waiting for activity. R1 was by the door of his room by the hallway, V8 reported that V8 was two rooms away from R1. CNA assigned to R1 was answering call light of another resident. Next thing I turned around and heard a noise coming from his room and checked R1. R1 was on the floor, sitting on the floor, next to the foot board of his bed. In between wheelchair and walker. R1 stated he was trying to get something in his drawer. We keep an eye on R1 and visualized R1, R1 tends to stand up by himself. R1 was already high risk for fall upon admission. We are keeping close monitoring to redirect R1 to sit back down when observed trying to get up from wheelchair. R1 at that time of his fall needs staff supervision with ambulation and standing from wheelchair. R1 has impulsive behavior of getting up from his wheelchair on his own. We will need to remind R1 repetitively not to stand up from his wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/14/24 at 9:30AM, V7 (Therapy Director) stated that R1 was admitted (5/6/24) as moderate to maximum for transfer, bed mobility was independent, walking was contact guard to moderate. Eating independent, toilet transfer contact guard. Shower and dressing contact to minimum. Contact guard somebody need to be with Resident walking with using walker with wheelchair behind R1 to follow. We did not allow the family to walk the resident. Staff will need to supervise the walking with the family. The wife had cognitive issue also and does not realized R1 has impairment. Care giver did not have the wheelchair behind R1 when they walked him that time. R1 was in Speech therapy for cognition. 5/6/24, 5/17/24: moderate to severe cognitive deficit with the SLUMS (cognitive test that assesses short term memory) score of 7/30. Readmission on 6/9/24 R1 score was 8/30 meaning moderate to severe cognitive deficit.</p> <p>Speech Therapy evaluation note (dated 5/11/24) documented as Reason for referral was exacerbation of decreased safety awareness, cognitive impairment, decreased functional ability tolerance, decreased socialization and decreased ability to respond to cues and instruction.</p> <p>On 8/13/24 at 2:40PM, V3 (ADON) stated that the fall on 5/11/24 were unwitnessed that the staff was not present at the time of R1's fall. Family came to visit and decided to walk R1. R1 had fallen. Probably due to R1 has a tendency to walk fast and maybe that's what happened during the first fall. R1 is cognitively impaired and very confused and with poor safety awareness, and that is the reason why R1 was being watch closely. Fall on 6/5/24, R1 was in the dining room along with other residents. CNA was supervising residents in the dining, but needed to leave to help another CNA who was having a behavior. The assigned nurse in that unit, was in the nurse's station getting endorsement, but the nurses station is enclosed room and needed to have the door open to see resident, but still physically far from residents in the dining room, just visual. Nurse heard the noise and observed resident on the floor. I cannot recall asking the nurse if the door was open at the time of the fall.</p> <p>On 8/14/24 at 9:20AM, memory care unit observation of the nurse's station with V3 (ADON. Nurse's station in the dining room enclosed room, can see the dining room but still far physically to any residents present in the dining room. Must also need to have the door open to have visual of the residents in the dining room.</p> <p>R1's care plan dated 5/10/24, reads in part: R1 is at risk for fall d/t weakness, unsteady transition and walking balance, Right hip and low back pain (s/p Right hip Fracture - non-surgical), daily use of antidepressant, impaired memory and safety judgment (forgetful), and a history of fall at home and nasal bone Fracture within 30 days before admission and one fall since admission to BHR on 5-11-24 resulted in Rt hip Fx (non-surgical). He scored 80 on Fall Risk assessment at re-admission. Unwitnessed fall on 5/11/2024, 05/27/24 and on 06/05/24. Intervention dated 5/26/24: Staff will take R1 to activities during daytime to stay in supervised environment.</p> <p>Managing Falls and Fall Risk policy dated 3/2018, reads in part: Based on previous evaluation and current data, the staff will identify interventions related to resident's specific risks and causes to try and prevent resident from falling and to try to minimize complication from falling.</p> <p>The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with history of falls.</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>If a systematic evaluation of resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions.</p> <p>If the falling recurs despite initial interventions, staff will implement additional or different intervention of indicate why the current approach remains relevant.</p> <p>If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as avoidable.</p> <p>If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified.</p>		