Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008916	A. BUILDING: ______ B. WING ______	C 03/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF EVANSTON L & R, THE	500 ASBURY STREET EVANSTON, IL 60202

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S 000	Initial Comments Complaint Investigation 1991423/IL109910	S 000		
S9999	Final Observations Statement of Licensure Violation 300.610a) 300.1210b) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999	**Attachment A** **Statement of Licensure Violations**	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 04/08/19

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d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These Regulations were not met as evidence by:

Based on observation, interview and record review, the facility failed to ensure a wall mounted upholstered headboard was securely fastened to the wall in 1 of 3 residents (R1) reviewed for safe equipment in resident rooms.This failure resulted in the upholsterd headboard falling off the wall on to R1's head and face. R1 was sent to local hospital and was admitted and treated for sustained facial swelling and facial cellulitis.

Findings Include;

R1 was a 68 year old resident with diagnoses include, diabetes mellitus type two, dysphagia, anxiety disorder, vascular dementia and hypotension.

The Facility Incident Report dated 3/4/19 documents ; On 2/26/19 at 11:30 PM, nurse (V14) was making rounds, heard a sound coming from the resident's (R1 room.) Nurse noted that the decorative cushion frame that was attached to the wall had accidentally fallen on residents face. The nurse called for assistance and the frame

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was removed from the resident immediately. Complete assessment was done, slight redness noted initially on resident's face. Neurocheck was initiated. No grimacing noted. MD (Medical Doctor) was informed, x-ray of face ordered and done. X-ray result does not show any fracture. But by morning of 2/28/19 should be (2/27/18) resident left side of face had swollen. MD informed and ordered to send resident to the emergency room at hospital. Resident admitted with diagnosis of head injury.

Progress Notes dated 2/27/19 document; at 7:45 AM R1 remains left side of face redden swelling. 11:14 AM V12 MD (Medical Doctor) notified of x-ray result, left eye result shows negative for fracture, and dislocation. MD was informed of swelling was not gone (going) down, left eye closed due to swelling. V12 MD order to send resident to local hospital ER (emergency room) for evaluation. At 12:10 PM resident transported to hospital. DON (Director of Nursing) and family made aware. Progress notes dated 3/1/19 ; At 6:20 PM (R1) re-admitted this 68 year old patient of V12 MD from hospital, brought to facility by ambulance per stretcher accompanied by 2 crew members. Resident is non-verbal and does not follow any instruction, generalized weakness,breathing with no labor, skin warm and dry,... readmitted with dx (diagnosis) of facial cellulitis. Resident's left side of face swelling, redness, and blisters. Resident started on doxycycline 100 mg (milligram) (antibiotic) by mouth two times a day for seven days.

On 3/14/19 at 10:25 AM via telephone V14 LPN (Licensed Practical Nurse) stated; The resident (R1) is always nonverbal. I was doing rounds around 11:00 PM. I saw R1 with a board covering her head, the board was sideways and covering

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R1's left face and head. I told the roommate to use call light for help. I called V15 , another nurse for help, and we removed the board. The board had round buttons on it, and it left blanches (white areas) on R1's face. I put ice on face (the). The blanches went away and the face became red, I don't remember if it was swollen. I texted the DON (Director of Nursing) around 12:28 AM. I texted the doctor (V12) around 6:00 AM when I saw a blister on her face. V12 MD (Medical Doctor) texted back to do facial x-rays. I did not speak to the doctor. I called the family around 7:00 AM before I left. I gave a report to the morning nurse about the x-rays My shift was over, and I left.

On 3/14/19 at 9:45 AM via telephone V12 Medical Doctor and Primary Care Physician for R1 stated; R1 was a long term resident at this facility. The facial cellulitis and facial swelling was most likely caused by the incident involving the head board falling on her. She probably had a small skin cut which allowed bacteria in and caused the cellulitis. R1 went back to the hospital about a week later for shortness of breath. She was diagnosed with pneumonia, which caused the septic shock and her death. The family decided to put her in Hospice during this time. The facial cellulitis did not have anything to do with her death.

On /3/12/19 at 1:30 PM V4 Nurse Consultant sated; R1 could not have removed the upholstered inset herself, R1 needed help with all ADL's (Activities of Daily Living). R1 required assistance to move in bed and get out of bed. R1's roommate also would not be able to remove the insert. She was bed bound. We have no idea how this happened.

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On 3/12/19 at 12:50 PM with V5 Director of Maintenance observed R1's former room where the decorative wall headboard fell on R1 . There is a wood frame on the wall behind the bed. The upholstered inset is missing. There are nine round areas approximately one inch across within the wood frame, that look like adhesive. There is a hole in the wall, approximately 3/4 of an inch across near the bottom of the wall, there is no stud (wood support) exposed.

On 3/12/19 at 12:45 PM V5 Maintenance Director stated; the upholstered board that's on the wall behind the bed fell on R1. I went to R1's room the morning on 2/27 /19 at about 6:00 AM, it was leaning against the wall. There was one nail approximately 2 inches long still attached to the board. There were three nails on the floor behind the bed. It appeared to be attached originally with four nails and some type of adhesive on the back. The hole in the wall is where one of the bottom nails was. I don't check the wall insert boards per se. I do a general room check every two weeks, when I check the light bulbs. I rely on the housekeepers and nurses to tell me if there is a problem. I do not know how this happened. The insert should have fallen straight down. This is the first time this has happened. I checked all the rooms after this happened, and a couple of rooms had loose wall insert head boards, I fixed them with additional adhesive. There are 99 decorative wall inserts in the building. They are 3 feet 8 inches long and 3 feet 5 1/2 inches wide, they weigh 24.4 pounds. They were installed about 10 years ago by a contractor, I did not install them.

The facility policy titled, Maintenance dated 2/20/17 documents; It is the facility policy to maintain equipment and the building. Procedure

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S9999	Continued From page 5 1. All resident care equipment and the building environment will be maintained by the maintenance department. (B)	S9999		