STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010367	A. BUILDING: _____ B. WING _____	C 08/26/2021

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CHATEAU NRSG & REHAB CENTER	7050 MADISON STREET WILLOWBROOK, IL 60521

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S 000	Initial Comments Facility Reported Incident of 8/17/2021-IL137377	S 000		
S9999	Final Observations Statement of Licensure Violation: 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 agent of a facility shall not abuse or neglect a resident. These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow care plan interventions to prevent a resident from falling from a wheelchair, while being propelled by facility staff from one area of the facility to another area. This failure resulted in R1 experiencing a fall from her wheelchair and sustaining a scalp laceration requiring closure with sutures, subgaleal hematoma, and acute fracture of cervical and thoracic spine vertebrae.	S9999		

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S9999	Continued From page 2 This applies to 1 of 3 residents (R1) reviewed for falls in the sample of 3. The findings include: On August 24, 2021 at 12:09 PM, R1 was sitting in a reclined wheelchair in her room. R1 was wearing a hard plastic cervical collar. R1's bilateral feet were strapped to leg rests on the wheelchair, and R1 was wearing a seatbelt. R1's left arm was contracted at the elbow and wrist and her arm was held tightly to her chest. R1 was using her right arm and hand to frequently reach up to her cervical collar, attempting to remove the collar. A personal caregiver was sitting at R1's right side and frequently reached for R1's right hand to keep R1 from removing her cervical collar. R1 was not able to be interviewed due to her cognitive status. The EMR (Electronic Medical Record) shows R1 was admitted to the facility in December 2019. R1 was recently hospitalized on August 17, 2021 following a fall and returned to the facility on August 19, 2021. R1 has multiple diagnoses including, Parkinson's disease, repeated falls, right humerus fracture, stable burst fracture of the first cervical vertebra, fracture of the fourth thoracic vertebra, unsteadiness on feet, major depressive disorder, dysphagia, difficulty walking, displaced spiral fracture of the shaft of the right humerus, dementia, hearing loss, heart disease, age-related osteoporosis, and abnormal posture. R1's MDS (Minimum Data Set) dated July 5, 2021 shows R1 has severe cognitive impairment, is totally dependent on facility staff for transfers between surfaces and bathing, requires extensive assistance with bed mobility, dressing, and toilet	S9999		

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S9999	Continued From page 3 use, limited assistance by one facility staff member with locomotion on and off the unit, and requires supervision with eating. R1 is always incontinent of bowel and bladder. On June 13, 2021 at 7:45 PM, V9 (RN-Registered Nurse) documented: "[R1] was sitting in wheelchair, being pushed to her room by [V3] (Activity Aide). The resident had her legs raised while being taken to her room and suddenly lowered her feet to the floor, leaned forward and she fell out of her wheelchair. The resident was assisted from the floor with the use of a [mechanical lift] and she was assisted to bed. A head-to-toe assessment was done at that time. There were no new open areas, bruises, lacerations noted on the resident. The resident was able to move all extremities as before the fall. The resident was unable to move the left upper extremity before the fall due to paralysis. The resident denies pain, or discomfort at this time ...." The facility's Fall Root Cause Analysis Form dated June 14, 2021 shows: "Root cause determination: While being pushed by staff, resident put her foot down and came out of w/c (wheelchair). Based on the above assessment and direct observation at the location of the fall, the FMT (Fall Management Team) determines the following new interventions and recommendations need to be implemented: Re-education to staff. Will allow resident to propel own w/c or apply leg rest when propelling w/c for resident." On June 14, 2021 at 1:03 PM, V4 (Restorative Nurse) documented, "[R1] incident reviewed at fall committee meeting. Staff agreed to have a meeting with [V5] (POA-Power of	S9999		

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S9999	Continued From page 4 Attorney/Daughter) and daughter-in-law. Team discussed incident from 6/13/21. Family is going to supply leg rest for wheelchair and restorative team placed a leg rest holder bag on the back of wheelchair for leg rests to be kept when resident is propelling self. Staff will apply leg rest to wheelchair when staff is propelling her. Therapy team is going to continue to work with transfers." R1's fall care plan, initiated December 23, 2019 shows multiple approaches/interventions, including the following approach initiated on June 14, 2021: "Leg rests to be applied to wheelchair before staff propels wheelchair for resident. Replace leg rests in bag in back of wheelchair when resident is propelling self." The facility provided Educational Inservice Sign In Forms for this investigation. On May 22, 2019, multiple facility staff members, including V3 (Activity Aide) were educated and signed the employee attendance for the in-service on the following: "Goals: Residents without leg rests cannot be transported." On June 15, 2021, multiple facility staff members, including V3 were educated and signed the employee attendance for the in-service on the following: "Goals: [R1] now has a bag on the back of wheelchair to hold her leg rest. When she is being transported by staff, she needs leg rest put on and then taken off when she is going to propel by herself." On August 17, 2021 at 9:05 AM, V10 (LPN-Licensed Practical Nurse) documented: "This writer was informed by the activity aide on shift that [R1] had fell forward out of her w/c while in dining area and hit her head. Upon arrival to	S9999		

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S9999	Continued From page 5	S9999		

resident's location, resident was observed on floor on her back. Resident alert/awake with scant amount of blood on floor area right side of her head. [R1] was noted with laceration to the frontal lobe. Direct pressure/ice pack applied to area. Full set of vitals obtained all within resident's normal range. Family notified/aware, MD notified, notified/aware gave orders to send resident out for evaluation. Stretcher accompanied by EMT x 2 with f/u with hospital later for update."

The facility's fall root cause analysis form dated August 18, 2021 shows R1 placed her foot down while being moved in activity.

R1's hospital records show CT (Computed Tomography) Scan Spine Cervical results dated August 17, 2021: "Impression: Acute fracture of the right anterior and posterior arches of C1 (Cervical vertebrae number 1) with mild displacement. Interval worsening of anterior wedging at T4 (Thoracic vertebrae number 4) compared to 6/1/2021. Consistent with acute on chronic compression fracture. Otherwise unchanged examination compared to 6/1/2021."

CT head/brain dated August 17, 2021: "Gas and fluid-filled frontal subgaleal hematoma. No calvarial fracture. No acute intracranial abnormality."

Laceration: 1.5 cm laceration to central superior scalp requiring three sutures to close.

On August 24, 2021 at 11:16 AM, V1 (Administrator) and V2 (DON-Director of Nursing) said, "[R1] was in the hallway after breakfast and going to an activity. The resident was propelling herself to the dining room and [V3] (Activity Aide)

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S9999	Continued From page 6	S9999		

decided to assist her and was trying to push her. [R1] kicks her feet out all the time and so we don't keep the leg rests on the wheelchair. We use the footrests for long distances. This is something we worked out with the family. The distance wasn't far, maybe less than ten feet. We worked with the family prior to her return to the facility. The family has provided a one-to-one sitter for [R1] to prevent [R1] from removing her cervical collar because the hospital reported she was pulling her cervical collar off and the hospital had to restrain her. She has Parkinson's and she has a contracted left arm and the other arm hangs down and [R1] didn't have the ability to put her hands down to break her fall."

On August 24, 2021 at 12:34 PM, V4 (Restorative Nurse) said, "[R1's] family has been very involved in her care. She propels herself and sometimes she scoots herself down in the seat and puts her right leg up in the air and brings it down to get a heel/toe motion to get going. What that has caused is her falling forward out of the chair doing this motion. It was during a transport by facility staff that she put her foot down and she came forward out of the chair. This happened twice in the last few months. We do train the staff to use the leg rests when moving the residents. I think [V3] was just rearranging [R1] in the dining room and I don't know if she thought about putting the leg rests on. We have a policy that people should not be pushed in a wheelchair without the leg rests if you are pushing a resident . I believe it was her thought that she wasn't going far so she didn't know if she should use the leg rests. We did an in-service with all staff back in June 2021 after [R1] fell from the wheelchair while being pushed by the staff. A care plan intervention was put in place on June 14, 2021 to use leg rests when pushing [R1] in the wheelchair, and we had

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S9999	Continued From page 7	S9999		

the leg rests and the bag on the back of [R1's] wheelchair. There were notes posted by us and the family to alert staff. There is a care card is in [R1's] room and it was definitely on her care card before the fall on August 17 to use the leg rests when pushing her in the wheelchair. The bag with the leg rests was actually right there on [R1's] wheelchair when she fell on August 17."

On August 24, 2021 at 1:39 PM, V3 (Activity Aide) said, "I've worked here a long time. The most recent fall was the first one I've experienced with [R1]. I was starting activities around 9:00 or 9:15 AM. I saw [R1] in the hallway and wandering in her wheelchair, propelling herself which is typical for her. I went over to her and I started pushing her into the dining room from the hallway. I pushed her wheelchair about 20 feet. Suddenly, she put her foot down and she started falling forward and I just couldn't stop it. She hit her head on the floor. She couldn't put her hands out to stop her fall because she always holds her left hand up against her chest and can't move that right hand very well. I don't remember being told she needed leg rests on before pushing her. I know there are care cards in the room, but I don't go in the resident rooms, so I never saw the care card with care instructions for [R1]. I would never see the resident care cards. She usually doesn't have her leg rests on because she wanders in the hall. I wasn't thinking about it. [R1] was sitting on a [mechanical lift] sling in her wheelchair. The sling was hanging over the back of the wheelchair and the leg rests were hidden behind the sling. As an activity aide I cannot see the care plan interventions in the computer. We don't get any report from the nurses on the care of the residents."

On August 24, 2021 at 4:19 PM, V5 (POA/Family

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S9999	Continued From page 8	S9999		

Member), V6 (Family Member), and V7 (Family Member) said, "[R1] has had many, many falls at the facility. She had a fall in June 2021 from her wheelchair. A facility staff member was pushing her in her wheelchair without leg or footrests in place and [R1] put her foot down abruptly and she fell forward out of the wheelchair and hit her head. We have had multiple meetings with the facility regarding [R1's] many falls, and it was decided that leg rests would be put on [R1's] wheelchair anytime facility staff were propelling her wheelchair or moving her. We wanted our mom to be able to still have some independence and she loves to self-propel her wheelchair with her legs and feet, so we did not want to take that away from her. The goal was to maintain her independence and keep her safe at the same time. We cooperated fully with the facility to prevent another accident from happening again. We purchased new leg rests for her wheelchair with a bag that was to be hung from the back of her wheelchair, making the leg rests readily available for all staff. We were told all facility staff were given training to ensure leg rests would always be put in place anytime they were moving [R1]. There was never a stipulation during our meetings about the distance she was being pushed before the leg rests would be applied to the wheelchair. The facility ensured us if anyone was pushing the wheelchair, the leg rests would be used. There was even a sign in her room visible to anyone who walked into her room that said to make sure leg rests were used when pushing our mom in her wheelchair. It was understood that if they were pushing her, the leg rests would be put in place. Our understanding was they knew there was a risk and if they pushed her wheelchair without the leg rests, in doing so, it could result in an injury. When they called us on August 17, 2021 and told us she fell

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S9999	Continued From page 9	S9999		

and needed to go to the hospital, we asked for two days for details of what happened. We were finally told she was being pushed by a facility staff member without the leg rests on her wheelchair and she fell forward out of the wheelchair. She required a hospital visit, sutures to her head, has two fractures in her vertebrae, and now needs to wear a cervical collar until the fracture is healed because she wasn't a good candidate for surgery. We had to hire a one-to-one care giver to sit with her to ensure she does not remove the cervical collar since she has dementia and doesn't understand instructions to keep the collar on. It is very sad and disheartening for us as a family to see her go through this."

On August 25, 2021 at 2:42 PM, V12 (Therapy Director) said, "If any facility staff member is to push a resident from one location to another, therapists want to see the wheelchair with the leg rests on. I would tell you to put the leg rests on the anywhere at any time. It's a safety issue."

On August 25, 2021 at 3:02 PM, V1 (Administrator), V2 (DON), and V4 (Restorative Nurse) said during meetings with R1's family, the facility assured the family leg rests would be used whenever facility staff propels R1 in the wheelchair. V1 said at no time did the facility tell R1's family the leg rests would be used for propelling R1 for long distances only.

On August 24, 2021 at 2:41 PM, V8 (Medical Director/R1's Physician) said, "I would absolutely expect the facility to follow their care plan interventions. No nursing home resident should fall and break their bones. The head laceration, head hematoma and the cervical and spinal fractures were most definitely caused by the fall and the facility's failure to apply leg rests to the

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S9999	Continued From page 10 wheelchair before pushing her in the wheelchair." (B)	S9999		