STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009856	A. BUILDING: _____ B. WING _____	C 02/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WENTWORTH REHAB & HCC	201 WEST 69TH STREET CHICAGO, IL 60621

(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
S 000	Initial Comments Complaint Investigation 2080446/IL119329	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210d)6) 300.3240a) 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. 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on observation, interview and record review the facility failed to use safe technique to reposition one (R1) of 3 residents reviewed for falls in the selected sample. This failure affected R1 who was hospitalized with a head injury.

Findings include:

R1 was an 85-year old admitted to facility on 8/15/2019 with diagnoses to include traumatic subdural hemorrhage, schizoaffective disorder, absolute glaucoma and Alzheimer's Disease. R1's mental status was severely impaired as noted in the Brief Interview for Mental Status score of 00 out of 15 dated 8/22/2019. Section G of the Minimum Data Set (MDS) for R1 noted she was a two-person transfer with mechanical lift. R1 was also dependent on staff for all Activities of Daily Living Skills (ADLS).

R1 was a fall risk and fell at facility on 1/15/2020. Fall care plan noted interventions for falls.

Incident report for R1 dated 1/15/2020 noted V4 (Certified Nursing Assistant/CNA) observed the fall as she (V4) tried to reposition R1 in reclined chair. R1 fell and she was observed to be bleeding from the back of her head. R1 was sent to community hospital and expired. The Death Certificate for R1 noted the cause of her death was "Closed Head injury due to Post Fall."

Hospital record for R1 dated 1/14/2020 documented, "Subdural Hematoma with left

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S9999	Continued From page 2	S9999		

posterior scalp laceration with active bleeding. Dried blood in bilateral nares."

On 2/18/2020 at 11:00AM, V2 (Director of Nursing/DON) said R1 sustained head injury when V4 tried to reposition R1 in reclined chair. V2 said they completed an investigation into the incident and V4 was still on suspension for the incident.

On 2/18/2020 at 12:30PM, V4 (via telephone) said she tried to reposition R1 in reclined chair while she stood at the back of the chair. According to V4 the fall happened very quickly. V4 said the back of the chair was not reclined and she locked the back of the chair in the upright position.

On 2/18/2020 at 2:00PM, V5 (Physical Therapy Director) said she could not picture R1 falling backwards if V4 stood at the back of the chair.

On 2/21/2020 at 10:40AM, V8 (Certified Nursing Assistant/CNA), V3 (CNA) and V10 (Restorative Nurse) demonstrated the repositioning of R5 in reclined chair and with a mechanical lift sling on the chair. According to staff present, R1 had a similar reclined chair as R5. It was difficult to complete the task standing at the back of the chair with the back of the chair in the upward position. All staff present said the back of the chair should have been reclined and locked if the staff wanted to stand at the back.

On 2/21/2020 at 11:34AM, V9 (Nurse Practitioner/NP) said R1's fall could have been avoidable if only the staff had used two persons to reposition R1 in the chair. V9 said R1 was a two-person assist for transfers, however, since the resident had limited use of the right arm, the

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S9999	Continued From page 3 staff should have used two persons for safe repositioning. Facility did not present a policy on repositioning of residents in reclined chair. (A)	S9999		