STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009757	A. BUILDING: _____ B. WING _____	C 12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERFRONT TERRACE	7750 SOUTH SHORE DRIVE CHICAGO, IL 60649

(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
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210d)6) 300.1220b)3) 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 300.1220 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	S9999		

Attachment A - Statement of Licensure Violations

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S9999	Continued From page 1	S9999		

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 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, facility failed to implement interventions to reduce the risk of falling for 1 of 3 residents reviewed for falls. This failure resulted in R10 falling to the floor and being transported to the hospital for evaluation and assess to have a left hip fracture.
Findings include:
R10 face sheet documents a date of birth of 6/17/17, making R10, 96 years old. Diagnoses included on Face sheet include: Right Cerebral Vascular Accident, Diabetes, Organic Psychosis, hypertension, Chronic Obstructive Pulmonary Disease, Glaucoma, Dementia, Depression, Left Hip Fracture of femoral neck.
Psychiatry note of 8/5/14 describes R10 as disoriented with impaired judgement. Annual minimum data set of 9/9/14 codes R10 as having a score of 3 out of 15 on the brief interview for mental status. R10 did not identify the correct year, correct month, or correct day of the week. R10 was coded as having behaviors of inattention which fluctuates and continuous disorganized thinking. In addition R10 was coded as having physical and verbal behavioral symptoms(E0200) directed toward others. Potential indicators of psychosis included delusions(E0100). Under

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S9999	Continued From page 2	S9999		

E0500 of the M.D.S presence of identified symptoms was noted to place R10 at significant risk for physical illness or injury.
R10 has 3 documented falls since May: 5/23/14, 7/11/14,9/8/14 and 9/29/14. Incident report for 5/23/14 with time of 7:45 pm indicated R10 fell because she slipped out of wheelchair. The fall was unwitnessed. 7/11/14 nursing note at 6:30 pm states R10 was found in her room on the floor next to her bed. Nursing note was not found for 9/8/14 fall incident. Incident report describes an unwitnessed fall in the hallway at 6:00 pm. The next fall was on 10/18/14 at 4:25 am in her room which resulted in a hip fracture. All reports were faxed to I.D.P.H (Illinois Department of Public Health) with appropriate physician notifications.
R10 fall assessment on 7/11/14, 9/19/14 and 10/18/14 consistently codes her as at risk for falls with a score of 26. The fall screening tool notes Psychiatric/Cognitive/Behavior ' s contributing to risk for fall include: Dementia, depression, physical aggression and resistance.
On 11/7/14 at 4:30 pm E10(nurse, falls coordinator) explained All falls for her were from wheelchair except for 10/18. When in sitting position she is at risk for fall. "
R10 has care plans for behavioral symptoms related to Dementia with goal date of 12/19/14 and falls related to diagnosis of dementia. R10 has problem of " attempting to transfer without assistance " with original date of 10/18/14. The goal for the fall care plan is to keep R10 free from injury related to fall. One approach in the care plan for behaviors is to " intervene when any inappropriate behavior is observed. " Level of supervision required is not addressed in either the fall or behavioral care plan.
R10 had 2 hospitalizations in October . Hospital radiology report with a service date of 10/18/14 notes, " There is an impacted comminuted

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S9999	Continued From page 3	S9999		

intertochanteric fracture of the left femur with medial displacement to the varus deformity. Vascular calcifications are seen. Z2(Admitting Physician) progress note from the hospital with an admit date of 10/31/14 states, " 97 year old African American female nursing home resident recently discharged from hospital fracture left hip as p.o.a(power of attorney)declined surgery ... " Two staff members responsible for care of R10 on 10/18/14 when the fall with fracture occurred were E8(Licensed Practical Nurse) and E9(Certified Nursing Assistant).
Nursing note of 10/18/14 at 4:25 am indicates E8(Licensed Practical Nurse) heard the R10 talking then heard a loud thump. R10 was found on the floor and complained of left thigh pain. Nursing note of 10/18/14 at 4:25 am states R10 body was inspected for injuries, " none were apparent when writer rendered passive range of motion to upper extremities, no c/o(complaints) was voiced. When writer began PROM to lower extremities, resident voiced pain to left thigh. Resident was cleaned and dressed and sat in her chair. " R10 was then sent to the hospital at approximately 8:20 am. Nursing note of 10/18/14 at 6:35 pm documents admitting diagnosis to the hospital was Left Hip Fracture.
E9(Certified Nursing Assistant) was the C.N.A on duty and in charge of R10 when she fell and fractured her hip. On 11/7/14 at 1:30 pm stated, " I had to keep putting her legs back in bed. I would put her back. She kept sitting up in the side of bed, facing towards roommate. Scared me because I didn ' t want her to fall. I have seen her sit on side of bed with no problem. She was sitting so close to foot of bed. Scooted to edge of bed. Twice I went into room to scoop. I don't want to lay down(she said). She didn ' t seem like confused. Not to my knowledge she hasn ' t fallen out of chair before. If had known she had

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S9999	Continued From page 4	S9999		

fallen before then I would have thought of her as unsafe to sit on edge of bed. I would have put her in chair. "
On 12/16/14 at 1:51 pm Z3(Attending Physician) stated, " if someone falls down, need to stay there and call 911, " and " Could cause more damage. Need assessment. With hip fracture can ' t move leg. " R10 was moved to a sitting position after " resident voiced pain to left thigh " according to the nursing note of 10/18/14 at 4:25am. Z3 continued, " It ' s more common sense. They should have said don ' t let her sit up or be there when sitting up alone. Can ' t leave alone. Risk for injury, " and " failed to give adequate supervision. Failed properly assess after fall. "
On 11/7/14 at 4:30 pm (Director of Nursing) stated in regards to R10 behavior, " feet in and out of bed. Should have patient ' s nurse to see if can redirect or see what problem is. Intervention to prevent fall was not adequate. Going in and out of room not enough. "

(A)

Imposed POC

WATERFRONT TERRACE
PLAN OF CORRECTION
12/17/14 SURVEY

F 323

The following Plan of Correction shall also serve as the Facility's written credible allegation of compliance which will be achieved by the stated date of completion.

The Facility reasonably assures that the resident environment remains as accident free as possible.

I. Corrective action for residents identified in the deficiency.

R-1 was reassessed, a new fall risk assessment completed and Care Plan updated.

II. Identifying other residents with potential for being affected and corrective action.

The Facility will provide each resident with the level of supervision that he or she needs at any given time.

Interventions to reduce the risk of falling will be implemented for residents who are at risk of falling.

Residents will be properly assessed after a fall.

III. Systemic changes to reasonably assure deficiency does not recur.

On or before 12/31/14, inservices will be held with appropriate Facility staff. Director of Nursing or her designee will conduct the inservices. The inservices will include: 1) a review of the requirement that the Facility reasonably assures that residents' environment remain as

Attachment B- Imposed Plan of Correction

accident free as possible; 2) a review of the alleged deficiency; and 3) a review of the Facility's policies and procedures regarding falls.

IV. How corrective actions will be monitored.

Charge Nurses and/or their designees will perform spot checks at least weekly to determine level of staff compliance. These will be documented on a Quality Assurance checklist. Director of Nursing and/or her designee will monitor for overall compliance through his general supervision and reports from Charge Nurses an staff compliance.

V. Completion Date: 12/31/14 accepted