STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003057	A. BUILDING: _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF LAGRANGE PARK, THE	701 NORTH LAGRANGE ROAD LA GRANGE PARK, IL 60526

(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: 2079562/IL129285	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b) 300.1210d)6) 300.3240a) 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. Restorative measures	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 shall include, at a minimum, the following procedures: 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 agent of a facility shall not abuse or neglect a resident. These requirements are not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a hazard free environment, and failed to use adequate supervision and safety devices while assisting a resident to ambulate after receiving a shower. This applies to 1 of 3 residents (R1) reviewed for falls. As a result R1 fell, sustained a left femur fracture and underwent a revision total left knee replacement. The Findings Include: 12/15/20 at 10:15AM, R1 was laying in bed ,with dark red discoloration to the mid right arm. R1 said, "V4 (Certified Nursing Assistant) took me into the shower and gave me a shower. After my shower was complete V4 folded up a blanket, put it on the floor, placed my walker in front of me	S9999		

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S9999	Continued From page 2	S9999		

and told me to walk towards my walker. I told him I can't. He said yes you can. I stood up from the shower chair with the walker in front of me and I got caught on the walker with the blanket on the floor. He gave me a little push to reach the door. My knee buckled under me and I fell. V4 did not use anything on my waist. (No gait belt) I went down on my knee and broke my leg. I had to go to the hospital and I had surgery. I cannot walk now. I worked with V4 (CNA) before, I do not know if he pushed me intentionally. I told him twice I could not walk. I told the hospital what I am telling you."

On 12/15/20 at 10:58 AM, V2 (DON) said V4 (CNA) resigned on good terms. He worked here for two years. V2 said the facility does not have a policy on transferring residents from chair to bed, etc. V4 said the restorative aides will know how to transfer a resident. V2 said she spoke to V4 about the fall and V4 said after the shower R1 became weak and he assisted R1 to the floor. V2 said R1 is a bigger resident. V2 said V5 (Nurse) was in the hallway when V4 yelled for help. V5 came right away and R1 was transferred to bed. V2 said the root cause analysis was weakness. V2 said R1 uses a walker for short distances and a wheelchair to ambulate in the hallway. V2 said R1 told her after the shower she felt weak and V4 was with her and she lost her balance and fell.

On 12/15/20 at 11:40AM, V8 (Restorative Nurse) and V9 (Restorative Nurse) said there is no policy on how to transfer a resident without the use of a mechanical lift. R1 requires extensive assist with activity of daily living skills except eating, meaning 50 % of weight bearing from staff. V8 and V9 demonstrated how a resident should be transferred and said always use a gait

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S9999	Continued From page 3	S9999		

belt.

On 12/15/20 at 11:53AM via telephone, V4 (CNA) said "
After I showered R1, I put the walker in front of her, the wheelchair was on the side. I put a blanket on the floor. The transfer was difficult. Surveyor asked V4 to "explain difficult". V4 stated In the shower, R1 was quite heavy. When she was moving from the shower chair to the walker, she stood and lost her balance and I lowered her to the floor. This was the first time that I ever showered her. I was right behind her and asked her to walk. She could walk a little bit. It would have been easier with two people assisting herV4 stated he had been trained on transfers. " You must use a gait belt and two people if you need it.
She had a gown, shoes and no diaper and I did not use the gait belt and did not use two people. The nurse helped me transfer her from the floor to her bed.

Shower Sheets were reviewed for R1 from 10/20 to 12/4/20. V4 signed that he gave R1 a shower on 11/9/20, 11/11/20 and 12/4/20.

V2 said the root cause analysis was weakness.The Root Cause analysis did not mention the blanket on the floor, no gait belt use, the residents weight or one staff assist.

On 12/15/20 at 4PM V7(Medical Doctor) said "In my 20 years of practice I have never had to call anything in but this once. R1 came into the emergency room and told me she was "shoved" onto the floor after a shower. She was able to give me the aides name. R1 said V4 put blankets on the floor, told her to walk and gave her a shove and she said she fell. The fall

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S9999	Continued From page 4	S9999		

caused a femur fracture. R1 is alert and cognizant, but a heavier resident. Not having two people assist her or using gait belt upon transfer or ambulation could possibly cause the fracture, but a shove can cause a fracture.

On 12/16/20 at 10:11AM via telephone V1(Administrator), V2(Director of Nursing) and V3(Assistant Director of Nursing) were made aware of allegation of R1 being pushed. V1, V2 and V3 stated they were not aware that R1 said V4(CNA) shoved her.

12/16/20 V11 (Facility's Medical Director) said R1 had demineralization around the old hip replacement/knee replacements site and likely osteopenia. The doctor said she placed her hands on the walker why would the aide tell her to walk towards the walker. facility should The doctor began to discuss different scenarios about what occurred in the shower room but did say he was not physically there to see what happened. V11 said R1 was confused about being shoved. Upon informing V11 that R1 informed V7(Medical Doctor) in the emergency room on 12/4/20. On 12/15/20 ,her statement did not deviate when she informed the surveyor. V11 had no response.

Hospital Interdisciplinary Note dated 12/5/20 says" R1 expressed to Emergency Room Physician that when she was attempting to transfer from the shower seat and step to her walker, there was carpeted tile on the ground and she did not feel she could safely step. V4 (CNA) told her she could do it and shoved her from behind causing her to fall. R1 has a new femur fracture."

Hospital Record dated 12/4/20 to 12/11/20 says

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S9999	Continued From page 5 R1 was admitted for distal left femur peri-prosthetic fracture and revision of left TKA (Total Knee Arthroplasty). The record says R1 is an obese resident. The Facility's Shower Sheets, Progress Notes, Minimum Data Set and Physician Orders were reviewed from 10/1/20 to 12/15/20. Summarized R1 sustained a left femur fracture after a shower on 12/4/20. R1 is alert and oriented with Brief Interview for Mental Status Scores of 15 indicating she is cognitively intact. R1 had 7 showers prior to 12/4/20 without injury. The functional status section on the minimum Data Set prior to R1's fall 11/18/20 shows that she was a extensive assist for transfers and bathing with one person physical assist. (A)	S9999		