FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: _ COMPLETED IL6010367 08/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7050 MADISON STREET CHATEAU NRSG & REHAB CENTER WILLOWBROOK, IL 60521 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S 000 **Initial Comments** \$ 000 Facility Reported Incident of 8/17/2021-IL137377 S99991 Final Observations S9999 Statement of Licensure Violation: 300.1210b) 300.1210d)6) 300.1220b)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care 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. 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: 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. Attachment A Statement of Licensure Violations Section 300.1220 Supervision of Nursing

linois Department of Public Health

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 09/15/2021 FORM APPROVED

Illinois	Department of Public	Health							FORM	APPROV	ΈD
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION					T/V			
	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:					10	(X3) DATE SURVEY COMPLETED		
			ăi:							С	
		IL6010367	B. WING						08/26/2021		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZII	P CODE						
CHATE	AU NRSG & REHAB CI		ISON STR					Š.			
(X4) ID	CIMMADVETA	WILLOWE TEMENT OF DEFICIENCIES	BROOK, IL	60521		**					
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR LO	ID PREFIX TAG	= (E	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLET DATE	E		
S9999	Continued From page	ge 1	S9999								\dashv
	Services			-						****	
	b) The DON sh	nall supervise and oversee the									- [
	nursing services of t	the facility, including:								}	- (
	3) Develop	ing an up-to-date resident									1
	care plan for each re	esident based on the									- 1
83	needs and goals to l	ensive assessment, individual be accomplished, physician's									ı
	orders, and persona	d care and nursing needs.		1							J
	Personnel, represen	iting other services such as									
	nursing, activities, di	etary, and such other							14		
	modalities as are ord	dered by the physician, shall									
11000	be involved in the pro-	eparation of the resident care be in writing and shall be		- 1127			d mercune			,	23 1
	reviewed and modifie	ed in keeping with the care					24				
	needed as indicated	by the resident's condition		-							
	i ne pian shali be rev	viewed at least every three	200								
	months.										1
a demonstration	Section 300.3240 At	nuse and Negloot		1994 199				139011			
		odde and regiect				d miles				y az zer i ni	2
İ	a) An owner, lice	ensee, administrator,									
	employee or agent of	a facility shall not abuse or									
616	neglect a resident.			100							
i		· 1	W								
	These requirements v	were not met as evidenced									
	by:			-			3 B B				ď
	Boood on observation	22	ĺ								П
ruesta autor	review, the facility fail	n, interview, and record	=:	1=1							1
	interventions to preve	nt a resident from falling		10E 20	50 700	100			NE C	-3	95
1	from a wheelchair, wh	nile being propelled by	2.0								
- 1	facility staff from one area.	area of the facility to another	3						W-		
	This failure resulted in	R1 experiencing a fall from								×	
	her wheelchair and su	staining a scalp laceration	= ==							83	
	requiring closure with	Sutures, subgaleal									
	hematoma, and acute	fracture of cervical and		*							
E	thoracic spine vertebra	ae.									ı

ols Department of Public Health ATE FORM

PRINTED: 09/15/2021

Illinois Department of Public Health FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: _ COMPLETED C IL6010367 B. WING 08/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7050 MADISON STREET **CHATEAUNRSG & REHAB CENTER** WILLOWBROOK, IL 60521 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) **PREFIX** (EACH CORRECTIVE ACTION SHOUL_D BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETE CROSS-REFERENCED TO THE APPRO PRIATE TAG DATE DEFICIENCY) S9999 Continued From page 2 S9999 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

linois Department of Public Health

PRINTED: 09/15/2021

FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ COMPLETED IL6010367 08/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **7050 MADISON STREET** CHATEAU NRSG & REHAB CENTER WILLOWBROOK, IL 60521 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) **TAG** CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 3 S9999 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

inois Department of Public Health

meeting with [V5] (POA-Power of

Illinois Department of Public Health FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED C IL6010367 08/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7050 MADISON STREET **CHATEAU NRSG & REHAB CENTER** WILLOWBROOK, IL 60521 SUMMARY STATEMENT OF DEFICIENCIES (X4)ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5)PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S 9999 Continued From page 4 S9999 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

llinois Department of Public Health

in dining area and hit her head. Upon arrival to

CYHA11

Illinois	Department of Public	Health			FORI	D: 09/15/2021 MAPPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDING	PLE CONSTRUCTION G:	(X3) DAT	(X3) DATE SURVEY COMPLETED C 08/26/2021		
	IL6010367						
NAME OF	PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY	, STATE, ZIP CODE		120/2021	
CHATE	AU NRSG & REHAB C	ENTER 7050 MA	DISON STR BROOK, IL	EET		25	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE OTHE APPROPRIATE	(X5) COMPLETE DATE	
S9999	Continued From pa	ge 5	S9999				
50 80 60 [floor on her back. I scant amount of blo her head. [R1] was frontal lobe. Direct area. Full set of vita resident's normal ra MD notified, notified	resident was observed on Resident alert/awake with and on floor area right side of noted with laceration to the pressure/ice pack applied to als obtained all within ange. Family notified/aware, l/aware gave orders to send		808 M 860 887 887	6 gail	3	
8	resident out for evaluation. Stretcher accompanied by EMT x 2 with f/u with hospital later for update."			8-		施	
	The facility's fall roo August 18, 2021 sho while being moved i	t cause analysis form dated lows R1 placed her foot down in activity.		2 g		50 m.,	
Market of S	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		-47-4-	197 - 197 - 198 - 198 - 198 - 198 - 198 - 198 - 198 - 198 - 198 - 198 - 198 - 198 - 198 - 198 - 198 - 198 - 19	THE REPORT OF THE PROPERTY OF		
s <u></u>	displacement. Intenwedging at T4 (Thorompared to 6/1/202 chronic compression	/al worsening of anterior acic vertebrae number 4) 11. Consistent with acute on	-		14 1000 14 1000		
Historia N	CT head/brain dated	August 17, 2021: "Gas and galeal hematoma. No	3				
	Laceration: 1.5 cm lascalp requiring three	aceration to central superior sutures to close.		8 X H H LELL		13. H	
	said, "[R1] was in the going to an activity. 〕	at 11:16 AM, V1 /2 (DON-Director of Nursing) hallway after breakfast and The resident was propelling oom and [V3] (Activity Aide)	100 E	\$ 5)	£ş		

is Department of Public Health

FE FORM

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY			
ANDRAI	N OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED			
	80					.i.		
IL6010367		B. WING	10		C			
NAMEOE	PROVIDER OR SUPPLIER				<u> U8/2</u>	26/2021		
I AVIAIC OF	PROVIDER OR SUPPLIER			, STATE, ZIP CODE				
CHATE	AUNRSG & REHAB CE		ISON STRI					
			ROOK, IL	60521				
(X4)ID PREFIX	SUMMARY STATE	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)		
TAG	REGULATORY OR LE	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	-DBE PRIATE	COMPLETE DATE		
				DEFICIENCY)		E //		
\$9999	Continued From page	ge 6	S9999					
		· U	-					
	IP17 kicks her foot o	er and was trying to push her. out all the time and so we don't	!	£5 83				
	keen the leg rests of	n the wheelchair. We use the		3				
	footrests for long dis	stances. This is something		THE PART OF THE				
	we worked out with	the family. The distance		***				
	wasn't far, maybe le	ss than ten feet. We worked				1 1		
200200	with the family prior	to her return to the facility.						
	The family has provi	ided a one-to-one sitter for						
	[R1] to prevent [R1]	from removing her cervical						
Y	collar because the h	ospital reported she was						
	pulling ner cervical o	collar off and the hospital had		12.				
	a contracted left orm	has Parkinson's and she has and the other arm hangs				10 4 10 <u>- 4</u> 4 (4)		
	down and IR11 didn't	t have the ability to put her				=		
	hands down to breat	k her fall "						
		The fall.						
	On August 24, 2021	at 12:34 PM, V4 (Restorative				_		
	Nurse) said, "[R1's] 1	family has been very involved		2.		32. 1		
Selection of the	in her care. She pro	pels herself and sometimes		makement services are consistent to the Con-	grow # Service	at the same of parties		
	she scoots herself d	own in the seat and puts her	15	77				
	right leg up in the air	and brings it down to get a				l		
	caused is berfalling	et going. What that has forward out of the chair doing		W 4 9		ve.		
4	this motion It was d	uring a transport by facility		2	-			
12	staff that she put her	foot down and she came		35		N 50 3		
	forward out of the ch	air. This happened twice in			32 - 132	ES		
= %=1	the last few months.	We do train the staff to use			11	100		
	the leg rests when m	oving the residents. I think						
3 J. S.	[V3] was just rearran	ging [R1] in the dining room	23	8		-		
helminterior	and I don't know if sh	ne thought about putting the	Total Control	The transfer of the second sec		and the same		
22	leg rests on. We have	e a policy that people should	8	₩		748		
170	riot de pushed in a w	heelchair without the leg		~ = = = = = = = = = = = = = = = = = = =	10 D			
59	was her thought that	ng a resident . I believe it she wasn't going far so she			200	000000000		
	didn't know if she she	ould use the leg rests. We						
164	did an in-service with	all staff back in June 2021						
	after [R1] fell from the	wheelchair while being				8		
	pushed by the staff.	A care plan intervention was						
	put in place on June	14, 2021 to use leg rests	(m)					
	when pushing [R1] in	the wheelchair, and we had						

illinois Department of Public Health

STATE FORM

PRINTED: 09/15/2021 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ COMPLETED C IL6010367 08/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7050 MADISON STREET CHATEAU NRSG & REHAB CENTER WILLOWBROOK, IL 60521 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 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

ols Department of Public Health

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING: _ COMPLETED IL6010367 B. WING 08/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7050 MADISON STREET CHATEAUNRSG & REHAB CENTER WILLOWBROOK, IL 60521 SUMMARY STATEMENT OF DEFICIENCIES (X4)ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 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

Illinois Department of Public Health

called us on August 17, 2021 and told us she fell

STATE FORM

CYHA11

<u>Department of Public</u>	Health				FOR	M APPROVE	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				(X3) DA	(X3) DATE SURVEY		
		A. BUILDING	8:		COI	MPLETED	
	IL6010367	B. WING		100		C	
NAME OF PROPERTY OF A COURT OF		DDRESS, CITY.	STATE ZIP CODE	<u> </u>	08/26/2021		
U NRSG & REHAB C	ENTER 7050 MA	DISON STRE	ET				
	WILLOW	BROOK, IL	60521				
(EACH DEFICIENC)	/ MUST BE PRECEDED BY CUIT	ID PREFIX TAG	! (EACH COR	RECTIVE ACTION S	HOULD BE	(X5) COMPLETE DATE	
Continued From pa	ge 9	S9999				11.81	
two days for details finally told she was member without the and she fell forward	of what happened. We were being pushed by a facility staff leg rests on her wheelchair out of the wheelchair. She	E .	: a 6	2		i#	
required a hospital two fractures in her wear a cervical collabecause she wasn't We had to hire a on her to ensure she decollar since she has	visit, sutures to her head, has vertebrae, and now needs to ar until the fracture is healed a good candidate for surgery. e-to-one care giver to sit with bes not remove the cervical dementia and doesn't	(0)	#2 ***			je je	
understand instructivery sad and dishea	ons to keep the collar on. It is rtening for us as a family to			to by the second second		and I become the later by	
push a resident from therapists want to se rests on. I would tel	y facility staff member is to one location to another, the the wheelchair with the leg you to put the leg rests on	20 2	e stance	er er en soon en	ent est tipe a segment	- Company	
On August 25, 2021 (Administrator), V2 (in Nurse) said during material facility assured the facility state whenever facility state wheelchair. V1 said	at 3:02 PM, V1 DON), and V4 (Restorative leetings with R1's family, the lamily leg rests would be used for propels R1 in the lating time did the facility tell				·· =	-(A)	
propelling R1 for long	distances only.		fall a		-36 -36,		
Director/R1's Physiciants Expect the facility to found interventions. No number in the facility to fail and break their both the facility in	an) said, "I would absolutely ollow their care plan sing home resident should ones. The head laceration, the cervical and spinal lefinitely caused by the fall		* = ₂₀	- X	4	J 550	
	PROVIDER OR SUPPLIER AU NRSG & REHAB C SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa and needed to go to two days for details finally told she was member without the and she fell forward required a hospital of two fractures in her wear a cervical colla because she wasn't We had to hire a on her to ensure she do collar since she has understand instructiv very sad and dishea see her go through t On August 25, 2021 Director) said, "If any push a resident from therapists want to se rests on. I would tell the anywhere at any On August 25, 2021 (Administrator), V2 (I Nurse) said during m facility assured the fa whenever facility staf wheelchair. V1 said R1's family the leg re propelling R1 for long On August 24, 2021 a Director/R1's Physicia expect the facility to fi interventions. No nur fall and break their bo nead hematoma and fractures were most of	IL6010367 PROVIDER OR SUPPLIER STREET A AU NRSG & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 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	ILEGUISER (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER ROF CORRECTION ILEGUISER PROVIDER OR SUPPLIER STREET ADDRESS, CITY, 7050 MADISON STRE WILLOWBROOK, IL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFKCIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 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 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 laceratio	IL O DEFICIENCIES NOF CORRECTION (X1) PROVIDER STREET ADDRESS, CITY, STATE, ZIP CODE TOSO MADISON STREET WILLOWBROOK, IL 60521 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 9 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 said 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 the anywhere at any time. It's a safety issue." On August 25, 2021 at 3:302 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, nead hematoma and the cervical and spinal ractures were most definitely caused by the fall	INTO F DEFICIENCIES NOF CORRECTION (X1) PROVIDERS UPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE TOPO MADISON STREET WILLOWBROOK, IL 60521 SUMMARY STATEMENT OF DETICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 9 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 the world during meetings with R1's family, the facility assured the family leg rests would be used whenever facility staff propeis 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 all and break their bones. The head laceration, head hematoma and the cervical and spinal fractures were most definitely caused by the fall	INTO E DEFICIENCIES NOF CORRECTION (X1) PROVIDERSUPPLIERCULA DENTIFICATION NUMBER (IL8010367 STREET ADDRESS, CITY, STATE, ZIP CODE TOSO MADISON STREET WILLOWBROOK, IL. 60521 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATION OF OR SIDENTIFINING INFORMATION) COntinued From page 9 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 is to 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 dossn't understand instructions to keep the collar on. It is very said 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, therapiests 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 staff propels R1 in the wheelchair. The plantage of the 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 all and break their bones. The head laceration, head hematoma and the cervical and spinal factures were most definitely caused hy the fall.	

PRINTED: 09/15/2021

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: _ COMPLETED IL6010367 B. WING 08/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **7050 MADISON STREET CHATEAU NRSG & REHAB CENTER** WILLOWBROOK, IL 60521 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE DATE **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S9999 Continued From page 10 S9999 wheelchair before pushing her in the wheelchair." (B)

illinois Department of Public Health

STATE FORM

689

CYHA11

If continuation sheet 11 of 11