STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510522	A. BUILDING: _____ B. WING _____	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TERRACE GLENVIEW	4700 W LAKE AVENUE GLENVIEW, IL 60025

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A 000	Initial Comment Annual Licensure Conducted Violations 295.6000 Resident Rights 295.2000 Residency Requirements	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: Type 2 Section 295.2000 Residency Requirements a) No individual shall be accepted for residency or remain in residence if the establishment cannot provide or secure appropriate services, if the individual requires a level of service or type of service for which the establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide such services. (Section 75(a) of the Act) These Requirements are not met as evidenced by: Based on interview and record review, 1 resident (R9) out of 4 reviewed for residency requirements remained in the Assisted Living despite requiring a level of care outside of the facility's abilities to provide. R9 died as a result of a hemorrhagic stroke but also suffered additional injuries including fracture of ribs and left hip during a fall. As early as 10/2023 facility had made	A2000		

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recommendation for memory care admission.

Findings include:

R9 admitting diagnoses to facility includes history of a benign meningioma (Brain mass), hypertension and depression. The depression was being managed by psychiatric treatment group. It's not clear from the document review when exactly a diagnosis of Dementia was made but there is a diagnosis of "Dementia with psychotic disturbance" included in documentation of 5/23/24. SLUMS measure of cognitive function is scored at a 5 on 5/7/24 indicating cognitive impairment.
R9 was admitted to the facility on 9/19/22 and discharged to hospital after a fall down facility front stairway on 9/7/24 at approximately 2:05 pm. R9 facility clinical course is characterized by deterioration in cognition, confusion, fall risk, falls on 5/25/24, 8/26/24, 9/7/27, facility known safety issues with use of facility front stairwell, order for therapy in July due to "gait instability" and recommendation for memory care admission by former Director of Nursing as documented in 10/26/23 nursing note. On 8/26/24 at 10:11 am E10(Registered Nurse) stated in part, "(R9) was a fall risk."
E10's(nurse) assessment of fall risk especially down the facility front stairwell is discussed in interview of 11/7/24 in which E10 recalls hearing other staff say don't go by stair, go by elevator. There is also a Prescription dated 7/1/24 written by Z1(Attending Physician of R9) requesting Physical therapy and occupational therapy evaluation and management of R9 for indication of "gait instability." E1(Executive Director) was asked for copies of the physical and occupational therapy notes. On 11/6/24 at 2:00 pm E1 stated R9 had refused therapy. Documentation from

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therapy was presented supporting R9's refusal of treatment.
On 11/7/24 at 8:26 am, (Z1) Attending Physician of R9 explained, according to neurosurgeon the bleed was not from the fall causing trauma but was a result of a hemorrhage and then (R9) fell. Z1 maintains, "If it was a trauma bleed, it would look different." R9's nursing note review showed R9 was having problems with walking down the stairs even before the 9/7/24 fall which resulted in fractures.
That change in maneuvering of stairs is not documented as being reported to Z1(Attending Physician) in the nurses note of 8/27/24 at 7:12 pm and on interview of 11/7/24, Z1 stated he was not aware of the change in R9's ability to functionally handle stairs and she should not have been allowed to use the stairs. There is no examination to determine what is causing the change in R9's ability to manage the stairs.
Z1 was read an 8/27/24 7:12 pm entry by E4(nurse), "(R9) noted having trouble walking down the stairs. (R9) was holding onto rails and leaning to one side. This writer managed to escort (R9) back upstairs and tried to get (R9) to use the elevator. (R9) became agitated and tried to hit this writer and then started crying. (R9) noted several more times trying to use the stairs but was escorted away each time. Currently in theater room watching a movie." After review of this entry, Z1(MD) ,"yes, should not be using stairs ...harm from fracture ribs on stairs ..."
Facility investigation report of fall included documentation of left rib fracture and left hip fracture.
Last Assessment and service plan of 5/7/24 before the fall with injury of 9/7/24 states, "(R9) ambulates independently without assistive device. At risk for falls due to psychotropic medications. (R9) will use the main stairs to go up and down

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floors. Please encourage her to use the elevator which (R9) will most likely refuse. Please remind (R9) to hold onto the railings while going up or down the stairs." There are no additional updates or revisions to this service plan which is the last service plan before R9 falls down the facility front stairs.
E2(Director of Health/Nursing/LPN) on 11/6/24 at 2:30 pm initially stated R9 did not have any falls but then clarified R9 could have had falls "but not on my shift." E2 recalls he did not make any updates to R9's service plan and "nurses don't put interventions." Both E2 and E1 recall R9 as having a companion but there is no documentation of a companion in place and E2 recalls the companion was not on duty when R9 fell with injury. Neither E1, E2 or E10(RN) could give a schedule for when the companion was on duty. E10 reported facility staff were responsible for R9's care not the companion who was described as a lay person providing R9 company.
Based on review of service plan, statements and clinical record, facility failed to update R9's service plan to include:
Interventions associated with R9 falls while in the facility or reasons why service plan did not need updating;
When R9 refused therapy as an intervention, facility failed to address gait instability documented by physician and failed to adequately address fall risk presented by facility front staircase. R9's service plan continues to assess R9 as independent in ambulation despite R9's fall risk. R9 was not monitored and despite cognitive impairment affecting safety, confusion, history of falls and documented problem walking down the staircase in an 8/27/24 nursing notes R9 continued to have access to the staircase. As a result, R9 continued to use the front staircase resulting in harm from a fall down this staircase

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A2000	Continued From page 4 on 9/7/24. The fall itself was caused by a stroke according to Z1(Attending Physician) in consultation with hospital neurosurgeon. The harm occurred as documented in the summary of investigation completed by the facility administration. R9 is documented as having "left hip fracture, left rib fracture ..." in addition to the brain bleed due to the fall down the staircase. A staircase R9 had demonstrated previous functional impairment with. This incident was not communicated to Z1(Attending Physician) for further medical follow up according to interview. However, there is an identified change in gait which Z1 is aware of because on 7/1/24 Z1 wrote an order for Physical and Occupational therapy which R9 refused. Based on R9's diagnosis of moderate phase Dementia, unstable gait with inability to safely maneuver staircase, falls, cognitive impairment affecting judgement related to safety, and facility failure to adequately monitor and mitigate the ongoing risk of injury from the staircase shows facility was unable to provide the level of service/monitoring and intervention necessary to maintain R9 safe from predictable risk staircase presented.	A2000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Level 2 Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law,	A6000		

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A6000	Continued From page 5 the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; These Requirements are not met as evidenced by: Based on interview and record review, 1 resident(R3) with cognitive impairment out of 3 reviewed eloped from the Assisted Living Facility and 4 residents (R1, R2, R3, R4) were asked to sign a document titled, Shared Responsibility Agreement, which attempts to take away legal rights to hold the facility liable. The SRA is also included in R1, R2, R3 and R4 service plans. Findings include: R3 was originally admitted on 10/2/23 to the Assisted Living section of the facility with diagnoses including but not limited to Confusion, Dementia with agitation, Multiple Sclerosis, Diabetes Mellitus and Stroke. R3 had moved from a private residence with spouse due to "progressing cognitive decline with dementia. Due to lack of safety awareness and higher balance deficits," according to Occupational therapy evaluation of 10/16/23. While in the facility, R3 exhibits aggressive and unsafe behaviors which is documented in the nursing notes as follows: 4/16/24 Struck writer;	A6000		

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A6000	Continued From page 6 On 8/26/24 R3 states she wants to kill herself; 9/23 attempted to hit writer on head; and 10/2/24 Threw water at nurse. Threw walker at nurse. Tried to strangle herself with her hands. R3 has confusion, Dementia, lack of safety awareness and behaviors while in assisted living. R3 successfully elopes from the facility in the middle of the night via the northeast corner of the building on 3/18/24 at 12:29 am and then reentry to the building through the main entrance at 12:36 am. Facility reviewed camera footage discovering the time and route of the elopement. Nursing note written on 3/18/24 documents this incident. Accident/incident report of 3/18/24 documents an alarm going off for door 106 via pager and "NOD(nurse on duty) was on her way to check the alarm when paramedics came to bring another resident back to the community, so she had to open the door for them. NOD then went to check the northeast stairwell but did not find anyone. By the time the paramedics were heading out of the building, they saw the resident(R3) walking in the hallway and informed the nurse. The nurse concluded that she was the resident who exited the building. Resident stated she was looking for her husband." Facility failed to maintain R3 who is a known safety risk, inside the community. Given R3's safety risk, R3 should not have been able to leave the facility unsupervised placing her at risk for harm. E1(Executive Director) confirmed R3 had eloped.	A6000		

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A6000	Continued From page 7 In addition to the resident right to receive supervision to meet their needs for safety, residents and or their legal representatives have a legal right to seek legal counsel and decide to hold a facility liable for injuries sustained while under the care of the facility. Facility has document titled, "Shared Responsibility Agreement," which is listed as "SRA required" on resident service plans for a variety of risks including "fall." The signed document releases the facility known as "community" and or its affiliates and related companies from liability for injuries or other losses sustained due to identified risks. The document reads in the last line, "I agree not to hold the Community or its affiliates and related companies liable for injuries or other losses sustained due to these risks." R1, R2, R3 and R4 and or their family representative have a copy of this signed document present in facility binders. E1(Executive Director) was asked about this document and reported it was a corporate developed agreement. E1 was referred to resident rights language allowing guarantees under the law which could not be taken away by the facility.	A6000		