| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145681 | A. Building<br>B. Wing | 09/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Palos Heights Rehabilitation | 13259 South Central Avenue<br>Crestwood, IL 60418 |

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) |
|---|---|
| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45000<br><br>Based on observation, interview, and record review, the facility failed to monitor its call light system and answer call lights within a timely manner for four residents (R2, R3, R4, R6) out of six residents reviewed for call light response times.<br><br>Findings include:<br><br>On 09/07/2024 at 9:58AM, V13 (R2's Family Member) states he lives in another state but came to visit R2 once V13 was informed that R2's health was declining and R2 was in the process of expiring. V13 states he was located inside of R2's room approximately two weeks ago and R2 appeared to be in pain. V13 states he located R2's call light and pressed it because he is not sure if R2 could use the call light on her own. V13 states he waited 45 minutes for someone to come to R2's room to answer R2's call light. V13 states he waited for so long that he went to the nurses' station to go and find a staff member to help assist R2 with her needs. V13 states he also made V1 (Administrator) aware that he waited a long time for someone to answer R2's call light.<br><br>On 09/07/2024 at 9:23AM, V5 (Certified Nursing Assistant/CNA) states he has not seen R2 use her call light but V5 makes sure he still places R2's call light within her reach. V5 states the call light system is not audible, it is only visual. V5 states the staff answers call lights by observing the illuminated light located at the top of the resident's room door.<br><br>On 09/07/2024 at 11:08AM, V1 (Administrator) states she received an email from V6 (Admissions Director) who was the manager on duty that shift on 08/24/2024. V1 states the email from V6 informed V1 that V13 had a concern with waiting more than 30 minutes for R2 to be changed because R2 was soiled. V1 states she is not certain if R2's call light was on that day on 08/24/2024 but a call light should be answered within 10-15 minutes depending on if staff are busy.<br><br>On 09/07/2024 at 11:56AM, V6 (Admissions Director) states she was the manager on duty during the day shift on 08/24/2024. V6 states she was inside of her office which is located near the receptionist desk. V6 states she heard V13 (R2's Family Member) ask the receptionist if he could see the facility license to operate. V6 states she then offered to assist V13. V6 states V13 told her that he had concerns of waiting for a nurse for 30 minutes. V6 states V13 informed her that R2 needed medication, needed to be changed, and R2's air conditioning was not working. V6 states once she made it to R2's room, R2's call light was not on and V6 saw the nurse (identified as V7/RN) standing inside of R2's room doorway.<br><br>(continued on next page) |

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 |
|---|---|---|

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 09/07/2024 at 1:19PM, R3 states he often has to wait for long periods of time to have his call light answered. R3 states he waited three hours to have his call light answered today. R3 states he pressed his call light button for assistance this morning at approximately 9AM and no one came to answer his call light until approximately 12PM.<br><br>On 09/07/2024 at 2:44PM, V8 (Agency CNA) states she is an agency CNA and last worked at the facility on Saturday 08/24/2024. V8 states she was not the CNA assigned to care for R2 on 08/24/2024. V8 states she was standing near the nurses' station in unit 1C when she saw V13 (R2's Family Member) approaching her and she met V13 half way to help assist V13. V8 states she observed at that time that R2's call light was illuminated but is unsure of how long R2's call had been illuminated. V8 states she was surprised to see R2's call light on because R2 does not press her call light. V8 states staff usually goes inside of R2's room frequently to check on R2. V8 states V13 informed her that he needed to see the nurse and that no one had been at the nurses' station to help V13. V8 states V13 seemed very frustrated so she tried to calm V13 down. V8 states she turned R2's call light off and went to find the nurse (identified as V7/RN) to inform V7 of V13's request because no one was at the nurses' station at that time. V8 states V7 told her that she would assist V13 shortly and V8 informed V13 of this and V13 said okay. V8 states she is not sure of how long it took for V7 to assist V13. V8 states she was in the process of caring for one of her assigned residents when a staff member asked V8 if she could change R2's incontinence briefs due to R2 being soiled. V8 states when she arrived inside of R2's room, she informed V13 that she needed to perform care for R2. V8 states at that time, R2's incontinence briefs and under pad were soiled with urine. V8 states she is not sure of how long R2 was soiled since she was not R2's assigned CNA. V8 states when she left R2's room she saw V13 talking to V7 at the nurses' station.<br><br>On 09/07/2024 at 3:48PM, R4 states she had to wait over an hour to have someone assist her with her needs after she pressed her call light button. R4 states approximately 1 week ago, she made a bowel movement and needed assistance with having her incontinence briefs changed. R4 states she pressed her call light, and a CNA came into her room to see what she wanted. R4 states she told the CNA that she needed to be changed and the CNA turned her call light off and told R4 that she would return to assist R4. R4 states she waited for over an hour and decided to press her call light again. R4 states by this time, it was a change of shift at approximately 11PM and another CNA came into R4's room to answer R4's call light. R4 states this CNA told R4 that all staff from the previous shift have left the facility and that she will now assist R4 with changing her incontinence briefs. R4 states this is not the first time this has happened and states that she has had issues with having to wait too long to have her call light answered prior to this incident.<br><br>On 09/08/2024 at 12:46PM, surveyor observed R6's call light illuminated above his room door. Several staff members observed ambulating down the hall where R6 room is located, housekeeping staff observed cleaning rooms in the hall where R6's room is located, and staff passing resident meal trays in the same hall as R6's room and does not answer R6's call light.<br><br>On 09/08/2024 at 1:00PM, V12 (CNA) observed entering R6's room and turned off R6's call light. V12 stats she noticed about 5 minutes ago that R6's call light was illuminated but she was busy at that time. V12 states R6 pressed his call light requesting to be repositioned. Surveyor observed R6 leaning over in bed towards the left side of his bed.<br><br>On 09/08/2024 at 1:04PM, R6 states approximately 1 week ago, he had to wait over an hour for a staff member to respond to his call light.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Concern form dated 08/24/2024 documents that V13 (R2's Family Member) made a concern with R2 needing to be changed.<br><br>R2's MDS/Minimum Data Set, dated dated dated [DATE] documents that R2 has a BIMS/Brief Interview for Mental Status of 5/15, indicating that R2 is severely cognitively impaired. R2's MDS documents that R2 is dependent with ADL care.<br><br>R3's MDS/Minimum Data Set, dated dated dated [DATE] documents that R3 has a BIMS/Brief Interview for Mental Status of 14/15, indicating that R3 is cognitively intact. R3's MDS documents that R3 is dependent with ADL care.<br><br>R4's MDS/Minimum Data Set, dated dated dated [DATE] documents that R4 has a BIMS/Brief Interview for Mental Status of 14/15, indicating that R4 is cognitively intact. R4's MDS documents that R4 requires substantial/maximal assistance with ADL care.<br><br>R6's MDS/Minimum Data Set, dated dated dated [DATE] documents that R6 has a BIMS/Brief Interview for Mental Status of 9/15, indicating that R6 is mildly cognitively impaired. R6's MDS documents that R6 is dependent with ADL care.<br><br>Facility policy dated 08/2008 titled Answering the Call Light documents in part, Purpose- The purpose of this procedure is to respond to the resident's requests and needs. 8. Answer the resident's call light as soon as possible. 4. Do what the resident asks of you, if permitted. If you are uncertain as to whether or not a request can be fulfilled or if you cannot fulfill the resident's request, ask the nurse supervisor for assistance. 5. If you have promised the resident you will return with an item or information, do so promptly. |