STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510049	A. BUILDING: _____ B. WING _____	C 11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AXELSON ASSISTED LIVING	2195 FOXGLOVE DR NORTHBROOK, IL 60062

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comment FRI (Facility Reported Incident): #IL177370 - Substantiated.	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation Section 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. b) The service plan shall be developed by: 1) The resident, resident's representative or any individual requested by the resident. 2) The manager or manager's designee; and 3) A registered nurse, if the resident is receiving nursing services or medication administration or is unable to direct self-care. d) The service plan, which shall be reviewed	A4010		

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A4010	Continued From page 1	A4010		

annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act)

e) The service plan shall be reviewed and revised, if necessary, immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000).

This requirement is not met as evidenced by:

Based on interview and record review, the establishment failed to ensure detailed fall interventions are in place in a resident's Service Plan in order to help prevent fall incidents from reoccurring. They also failed to conduct a fall risk assessment after a fall incident, failed to conduct fall root cause analysis upon which to base their fall interventions on.

These failures contributed to a resident's (R1) unwitnessed fall incident in the establishment resulting in hospitalization, surgical repair of left hip fracture/sub capital femoral neck fracture, subsequent skilled nursing admission for intensive rehabilitation.

This applies to 1 (R1) resident reviewed for fall with injury.

Findings include:

R1 is a 99-year-old female resident admitted to the establishment on October 12, 2023 with diagnoses of macular degeneration, arthritis,

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A4010	Continued From page 2	A4010		

Alzheimer's disease, congestive heart failure, depression, spinal stenosis, lumbar region, essential HTN, hypothyroidism, difficulty in walking, abnormalities of gait and mobility, lack of coordination, and abnormal posture.

E1 (Director of Assisted Living) and E2 (RN Nurse Manager) confirmed R1 had a fall incident in the establishment on August 23, 2024 as reported to the Department. E1 stated R1 was sent to the hospital, was diagnosed with left hip fracture, and then stayed at a skilled facility from August 26, 2024 to September 19, 2024.

E2 added R1 also had a fall incident without injuries in the establishment on August 22, 2024. E2 explained this was after R1 stayed up late with her daughter for her birthday.

The establishment's Initial Report to the Department dated August 23, 2024 showed, "R1 ambulated independently in her apartment and in the community. She was observed on her apartment floor, in the center of her studio. She was laying on her right side. Resident was unable to explain how the fall occurred. Nurse assessed and resident complained of pain in her neck and back. Left hip was painful to touch. No loss of consciousness, resident remained alert at her baseline. Vitals were all within normal limits. 911 was called and transported resident to the emergency room. POA and doctor were notified. 1st report from Glenbrook Hospital emergency room indicated fracture of left hip and stated that resident will be transferred to Skokie Hospital."

The establishment's Final Report to the Department dated August 30, 2024 showed, "Resident was transferred to Skokie Hospital and had surgical repair of fractured left hip. She was

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A4010	Continued From page 3	A4010		

transferred to Skilled Nursing and Rehab on August 26. She is receiving intensive rehab and will be re-assessed for return to AL once rehab is complete."

The establishment's Clinical Notes Report dated August 23, 2024 confirmed the establishment's Report.

R1's Service Plan dated June 22, 2024 showed for her cognition she was assessed as needing maximum assistance. R1 requires redirection from the staff as she has some forgetfulness. R1 was not assessed as high risk for fall for this Service Plan date. No fall interventions were put in place.

After R1's fall incident on August 22, 2024, there was no fall risk assessment that was conducted. There were no interventions for fall prevention put in place for R1.

R1's Service Plan dated October 2, 2024 showed R1 needed assistance with some of her ADLs such as grooming, bathing, transfers, and ambulation. The same Service Plan also showed R1 was assessed as "fall risk and requires extensive assistance." However, the intervention portion of the Plan of Care only showed, "Resident remains at high risk for fall related to pain and requires staff interventions to ensure safety." There are no actual interventions listed to help prevent fall incidents from happening again.

A separate establishment's Fall Care Plan Form for R1 showed an assessment category under Falls. The goal is to reduce the incidents of fall. The same Care Plan showed for August 22, an intervention of (R1) educated to call for assistance (in spite of R1 assessed as being

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A4010	Continued From page 4 forgetful with diagnosis of Alzheimer's disease) and for August 23, 2024, an intervention of upon return of resident, staff to do frequent rounds to prevent resident falls. E2 (RN Nurse Manager) presented a separate Life Connect assessment for R1 dated October 2, 2024. The Fall Risk/Care category showed an intervention of "Staff to do frequent rounds as (R1) forget to use the call button to call for assistance." However, this was not translated/shown in the actual Service Plan. The assessment was conducted by E2, and the caregivers/CNAs will look at the actual Service Plan. E1 and E2 said they will make sure to conduct an audit of all Service Plans of the residents. They will make sure initial Fall interventions will be listed and followed. They will also make sure changes will be made to the interventions after each fall incident and documented/listed in the Service Plans.	A4010		