STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145994	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Inverness Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1800 W Colonial Parkway Inverness, IL 60067	

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34071 Based on observation, interviews and record reviews, the facility failed to ensure call lights were answered in a timely manner for two (R44 and R87) of two residents in a sample of 44 reviewed for accommodation of needs. Findings include: R44 is a [AGE] year old, female, initially admitted in the facility on 08/21/2017 with diagnosis of Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non-Dominant Side; and Cerebral Infarction, Unspecified. On 07/08/24 at 12:40 PM, R44 pushed the call light. At 12:50 PM, her call light was observed still on. R44 stated, I want my CNA (Certified Nursing Assistant). I want to get up now. At 12:55 PM, observed V14 (CNA) go to R44's room and respond to her call light. It took 15 minutes for V14 to respond to R44's call light. R87 is a [AGE] year old, female, initially admitted in the facility on 11/21/2023 with diagnosis of Nontraumatic Chronic Subdural Hemorrhage; Dementia in other Diseases Classified Elsewhere, Unspecified Severity, with Other Behavioral Disturbance; and Multiple Fracture Ribs, Left Side, Subsequent Encounter for Fracture with Routine Healing. On 07/08/24 at 12:25 PM, R87's call light was observed on. It was observed that there were no staff present in the hallway and by the nurses' station. At 12:40 PM, her call light was still on. Surveyor went to R87's room, observed lunch tray at bedside table. Bedside table was situated at the foot of the bed. R87 stated I tried to call to turn that table around so I can eat but I still have no assistance. V11 (Licensed Practical Nurse, LPN) was observed sitting at the nurses' station. At 12:59 PM, V15 (CNA) was collecting food trays in the hallway where R87's room can be found. Surveyor observed that V15 left and went to other unit. V15 did not go to R87's room. At 1:00 PM, R87's call light was still on. V13 (Housekeeping) was observed in R87's room. V13 was observed going to the nurses' station and talked to V11. V13 was asked if she told V11 about R87's call light. V13 stated, I told her (V11) and she said that one CNA is attending other residents. At 1:06 PM, R87's call light was still on, V11 was observed going to R87's room to provide assistance. It took 41 minutes for a staff to respond to R87's call light. R87's care plan documented: ADL (Activities of Daily Living) self-care performance deficit - Interventions - eating: one-person assist; encourage to use call light to call for assistance. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145994	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024

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Inverness Rehab	1800 W Colonial Parkway Inverness, IL 60067

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/09/24 at 1:19 PM, V2 (Director of Nursing, DON) was interviewed regarding call lights. V2 stated, We received complaints from residents regarding call lights. We do staff in-services regarding responding to call lights; department heads do rounds on a daily basis during morning shift ensuring call lights are responded. Staff on the floor do rounds at least every two hours and as frequent as needed. Reasonable time to respond to call light is not more than 5 minutes. Any staff in the facility should respond to call lights. I have talked to housekeeping and kitchen staff to not respond related to care but at least respond to call lights. If they responded to call lights and its related to care, they have to notify the nurse. 40920 On 07/8/24 at 11:00 AM to 11:30AM during observation in unit one of the facilities, observed several call lights going off in resident's rooms that were not answered promptly, some resident's beds were noted with no linens and stripped naked. On 07/9/24, between 9:46AM and 10:30AM, surveyor observed several call lights turned on in the 200 section of unit one with no staff observed answering responding to them. Surveyor responded to one of the lights and notified staff that resident needs to go to the bathroom. Several residents screened had concern with the call light not being answered in a timely manner, some residents said that it takes 30 mins to one hour for the call light to be answered. On 07/9/24 at 11:20 AM, V8 (Registered Nurse, RN) was presented with this observation, and she said that there are two CNA's that are assigned to the unit, one just went on break and the other one is probably in another room. Surveyor asked V8 why the call lights are not being answered in a timely manner and she said, The CNA's are usually pulled to help with lunch, right now one of them is on break and the other one is probably assisting another resident. On 07/9/24 at 1:15PM, V2 (DON), said call light response has been a concern and the expectation is that it should be answered in a timely manner, they provide in-service to staff and the department heads also do angel rounds during the day, the facility does not have managers in the evening so the floor nurses and CNA's will be responsible for monitoring the call light and ensuring that it is answered timely. V2 was asked to be a little more specific on what is considered timely, and she said within 5 minutes. The facility does not have any system in place to show how long a call light has been on before it was answered. She added that when a call light is on, any staff can answer it, even if they cannot provide the type of assistance that the resident needed, at least they can get the right person to assist the resident. Facility's policy titled, Call light Policy, dated 1-28-23 stated in part but not limited to the following: Purpose: To respond to the resident's requests and needs in a timely manner. Performed by: All Staff Procedure: 1. Answer call light promptly and turn the light off after entering the room. Knock on the door before entering.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50036 Based on observation, interview and record review, the facility failed to implement effective fall interventions and adequate supervision for a dependent resident assessed as a high risk for falls with diagnoses of Parkinson's disease and Dementia. This failure affected one (R99) of three residents reviewed for falls in the sample of 44. This failure resulted in (R99) experiencing repeated falls that resulted in hospitalization s, sustaining lacerations on two occasions, with one laceration requiring three sutures. Findings include: R99 is a [AGE] year-old resident admitted to the facility on [DATE] with diagnoses including but not limited to: Parkinson's disease, dementia, depression, ataxic gait, cognitive communication deficit, urgency of urination and visual hallucinations. On 07/08/24 at 12:44 PM surveyor observed R99 dining in reclining chair with no concerns. R99 had an approximate quarter size yellowish purple bruise to right outer eye area. On 07/08/24 at 2:59 PM surveyor observed R99 sitting in TV (television) area with drink on table within reach. Surveyor requested to have staff bring resident to room for interview. Floor mat noted in room. Resident confused, does not want to talk with surveyor without staff present. When staff present resident stated, he is not the one I need to talk to. Surveyor observed an approximate quarter size yellowish purple bruise to right outer eye area. On 07/09/24 at 11:33 PM R99 is not in his room. R99 noted sleeping in reclining chair with seat cushion in place in front of nursing station by TV area. Surveyor observed an approximate quarter size yellowish purple bruise to right outer eye area. On 07/09/24 at 2:11 PM R99 is observed in reclining chair sleeping in TV area. R99 appeared comfortable. Surveyor observed an approximate quarter size yellowish purple bruise to right outer eye area. V16 (Registered Nurse - RN) stated, R99 has a laceration to back of the head, but due to resident sleeping surveyor unable to observe back of head. Surveyor observed large bruise to right hand area. V16 stated, he believes that was from a blood draw. MDS (Minimum Data Set) dated 05/07/2024 shows R99's BIMS (Brief Interview for Mental Status) score of 7 which means severe cognitive impairment. MDS dated [DATE] shows resident requires Substantial/maximal assistance for the following areas: toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear, sit to stand position, chair to bed transfer, toilet transfer and tub/shower transfer. Resident requires partial/moderate assistance with oral hygiene, upper body dressing, personal hygiene, rolling left and right, sit to lying, lying to sitting on the side of bed, and walking 10 feet. Fall risk assessments dated 2/26/24, 5/23/24, 5/29/24, 6/8/24, 6/28/24 and 07/06/2024, R99 is categorized high risk for fall. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Incident report/root cause analysis dated 2/25/24, R99 sustained 1-2 cm (centimeters) x less than 0.0 cm skin tear with minimal bleeding noted to lateral left parietal region behind left ear from unwitnessed fall. Predisposing environmental factors - wheelchair unlocked. Incident report/root cause analysis dated 5/22/24 R99 was noted on the floor in his room leaning up against wall. Writer noted bleeding on right side of his head. First aid immediately rendered and cold compress applied. CNA (certified nursing assistant) stayed with resident. Writer called 911 and resident was transferred to ER for evaluation. Predisposing factors: footwear and none. Predisposing physiological factors: cognitive factors - confusion/disorientation, cognitive factors- impaired memory, neuromuscular factors - gait imbalance, cognitive factors - impaired decision. Predisposing situation factors: ambulating without assist. Skin assessment dated [DATE] documents: 3 sutures noted to right lateral forehead. Denied pain or discomfort. With orders to apply dry dressing every 3 days and to remove sutures in 7 days per MD (medical doctor) & hospice order Hospital discharge instructions dated 5/23/24 document that reason for visit was fall and diagnosis was subarachnoid hemorrhage. This form also documents items done on this visit were laceration repair and wound/incision care. Imaging done on this visit were CT (computed tomography) brain without contrast and CT spine cervical without contrast. Progress note dated 05/23/2024 at 02:43 AM documents: Writer noted copious amounts of blood on the floor next to R99 and there was blood dripping from the right side of his head. Progress note dated 5/23/24 at 2:31 PM documents: Resident arrived back from ER, noted w/(with)skin impairment to right lateral forehead. Sutures intact. No bleeding noted. Denied pain or discomfort. MD made aware, Tx (treatment) and orders in place. Dry dressing applied. V19 (family member/power of attorney) and hospice updated. Hospital discharge paperwork dated 05/24/24 documents: This is a [AGE] year-old male with past medical history as below, who was seen in this ED 24 hours ago for fall diagnosed with small subarachnoid hemorrhage, ultimately discharged back to hospice who presents to ED again for another reported witnessed fall. This report also documents, discussed that there needs to be an improved plan of care for this patient. They understood the plan. CT Brain without contrast impression 1. No acute intracranial abnormality. 2. Chronic findings as above. Narrative findings: There is no hemorrhage, mass effect, midline shift or hydrocephalus. Incident report/root cause analysis dated 6/28/24 writer was notified by visitors that resident was on the floor at nurse's station. Writer observed resident sitting on the floor next to (geriatric) chair. Predisposing physiological factors: behavioral factors - agitation/combative, behavioral factors - restless/anxious, bowel/bladder elimination - incontinence, cognitive factors - confusion/disorientation and behavioral factors - resistive. No apparent injury. Incident report/root cause analysis dated 07/06/24 writer's attention was called by staff that resident is on the floor and immediately proceeded to the room and observed resident sitting on the side of the bed that is on low position, alert conscious and verbally responsive with not visible injury noted initially. Resident sustained laceration to back of head. Predisposing physiological factors: cognitive factors - confusion/disorientation, neuromuscular factors - gait imbalance. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Progress note dated 07/06/24 at 07:39 AM documents: Resident had a fall and had a laceration on the back of the head about 3/4 of an inch with minimal bleeding. Placed a call to sister/POA unable to answer call left voicemail about the incident. Spoke to hospice and they stated they will have a nurse come to see the patient. MD notified. Care plan dated 08/01/23 documents: Focus: R99 is at risk for falls related to Parkinson's, dementia, impaired cognition, anxiety, depression, visual deficits, history of fall, impaired balance, and psychotropic medication use. Prefers his independence and does things on his own. With episodes of impulsivity, agitation, and restlessness. Will attempt to ambulate without an assistive device. Goal: Prevent serious fall related injury Interventions: Offer to assist R99 with getting snacks as he allows. Make frequent purposeful rounds when R99 is in room and offer toileting assistance as needed. Place R99 at nurse's station for closer supervision when unable to sleep during the night. Ensure proper positioning in reclining chair and adjust positioning as needed towards back of seat. High risk for falls - FALLING STAR ANTICIPATE and MEET R99's needs. Redirect him if he is agitated. Be sure his CALL LIGHT is within reach and encourage the resident to use it for assistance as needed. Check his ENVIRONMENT for clutter or trip hazards and area is well lit. Encourage NONSKID FOOTWEAR as needed. Fall RISK evaluation. Keep BED IN LOWEST POSITION acceptable by the resident when the resident is in bed. Remind to REQUEST ASSISTANCE when getting up if needed. REPORT to PHYSICIAN any untoward side effects associated with the resident's MEDICATION use. Refer to hospice for therapy evaluation. Remind R99 to lock his wheelchair brakes prior to attempting transfers out of his wheelchair and to request staff assistance as needed with ambulation from the dining room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Remind R99 to request staff assistance with toileting needs. On 07/09/24 at 2:07 PM Interview with V17 (Certified Nursing Assistant - CNA). V17 stated, I have worked with R99 before. He is a fall risk. We put the mattress when he is in bed but sometimes, he tries to jump it. I can't think of anything else we do to help prevent falls for R99. R99 can be aggressive and combative. I have not been here when he has fallen. Sometimes we have seen R99 on the mat. I think he falls because he is confused. He used to make is bed and walk around and now is confused. On 07/09/24 at 1:57 PM Interview with V18 (CNA). V18 stated, I have taken care of R99 before. He is a fall risk. We have a large floor mat to go on one side of the bed when he is in the bed. No other things I can think of. He has fallen when I was working. Dementia caused the fall that time. On 07/09/24 at 2:00 PM Interview with V16 (Registered Nurse - RN). V16 stated, R99 is a high fall risk. We change the bed to the lowest bed, frequent checks, bring to nurses' station/TV area. When he starts to get up, we try to bring him where we can see him. V19 (family member) doesn't want him in nurses' station. I think his cognitive issues are causing the falls. He wants to do the same things he used to be able to do like walking around. We discussed with V2, director of nursing 2 days ago to put him back to a 6am wake up depending on sleep the night before. He is combative at times and will hold the wrists of the staff and twist. He has a bruise on right eye and laceration to back of head. I was here for the laceration to back of head. I went in his room on July 6, 2024. He was sitting on the foot part of the bed. He fell and hit his head on the post. He was bleeding very minimal. This incident caused a laceration to back of head. The hospice nurse had wanted to change Seroquel dose, but sister did not want to agree to that. I believe the bruise was caused by him hitting himself accidentally as he was being combative with staff during care. On 07/09/24 at 3:03 PM Interview with V21 Licensed Practical Nurse (LPN). V21 stated, I have taken care of R99 before. On 6/28/24 day R99 was at nursing station in reclining chair. I had just went to 900 hall for a minute to pass medication. I was actually talking to another resident in the hallway when I was notified by visiting family member of another resident that R99 was on the floor next to his geriatric chair. He is not 1:1 We were keeping him at nursing station to keep a better eye on him. I had just checked on him probably 10-15 minutes prior and he was sitting calm in the chair. He is a high fall risk. We kept bed in low position and locked and fall mat in place. While in reclining chair we try to keep an eye on him as much as possible between myself and CNA's. If he is anxious, we try to see what is causing it. We offer snacks, fluids toileting. In my opinion I feel like he is sundowning more in evenings and that is causing him to have more falls. If we offer to take to bathroom, he will go but then gets aggressive, paranoid, combative very quickly. I try to encourage to have CNA check and change him 2x or more during the shift especially if he is getting restless. If we keep him clean and dry, he tends to be more calm but taking him for peri care is when we struggle. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 07/09/24 at 3:15 PM Interview with V22 (LPN). V22 stated, I have worked with R99 before. On 5/23/24 it was around the start of shift, so my CNA who I do not recall who it was, was doing rounds and immediately called me. R99 had floor mat in place but he crawls on that and is able to stand up. He has a reclining chair. He has a low bed and that was in place. He had his call light within reach. He has been instructed multiple times on call light use but appears unable to be able to use call light. He is always checked on frequently like every 15-20 minutes just to make sure he is safe. I think his increased confusion, restlessness, anxiousness, and incontinence is causing his falls. He is so unpredictable so it is very hard to put anything in place to decrease falls except to increase medications, but family will not agree to that. On 07/09/24 at 1:24 PM Interview with V2 Director of Nursing (DON). V2 stated, R99 he is under hospice care and very active. He really doesn't know his limitations. He attempts unsafe transfers, He has Parkinson's, history of hallucinations. This very last fall he rolled out of bed, and we decided to put in place to be put in his chair as soon as he is awake as he allows. And toileting and have his needs met. He is very active, and he bumps his hands and I think that is why he is having bruising. He is aggressive at times. He is also not aware of safety issues. Fall policy labeled: Fall Prevention Program AA Healthcare dated 2/12/2024 provided to surveyor by V2, DON on 07/09/2024 states: Policy: The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents. Procedure: 1. A Fall Prevention program will be implemented and maintained to assure the safety of all residents admitted to the facility. The program will be inclusive of measures which determine the individual needs of each resident by assessing the risk of falls, and implementation of appropriate staff interventions to assure adequate supervision is provided, and that assistive devices are utilized when necessary. Fall Incident Reports will be reviewed, and quality issues identified to assure the on-going effectiveness of the prevention program. 4. The DON or designee will be responsible for implementing and communicating resident-specific recommendations from the Fall Risk Committee to the nursing staff assigned to the resident. The nursing staff will be responsible for assuring the recommendations are followed through. 7. Fall prevention strategies will be utilized for all residents at risk for falls including individualized interventions in accordance with the assessed needs of each resident. Fall alarms may be utilized to alert staff to resident attempts to rise without assistance unless they prevent the resident from rising or pose an increased risk for falls.