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
	IL6005904	A. BUILDING: ______ B. WING ______	C 07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR ESTATES NSG & REHAB	18300 SOUTH LAVERGNE COUNTRY CLUB HILLS, IL 60478

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S 000	Initial Comments Complaint Investigation 1994939/IL113736 1994985/IL113783	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 300.1220)b)3) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/13/19

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care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures 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 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or

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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 interview and record review, the facility failed to implement interventions for behaviors resulting in falls, provide supervision to a resident with a history of falls, and initiate an investigation for two falls for one (R3) of 3 residents reviewed for falls in the sample of 3.

These failures resulted in R3 sustaining a hip fracture requiring surgical intervention.

Findings include:

R3 is an 89 year old, non-ambulatory female who was admitted to the facility on 5/20/19 with diagnoses that include anemia, hypertension, urinary tract infection, dementia, major depression and a history of falls. R3 is cognitively impaired per the Brief Interview for Mental Status (BIMS) of 8 indicating impairment per the significant Minimum Data Set (MDS) dated 7/2/19. R3's fall assessments dated 5/20/19, 6/21/19, 6/25/19 and 7/1/19 document R3 to be high risk for falls due to unsteady gait, decreased safety awareness due to impaired cognition and history of falls.

On 7/12/19 at 3 PM, V2 (Vice President of Operations) stated R3 was known to have frequent falls and presented R3's clinical chart from R3's previous facility. The previous facility nurses' notes and social service notes (5/8/19, 5/7/19, 4/5/19, 4/30/19, 4/13/19, 4/10/19, 4/2/19, 4/1/19) document the repetitive standing from wheelchair, wandering/propelling around the

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nursing unit, falling and sustaining lacerations, being very confused and refusing medication. Care Conference note 4/4/19 documents multiple daughters, POA and son were present and the discussion was related to R3's multiple falls. Family stated "She is constantly falling at home and multiple prior facilities. We know she continues to strive to be independent but is not safe. We try to redirect her but she continues to act up."

R3 sustained 2 falls in this facility, one on 6/21/19 and the other on 7/1/19. There was no investigation into each fall.

The 6/21/19 nurses' incident note documents R3 fell in the television lounge. The documentation also includes assessment was done, no obvious injuries and resident refused her vitals being taken. R3 denies pain. Attempts to contact family and physician. Later, an x-ray order obtained. This nurses' note was entered into the computer system on 6/25/19 by V6 (Licensed Practical Nurse/LPN) 4 days after the incident.

On 7/12/19 at 3 PM, V3 (Director of Nursing/DON) stated that V6 failed to document the fall. V3 stated that V4 (Assistant Director of Nursing/ADON) had V6 write a statement on 6/25/19 for R3's fall. V6 has since resigned.

The nurses note 6/21/19 at 11:30 PM documents R3 refusing medications, kicking, screaming, biting and nurse holding her intravenous medication for safety reasons. Nurses' note dated 6/22/19 at 11:30 PM by V6 documents R3 being sent to hospital related to the x-ray results which showed hip fracture. R3 returned to the facility on 6/26/19 with 16 staples to the left hip per restorative note. R3 was in the hospital from

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6/23/19 to 6/26/19.

Nurse Practitioner progress note 7/2/19 documents R3 having surgery to the right hip with nailing and staples for closure.

On 7/15/19 at 12:41 PM, V5 (Certified Nurse Aide/CNA) stated she was assigned to R3 on the evening shift of 6/21/19. V5 stated R3 was propelling herself around the unit in her wheelchair. V5 stated that R3 was continuously trying to stand up from her wheelchair. R3 would use the hall grab bars to stand up from her wheelchair. V5 stated R3 was very agitated and a little combative. V5 stated that V6 and V10 (LPN) were passing medications. V5 stated that R3 stood up from her wheelchair, her knees buckled and she fell to her side. This all happened by the 3rd floor television lounge. V5 stated that she and another CNA (V5 does not recall who the other CNA was) picked R3 off the floor and placed her back in her wheelchair. V5 stated she could not recall if she and the other CNA had their hands on R3 to break R3's fall but added that R3 did not hit her head on the floor. V5 stated she was not questioned about this fall or asked to write a statement.

The facility's incident report dated 6/21/19 documents the fall was witnessed and R3 was agitated and slipped off the edge of the wheelchair landing on her left side. There were no staff statements as to what had occurred or what was witnessed.

Attempts to contact V6 were unsuccessful.

On 7/15/19 at 2:53 PM, V11 (CNA) stated R3 continuously stands from her wheelchair using the hall grab bars and does a side step along the

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hall railings/grab bars. V11 stated that R3 is feisty, hard to redirect and tries to hit the staff. V11 stated that R3 used her wheelchair's foot rest and tried to hit a CNA with it. V11 stated R3 is not understood due to gibberish speech. V1 stated when R3 is agitated and not re-directable, nothing is done. R3 is left alone.

On 7/15/19 at V10 (LPN) stated that R3 is a sundowner and is non-compliant with staying in her wheelchair. V10 stated that R3 will continuously stand from wheelchair and take a few shuffled steps and nurses will assist R3 back to sitting. V10 stated that the footrests on the wheelchair blocks her from going any distance and nurses are able to redirect her.

Nurses' incident note dated 7/1/19 documents at 7:45 AM, R3 is found on the floor wrapped in covers on the right side of the bed. R3's head was resting on a slipper. It was an unwitnessed fall. The facility's incident report documents the same. There was no investigation into the fall.

On 7/15/19 at 12:45 PM, V12 (LPN) stated she recalls finding R3 on the bare floor and asking for a floor mat to put down for R3. V12 stated the bed was in the lowest position about 17 inches from the floor.

On 7/15/19 at 9:10 AM, V3 stated there was no investigation into the 7/1/19 fall for R3.

Review of R3's fall risk care plan 5/30/19 documents the following fall interventions: anticipate and meet resident's needs, ensure call light is within reach, educate resident and family about safety, Physical Therapy to evaluate and treat and review information on past falls and attempt to determine cause of fall. Record

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possible root causes. The fall care plan was updated on 6/23/19 to continue "the at-risk plan," monitor, document and report any signs or symptoms for 72 hours following the fall to the physician, provide activities that promote exercise and strength building where possible and consult physical therapy for strength and mobility.

The facility's policy "Accidents/Incidents/Events - Investigating and Reporting" documents "should you witness an accident, render immediate assistance. Do not move the victim until she has been examined for possible injuries. The nurse supervisor or Charge nurse shall examine the victim and must conduct an immediate investigation of the incident. The following data must be included in the report, such as, the time and date of the incident, the circumstance surrounding the incident, the names of witnesses and their accounts of the incident, the injured person's account, the time the injured person's attending physician was notified as well as the time the attending physician responded with his instructions, the time and date the injured person's family was notified and by whom, the condition of the injured person including vitals and the disposition of the injured and any corrective action taken, follow-up information and the signature and title of the person completing the report. This report must be submitted to the Director of Nursing no later than 12 hours after the occurrence and to the administrator no later than 24 hours after the incident." This policy was not followed.

The facility's policy "Evaluating Falls and Their Causes" documents "the purpose of this policy is to provide guidelines for evaluating a resident after the fall and to assist staff in identifying causes of the fall. After a fall, a resident is

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S9999	Continued From page 7 observed on the floor, nursing staff will record vital signs and evaluate for possible injuries to the head, neck, spine and extremities. When a fall results in significant injury or condition change, nursing staff will notify the practitioner immediately by phone. Nursing staff will observe for delayed complications of a fall for approximately 72 hours after an observed or suspected fall and will document findings in medical record. The documentation will include at least statements about observed signs or symptoms of pain, swelling, bruising, deformity and/or decreased mobility. All incident reports must be completed for resident falls. The incident report form will be completed by the nursing supervisor on duty at the time and submit the report to the Director of Nursing no later than 12 hours after the fall occurs. Identifying the cause of the fall, nursing will begin to identify possible or likely cause of the incident. The Unit Manager or the Director of Nursing should consult with the attending physician or Medical Director to confirm specific causes from among multiple possibilities and document the basis for identifying specific factors as the cause." This policy was not followed. (A)	S9999		