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ROSE - ANGELA HALL	4200 NORTH AUSTIN CHICAGO, IL 60634

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W 000	INITIAL COMMENTS INCIDENT INVESTIGATION INCIDENT OF 8/22/16 / IL# 88297	W 000		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to thoroughly investigate 1 of 1 fall reviewed, involving R1. R1 fell on 8/22/16, and sustained a displaced right hip fracture, which required surgical intervention. Findings include: The facilities policy and procedure entitled, "Protocol for dealing with resident abuse and neglect" with a revision date of 2/5/15 was reviewed. This policy reads, but is not limited to: "5. Neglect: An employees failure to provide adecuate medical care, personal care or maintanance, as a consequence causes individual pain...results in the deterioration of an individual physical condition, or places the individual's health or safety at substancial risk..... Procedure: Investigation of all perspective abuse or neglect of a resident is mandatory....The final investigative report will properly detail the incident, and it's seriousness may make it easier for the facility to support or defend it's posistion to:	W 154		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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* Train or retrain staff as to proper procedures to avoid such future incidents."

The Incident Report for R1 dated and timed 8/22/16 at 12:30pm was reviewed. The incident notes that R1 had a witnessed fall, where she stumbled and fell on her buttocks. R1 complained of right knee pain. The nurse caring for R1 at the time, E3(Licensed Practical Nurse), assessed R1 and documented that R1 has full range of motion of her right knee, no bruising, swelling or broken skin. An ice pack was applied and Tylenol was administered. There is no indication that this fall was reported to the physician.

A second Incident Report involving R1, dated 8/28/16, with a time entered as unknown, was also reviewed. The incident notes direct care staff discovered a large bruise, 10 x 11 cm, purple/blue in color to her right inner thigh. This bruise was not correlated with any new incident. The incident states that R1 has been non-compliant with transferring/walking due to right knee pain. R1 had been seen by the physician, E4(Facility Cardiologist/Internist), on Friday(8/26/16), and is being treated with Motrin 200mg(milligrams) BID(twice per day). There is no indication this new finding was reported to R1's physician.

A third Incident Report for R1, dated 8/30/16 at 11:00am, was reviewed. The report indicates that after a fall R1 had on 8/22/16, R1 has been complaining of right knee pain. After range of motion assessments from multiple nurses, R1 responded that her right knee hurt. R1's(right) knee had no significant swelling, bruising or point tenderness. R1, when asked what hurt, pointed

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to her right knee every time. R1 was seen by the physician on 8/26/16. On 8/28/16, a bruise was discovered measuring 10 x 11 cm in diameter, and over night on 8/28/16, R1 was unable to ambulate to the toilet due to right knee pain, and was incontinent of urine. Further assessments were done due to the bruise to the inner thigh, and it was noted that R1's right knee was bent outward to the right lateral side. The physician was called,and an order for an x-ray to the right hip and knee was ordered. R1 had her x-ray performed on 8/30/16, and was sedated with Ativan 2 mg, at this appointment. The x-ray showed a displaced fracture of the right hip. R1's physician was notified, (E5,Medical Director), and he stated to go to the Emergency Room,(from the Radiology Department), where R1 was admitted for replacement surgery to her right hip.

This writer asked for the Incident Investigation regarding this fall and subsequent right hip fracture. E1 presented a document entitled, " Draft only", on 9/8/16 at 1:00pm, which had R1's name on it. This document is undated. E1 confirmed this is the only investigation report that she currently has, and that it really gives the time line of what occurred following the first fall R1 experienced on 8/22/16. The time line indicates the following:

8/22/16(Mon) - 12:30pm. (R1) fell on her butt backwards with impact. E3 checked her. R1 complained of her right knee(hurting her). E3 reported(documented) the following: full range of motion of right knee, no bruise, swelling or broken skin noted. Applied ice pack, Tylenol given. R1 stayed in the apartment in the afternoon.

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8/23/16 - Tuesday - Stayed in the apartment the whole day. Was complaining of her knee.

8/24/16 - Wednesday - Morning staff brought R1 to DT(Day Training), but R1 was crying and refused to stay in DT. Staff brought her back to the apartment and R1 stayed the whole afternoon there. Continued to complain of her knee(having pain).

8/25/16 - Thursday - Attended the DT in the wheelchair. They(staff) let her stay in the wheelchair the whole day. Continue to complain of her knee(being in pain).

8/26/16 - Friday - Attended DT- seen by E4(facility cardiologist/internist). Nursing brought her from DT without her wheelchair. Attended afternoon workshop. After the program, was brought back to the apartment without her wheelchair by 3 vocational instructors. At some point, R1 sat on the ground of the parking lot. Her QIDP got the wheelchair, and brought her back to the apartment. R1 continues to complain of knee pain, holding her knee and touching her knee all the time.

8/27/16 - Saturday - Stayed in bed most of the time except for mealtime. Was given a shower. While in the shower, was shouting and telling the staff that she wants to take a bath in the other bathroom. Was again complaining of her knee(hurting her), and staff and her QIDP helped her with her shower.

8/28/16 - Sunday - Had breakfast, stayed in the dining room with staff. Refused to get out of the washroom. Staff and Housemother helped to get her up, and finish her shower.

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W 154	Continued From page 4 8/29/16 - Monday - Attended DT and afternoon workshop. Nurse called the doctor. This investigation did not mention any bruise discovery, nor that an x-ray was ordered, nor that R1 had a newly diagnosed displaced right hip fracture. There are no interviews with any staff who may have cared for R1 during this time frame, nor is there any conclusion to this investigation. E1 was again asked if this is her final investigation on the same date at 2:00pm, and E1 confirmed that this is the only investigation that she has. During a follow up interview with E1 via the telephone on 9/15/16 at 10:00am, E1 was asked if it is part of their facility policy, to conduct interviews with key staff members and clients, to best determine what may or may not have occurred during their investigative process. E1 stated that their policy does not go into that much detail, but it is the expectation to speak with the key people who might have witnessed a fall, or assessed a client who fell, otherwise, it will be difficult to determine what actually occurred.	W 154		
W 318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on record review and interview, the facility failed to ensure nursing services met the needs of 1 of 1 client in the sample (R1) who fell, sustaining a comminuted, displaced Garden IV	W 318		

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W 318	Continued From page 5 subcapital fracture, of the proximal right femur with moderate resultant varus deformity, which required a total hip replacement surgery. The facility failed to: 1. Ensure repeated complaints of pain over an eight day time frame, expressed by R1, were adequately addressed, and diagnostically investigated. 2. Ensure nursing staff thoroughly assessed R1 as per their facility Assessment for Incidents Guidelines. 3. Ensure new physical assessment changes were immediately reported to the physician. 4. Ensure an order from R1's physician for a right knee and hip x-ray was obtained the day it was ordered. Findings include: Refer to deficiencies cited under: W331 - The facility must provide clients with nursing services in accordance with their needs.	W 318		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure nursing services met the needs of 1 of 1 client in the sample(R1) who fell, sustaining a comminuted, displaced Garden IV subcapital fracture, to the proximal right femur, with moderate resultant varus deformity, which required a total hip replacement surgery. The	W 331		

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facility failed to:

1. Ensure repeated complaints of pain over an eight day time frame, expressed by R1, were adequately addressed, and diagnostically investigated.
2. Ensure nursing staff thoroughly assessed R1 as per their facility Assessment for Incidents Guidelines.
3. Ensure new physical assessment changes were immediately reported to the physician.
4. Ensure an order from R1's physician for a right knee and hip x-ray was obtained the day it was ordered.

Findings include:

The Incident Report for R1 dated and timed 8/22/16 at 12:30pm was reviewed. The incident notes that R1 had a witnessed fall, where she stumbled, and fell on her buttocks. R1 complained of right knee pain. The nurse caring for R1 at the time, E3(Licensed Practical Nurse), assessed R1 and documented that R1 has full range of motion of her right knee, no bruising, swelling or broken skin. An ice pack was applied and Tylenol was administered. There is no indication that this fall was reported to the physician.

A second Incident Report involving R1, dated 8/28/16, with an time entered as unknown, was also reviewed. The incident notes direct care staff discovered a large bruise, 10 x 11 cm(centimeters), purple/blue in color to her right inner thigh. This bruise was not correlated with any new incident. The incident states that R1 has been non-compliant with transferring/walking due to right knee pain. R1 had been seen by the

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physician, E4(Facility cardiologist/internist), on Friday(8/26/16), and is being treated with Motrin 200mg(milligrams) BID(twice per day). There is no indication this new finding was reported to R1's physician.

A third Incident Report for R1, dated 8/30/16 at 11:00am, was reviewed. The report indicates that after a fall R1 had on 8/22/16, R1 has been complaining of right knee pain. After range of motion assessments from multiple nurses, R1 responded that her right knee hurt. R1's(right) knee had no significant swelling, bruising or point tenderness. R1, when asked what hurt, pointed to her right knee every time. R1 was seen by the physician on 8/26/16. On 8/28/16, a bruise was discovered measuring 10 x 11 cm in diameter, and over night on 8/28/16, R1 was unable to ambulate to the toilet due to right knee pain, and was incontinent of urine. Further assessments were done due to the bruise to the inner thigh, and it was noted that R1's right knee was bent outward to the right lateral side. The physician was called,and an order for an x-ray to the right hip and knee was ordered. R1 had her x-ray performed on 8/30/16, and was sedated with Ativan 2 mg, at this appointment. The x-ray showed a displaced fracture of the right hip. R1's physician was notified, (E5/Medical Director), and he stated to go to the Emergency Room,(from the radiology department), where R1 was admitted for replacement surgery to her right hip.

This writer asked for the Incident Investigation regarding this fall, and subsequent right hip fracture. E1 presented a document entitled, " Draft only", on 9/8/16 at 1:00pm, which had R1's name on it. This document is undated. E1 confirmed this is the only investigation report that

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W 331	Continued From page 8 she currently has, and that it really gives the time line of what occurred following the first fall R1 experienced on 8/22/16. The time line indicates the following: 8/22/16(Mon) - 12:30pm. (R1) fell on her butt backwards with impact. E3 checked her. R1 complained of her right knee(hurting her). E3 reported(documented) the following: full range of motion of right knee, no bruise, swelling or broken skin noted. Applied ice pack, Tylenol given. R1 stayed in the apartment in the afternoon. 8/23/16 - Tuesday - Stayed in the apartment the whole day. Was complaining of her knee(being in pain). 8/24/16 - Wednesday - Morning staff brought R1 to DT(Day Training), but R1 was crying, and refused to stay in DT. Staff brought her back to the apartment, and R1 stayed the whole afternoon there. Continued to complain of her knee(having pain). 8/25/16 - Thursday - Attended DT in the wheelchair. They(staff) let her stay in the wheelchair the whole day. Continue to complain of her knee(being in pain). 8/26/16 - Friday - Attended DT- seen by E4(MD). Nursing brought her from DT without her wheelchair. Attended afternoon workshop. After the program, was brought back to the apartment without her wheelchair by 3 vocational instructors. At some point, R1 sat on the ground of the parking lot. Her QIDP got the wheelchair, and brought her back to the apartment. R1 continues to complain of knee pain, holding her knee and	W 331		

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touching her knee all the time.

8/27/16 - Saturday - Stayed in bed most of the time except for mealtime. Was given a shower. While in the shower, was shouting and telling staff that she wants to take a bath in the other bathroom. Was again complaining of her knee(hurting her), and staff and her QIDP helped her with her shower.

8/28/16 - Sunday - Had breakfast, stayed in the dining room with staff. Refused to get out of the washroom. Staff and Housemother helped to get her up, and finish her shower.

8/29/16 - Monday - Attended DT and afternoon workshop. Nurse called the doctor.

This investigation did not mention any bruise discovery, nor that an x-ray was ordered, nor that R1 had a newly diagnosed displaced right hip fracture. There are no interviews with any staff who may have cared for R1 during this time frame, nor is there any conclusion to this investigation. E1 was again asked if this is her final investigation on the same date at 2:00pm, and E1 confirmed that this is the only investigation that she has.

R1's nursing notes were reviewed, starting from 8/22/16 through 8/30/16. The summaries of these entries are noted as follows:

8/22/16 - R1 had a fall while walking in the hallway, landing on her behind(buttocks). R1 complained of right knee pain. R1 has full range of motion to her right knee, no bruising, swelling or broken skin noted. At 7:20pm, Ibuprofen was administered for pain, documented as occasional

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moaning/groan, with a sad frightened face, and tense body language. The entry notes that there is no need to notify the physician of this fall.

8/23/16 - Pain medication again administered at 6:53pm., for right knee pain. (There is no other assessment noted of her knee at this entry, nor for this entire day).

8/24/16 - Pain medication administered at 9:09am. (No other documentation related to the assessment of her right knee).

8/25/16 - 4:34pm - Complained of right knee pain. No swelling, redness, warmth or bruising noted. When trying to ambulate, R1 refuses to put full weight on right leg at times. R1 is able to stand without assistance, but when assisting in ambulation, refuses to take steps with either leg. With 2 nurses assisting in ambulation, she will take one step, and then will not take the next step. At 7:31pm, pain medication administered.

8/26/16 - 11:24am, Acetaminophen administered for pain complaints to right knee. At 9:03pm, assessment documentation states that R1 complained of right knee pain. Refuses to walk, stands independently, and walks with staff assistance. Administered pain medication per E4's order.

8/27/16 - no entry for the entire day.

8/28/16 - Hematoma/bruise. Staff noticed a bruise on R1's right thigh while getting her out of bed, (right anterior inner thigh) which measures 10 x 11cm(centimeters). No new incident has been reported. R1 has been non-compliant with transferring/walking due to complaints of right

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knee pain. Was seen by MD on Friday(8/26/16), and is being treated with Motrin. (The physician was not notified of this new finding. There is no indication an assessment was performed on her right hip, upper leg area, even though there is a new bruise noted to her right upper inner thigh area).

8/29/16 - Pain medication administered at 4:09am. At 4:19am, assessment documented by nursing states R1 had been incontinent of urine x 1 because she was unable to get out of bed to toilet herself due to complaints of pain to her right knee. Upon assessment, the joint did not feel warm to touch. The right knee appears to be turned slightly outward to the right lateral side when R1 is sitting on the edge of the bed or on a chair with legs extended out in front of her. R1 is unable to bear any weight on right extremity and needed assistance to get cleaned up, changed, and back in bed. Put on E5's(MD) list to be seen tomorrow morning(8/30/16). E4(MD) was also called, and an x-ray of the right hip and right knee were ordered. An entry timed 9:22pm has documentation that nursing call E5 and requested a pre-sedation prior to medical procedures, because R1 has an x-ray tomorrow. New orders were received for Ativan 2mg(milligrams).

8/30/16 - Left for x-ray at 10:00am via van, accompanied by staff member for x-ray of right knee and hip. At 3:10pm, the entry states that after a fall R1 had on 8/22/16, R1 had been complaining of right knee pain. Was seen by the doctor on 8/26/16, and continued to complain of right knee pain. A bruise was discovered on 8/28/16, . Further assessments were done, and the doctor was called and an order was received for an x-ray of the right hip and knee. The results

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of the x-ray show a displaced fracture of the right hip. E5 was notified, and E5 stated that R1 needs to go to the emergency room, and she will be admitted for replacement surgery this evening, or the following day.

R1's x-ray results were reviewed. For her Right hip/pelvis view, findings read, "There is an apparent acute comminuted, Garden IV subcapital fracture of the proximal right femur, which exhibits superolateral displacement of distal fracture fragment, and moderate resultant varus deformity."

During an interview with E2(Director of Nursing) on 9/8/16 at 11:45am,E2 was asked why the initial fall was not reported to the physician. E2 stated that because they could not determine that there was an injury, they felt it was not necessary to contact the physician. E2 was asked to explain why it took so long for nursing to confirm, or begin to diagnose the repeated complaints of pain that R1 had been expressing for a total of eight days, with worsening physical findings. E2 stated that they as a nursing team tried to look at this, and what they determined is that a lot of people did something wrong. We are trying to look at it going forward, and how can we fix this in the future. E2 stated it was slight mistakes, but from many nurses. E2 also stated that it is hard to assess R1 because she has dementia. R1 is unreliable in expressing where her pain is coming from; R1 stated it was her knee, but really it was her hip. That is our fault. E2 stated that when R1 fell, it was a witnessed fall. Staff saw her land on her buttocks. The nurse should have done a full body assessment, and paid particular attention to the area she landed on(her buttocks). E2 stated that E3 is the nurse that was caring for R1 on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G191	A. BUILDING ______ B. WING ______	C 09/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE - ANGELA HALL	4200 NORTH AUSTIN CHICAGO, IL 60634

(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) COMPLETION DATE
W 331	Continued From page 13 22nd, and she has been out on vacation for a total of three weeks, so she has not been able to talk with her about it. E2 stated that all she can do is look at her documentation, and her documentation does not have any indication that she assessed her hip area. E2 stated that R1 will at times refuse to attend DT, so when she stayed home on Monday and Tuesday, she does that sometimes, but E2 thinks what happened is that the nurses did not take her pain seriously. E2 was asked why the nurses did not report the large bruise on R1's thigh on the 28th. E2 stated normally they do not report bruises, but now looking back at it, maybe they should have. E2 was also asked why R1 was not taken out the same day her x-ray was ordered. E2 stated that if it is a weekend, then staff will usually wait, because it is such a long process going to the emergency room for an x-ray, they would rather wait until a week day, and go to the radiology department instead. E2 stated she would have to check and find out why the delay, because the x-ray was ordered on a Monday, and they did not get the x-ray until Tuesday. E2 came back at 12:45pm, and stated that the reason staff did not take her out on Monday, is that they tried, but R1 refused, so they needed to call the doctor to obtain an order for Ativan to sedate her so she would be more willing to go out for the x-ray. E2 stated that nursing did not call for the Ativan until after 9pm that night, so then they had to wait until the following day to obtain the x-ray. During this same interview, E2 stated that they have new guidelines that were developed back in April, and all of the nursing staff have been in-serviced on them. E2 provided this surveyor with a copy of the guidelines. E2 stated that the guidelines clearly stated that if a client falls, and it is witnessed, staff should determine which body	W 331		

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W 331	Continued From page 14 part hit the floor, and what position they landed in. E2 stated if they would have done this, maybe they could have determined that the pain was coming from her hip area, as that is the area she landed on(buttocks). E2 stated that since this has happened, she printed out the guidelines again for the nurses, and told them all to read them again, but confirmed that to date, there has not been any formal re-training or in-servicing. The nurses did not sign anything, indicating they read the guidelines again. E2 stated that they are planning on doing the re-training next week. The Assessment For Incidents, Including Falls Guidelines, was reviewed. These guidelines are not dated. The guidelines indicate that nursing staff, after a fall, need to assess which body parts need to be checked for injuries, depending on how a client falls. If a fall occurs, they need to investigate why, and if witnessed, was it a soft or hard fall, and which part of the body hit the floor or object. E2, on 9/8/16 at 12:45pm confirmed that the nursing staff did not follow these guidelines as written. E2 stated that E3 needed to do a full body assessment, and assess range of motion on all joints, not just the area R1 was pointing to(right knee). E2 was asked why the investigation is not thorough, and missing documentation on the bruise that was discovered, or the delay in obtaining the x-ray. E2 stated that she is not sure, as E1 completed the investigation. During an interview with E1(Administrator) 9/8/16 at 1:00pm, E1 confirmed that she is the staff person responsible for completing the investigations in the facility. E1 stated that this is her investigation, and has nothing further to present. E1 stated that when this fall occurred,	W 331		

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W 331	Continued From page 15 she was on vacation. E1 stated that when a client states that they have pain in one area, someone with dementia might actually have pain someplace else, but they cannot express it accurately. E1 stated that R1 is unreliable. E1 also stated that R1 is someone who complains on a regular basis; she always obsesses and complains. E1 stated that they should error on the side of being cautious. E1 stated that they are going to re- in-service on the guidelines, they just have not done that yet. E1 stated that would cover training on documenting what you assess. E1 stated that a bruise that large should have been reported, especially because R1 has dementia, and is not a good reporter. E1 was asked if during the process of completing her investigation, if she interviewed any staff. E1 stated that there were staff interviews, but she just did not include them in her report. E1 stated that this did go on a long time(R1's complaints of pain), and that something more needed to be done. E1 stated that she thinks the nursing staff looked at it all as dementia, and they needed to rule out all medical first. E1 stated that when they saw the bruising on R1's right hip area, they were not thinking hip because R1 kept saying her knee hurt her; that is why nursing probably did not report the bruise immediately to the physician.	W 331		