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 |
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| | IL6009757 | A. BUILDING: ______ B. WING ______ | C 03/26/2021 |

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

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| S 000 | Initial Comments<br><br>Complaint Investigation 2181779/IL131844 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610 a)<br>300.1010 h)<br>300.1220 b)7)<br><br>Section 300.610 Resident Care Policies<br>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.<br><br>Section 300.1010 Medical Care Policies<br>h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. | S9999 | Attachment A<br>Statement of Licensure Violations | |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
7) Coordinating the care and services provided to residents in the nursing facility.

These regualtions are not met as evidenced by:

Based on interviews and record review, the facility failed to timely review and report the radiology result of a resident's fractured femur to the physician for one (R1) of three residents reviewed for improper nursing care. This failure resulted in a delayed hospital evaluation and treatment for R1's confirmed right femur fracture.

Findings included:

R1 is an 83 year old with a facility admission date of 4/3/19. R1's admission record documents, in part, diagnoses of dementia, muscle weakness and altered mental status. R1's brief interview for mental status (BIMS) score is assessed at 4 which indicates severe cognitive impairment.

On 3/23/21 at 12:43 pm, V3 (Licensed Practical Nurse, LPN) stated R1 is alert, confused, walks "slow and steady" and will toilet herself. V3 stated on 3/10/21, at approximately 7:00 am to 8:00 am, he observed R1 sitting on the floor in her room near the foot of her bed with her legs extended out in front of her. V3 stated R1 was dressed, wearing rubber slip on shoes, and was alert. V3 stated he called immediately for assistance from V7 (Certified Nursing Assistant, CNA) and V8 (CNA). V3 stated he did a full body assessment of R1 by checking her neurological status, asking her to move her extremities, and

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performing vital signs. V3 stated R1 was able to move her legs; however, R1 was not compliant with his commands when he asked her to lift her legs. V3 stated R1 was not able to give a description of what happened and was not in pain. V3 stated he, V7, and V8 transferred R1 back to bed. V3 stated he medicated R1 "prophylactic" for pain because R1 was rubbing her hands on her right knee. V3 stated he called and notified V15 (Attending Physician) of his observation of R1 on the floor, or an unwitnessed fall, and that R1 was able to move her leg, but that he couldn't tell if her leg was broken. V3 stated V15 ordered an X-ray of R1's right knee. V3 stated he documented the telephone order in R1's chart, then called the external radiology company to place the X-ray order and received a claims number for the pending X-ray. V3 stated he also notified V10 (Family Member) of R1's unwitnessed fall.

In R1's nurse's note, dated 3/10/21 at 8:02 am, V3 documented, in part, "(R1) observed sitting on the floor on her buttocks, unable to give description of what happened. Upon assessment, (R1) remain at base line, able to move all extremities without limit ... (V15) made aware with an X-ray to the right knee, claims #34404303."

R1's order summary report, dated 3/10/21, indicates a telephone order for R1's right knee X-ray.

On 3/23/21 at 12:43 pm, V3 stated by the end of his shift at 3:00 pm, R1's X-ray had not been performed yet. V3 stated R1's right knee X-ray wasn't ordered stat, but he "took the initiative to call them (external radiology company) to come as soon as possible." V3 stated he was told that

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the X-ray technician would come as soon as possible but provided no estimated time of arrival. V3 stated he told the on-coming nurse, V4 (LPN), during shift to shift report about R1's pending X-ray to be done, and to notify V15 of the results. V3 stated he also placed this information in the 24 hour report in the electronic charting system, which is reviewed by the nurses each shift.

On 3/23/21 at 4:10 pm, V4 (LPN) confirmed V3 informed him the external radiology company was going to come and R1's right knee X-ray wasn't done yet when he started his shift at 3:00 pm on 3/10/21. V4 stated R1's right knee X-ray was done "maybe at 5:00 pm to 6:00 pm" on 3/10/21. V3 stated X-ray results are sent to the 1st floor receptionist via fax, and then the receptionist pages the nurse after the faxed X-ray results report come into the facility. V4 stated the receptionist only stays at the front desk until 7:00 pm where the fax machine is located on the first floor. V4 stated if the faxed results report don't arrive at the facility before the receptionist leaves at 7:00 pm, then he doesn't have access to the fax machine, so the nurses will "follow up in the next morning." V4 stated when the on-coming nurse, V9 (LPN), came on her shift at 11:00 pm, he didn't have R1's X-ray results and told V9 to "look out for (R1's) results."

In R1's nurse's note, dated 3/10/21 at 8:42 pm, V4 documented, "R (right) knee X-ray completed. F/U (follow up) with (V15) when results are in."

R1's faxed radiology report for a right knee X-ray, with a date of service of 3/10/21 and a report date of 3/10/21 at 7:33 pm, documents an "acute fracture involving right distal femur with modest displacement." V18 (Radiologist) electronically signed R1's radiology report on 3/10/21 at 7:33

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pm. R1's faxed radiology report indicates in large print, "ALERT," under V18's signed results, and the faxed time stamp on this document is 3/10/21 at 8:37 pm.

On 3/24/21 at 12:30 pm, V9 (LPN) stated she worked the 11:00 am to 7:00 am shift the night of 3/10/21 and was R1's primary nurse. When this surveyor asked her about R1's unwitnessed fall that occurred earlier on 3/10/21, V9 stated, "No, (R1) didn't fall." V9 stated R1 slept throughout the night on her shift, performed her vital signs, and she "didn't bother (R1) too much." When this surveyor read V4's nursing note to V9 about R1 having a right knee X-ray done on his shift and to follow up with the X-ray results, V9 stated, "I don't remember that." V9 stated nurses fill out the 24 hour report and make notes for report to next shift's nurse. V9 stated she didn't recall seeing anything in the 24 hour note about R1's pending X-ray results or an unwitnessed fall. V9 also stated X-ray results get faxed to the facility by the external radiology company, and the faxed results report comes in the main office on the first floor. V9 stated there's no receptionist in the main office overnight and the faxed results report will be pending until "the morning shift comes in." V9 stated she did not call the external radiology company to follow up on obtaining R1's right knee X-ray results because she didn't know that the X-ray was taken.

On 3/24/21 at 2:39 pm, V2 (Director of Nursing, DON) stated if an X-ray is ordered and still pending to be performed, the nurse will document the claim number for the X-ray in the resident's chart and on the 24 hour report. V2 stated X-ray results are faxed to the facility's front office, and no receptionist works the in the office after 8:00 pm. V2 stated nursing staff do not have access

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to this fax machine after 8:00 pm. Furthermore, V2 stated nurses can see X-ray results in the resident's electronic chart when it is loaded. V2 stated the external radiology company is electronically linked to the facility's electronic charting system. V2 stated she expects her nurses to be checking for pending results of an X-ray, or they can call the external radiology company for the results.

On 3/24/21 at 1:40 pm, V13 (LPN) stated she had just started her 7:00 am to 3:00 pm shift on 3/11/21, when V16 (Nursing Manager) brought her a report of the X-ray results of R1's right knee showing a fracture. V13 stated, "I didn't know." V13 stated she found out about R1's unwitnessed fall from 3/10/21 when V16 notified her of R1's right knee fracture. V13 said she immediately notified V15 (Attending Physician) and V11 (Family Member). V13 stated she and V16 then prepared R1 for ambulance transport and transfer to the hospital for evaluation and treatment.

In R1's nurse's note, dated 3/11/21 at 8:35 am, V13 documented, in part, "Received X-ray right knee (+) for fracture. (V15) made aware to send (R1) out to hospital for evaluation ... 9:40 am: (Ambulance company) left with (R1) via stretcher accompanied by two attendants."

On 3/25/21 at 10:54 am, V16 (Nursing Manager) stated she is the nursing manager for R1's floor in the facility. V16 stated on 3/11/21, at the start of her shift, she always checks the 24 hour nursing report to see if anything abnormal occurred and checks for any labs or X-rays that were done on her floor within the past 24 hours. V16 stated she noticed an X-ray result for R1 and it showed a fracture of her right knee. V16 stated she printed a paper copy of R1's X-ray results from 3/10/21

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from the facility's electronic charting system, and hand delivered the X-ray report to V13 (LPN). V16 stated she did not work on 3/10/21 when R1 had an unwitnessed fall.

Facility document printed from the electronic charting system documents, in part, the report information for R1's right knee X-ray (order number 34404303) as: "Examination Date: 3/10/21 at 7:10 pm. Reported Date: 3/10/21 at 7:33 pm."

On 3/24/21 at 5:15 pm, V14 (External Radiology Company Personnel) confirmed her company performed an X-ray of the right knee for R1 with a performed date of 3/10/21 at 7:10 pm, and a report date of 3/10/21 at 7:33 pm. V14 stated on 3/10/21 at 7:10 pm is when the technician started "working the case in the facility", and at 7:33 pm is when he "clocked out of case while in the facility." V14 stated the technician submits the X-ray film electronically as he's clocking out. V14 stated the radiologist then can view X-ray film for reading exactly at that instant when the technician electronically sends it. V14 stated the radiologist then reads the X-ray film on his remote screen, and will electronically sign his results, which get sent to the facility. V14 stated the facility can receive X-ray results via two methods. V14 stated the X-ray results come as an electronic file in facility's electronic charting system, and as a faxed paper report to the facility.

On 3/25/21 at 10:11 am, V15 (Attending Physician) stated V3 (LPN) called him on 3/10/21, notifying him of R1's unwitnessed fall. V15 stated V3 informed him R1 was sitting on the floor and R1 complained of a little pain in her right knee. V15 stated he gave telephone orders to V3 to get a right knee X-ray "as soon as possible," to have

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| S9999 | Continued From page 7<br>R1 stay in bed until we get the X-ray report, and to notify him of the X-ray results. V15 stated the next morning (3/11/21), V13 (LPN) called him with R1's X-ray results of a right femur fracture, and he ordered to send her out to the hospital emergency room for further evaluation and treatment of her fractured femur. V15 stated, "We are not equipped to care for fractures in the facility." When this surveyor reviewed the time line with V15 about R1's right knee X-ray being performed on 3/10/21 at 7:10 pm, with it being resulted at 7:33 pm, and then he was notified of R1's femur fracture by V13 on 3/11/21 at 8:35 am, V1 stated he should have been notified of the X-ray results when the report was sent to the facility. V15 stated, "This is important. This is a critical result, and I should have been notified when they (facility staff) received the X-ray report. A resident will automatically be sent out to hospital with a fracture. I am no expert in that (fracture care). That's why we send a resident with a fracture to the hospital to be evaluated and treated."<br><br>On 3/25/21 at 10:54 am, V16 (Nursing Manager) stated the 24 hour report is the nursing shift to shift report. V16 stated when anything happens with a resident within your shift, the nurse must endorse to next nurse on 24 hour report. V16 added nurses can verbally tell next nurse too if it's important. V16 stated she expects all of her nurses to fill out the 24 hour report every time when they are leaving their shift and to read every time when they are coming on their shift. V16 stated then the nurse can't say, "You didn't relay that to me." V16 stated staff nurses can check for X-ray results at any time in the electronic charting system, and nurses should be monitoring for pending results of a completed X-ray. | S9999 | | |

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Facility policy, titled "Change in a Resident's Condition or Status", dated 11/2013, documents, in part: "Policy Statement: Our facility shall promptly notify the ... Attending Physician of changes in the resident's medical/mental condition and/or status. Policy Interpretation and Implementation: 1. If any direct care staff note a change in the residents' condition, they are to notify the nurse. The nurse supervisor/charge nurse will notify the resident's Attending Physician or On-Call Physician when there has been: ... A need to transfer the resident to a hospital/treatment center."

Facility policy, titled "Assessing Falls and Their Causes", dated 10/2020, documents, in part: "Steps in the Procedure After a Fall: 1. If a resident has just fallen, or is found on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spin, and extremities ... 3. If there is evidence of injury, provide appropriate first aid and/or obtain medical treatment immediately ... 5. Notify the resident's attending physician and family in an appropriate time frame. a. When a fall results in a significant injury or condition change, notify the practitioner immediately by phone."

Facility document, titled "Licensed Practical Nurse Job Description" and dated 3/2017, documents, in part: "Job Title: Licensed Practical Nurse. Supervised by: Director of Nurses. Job Summary: Assesses, plans and implements the person centered nursing care of residents within the skilled nursing setting. Responsible for ensuring continuity of care of the residents between shifts by providing direct care as well as supervising the care given by CNA's and supported staff members ... Duties and Responsibilities: Demonstrates Competency in

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| S9999 | Continued From page 9<br>the Following Areas: ... Assesses the resident's condition and nursing needs, prescribes appropriate nursing action ... Ability to interpret results of waived tests; take appropriate action on waived tests results ... notifies physician of changes in resident's condition and follows through until appropriate action is taken ... gives a thorough report to oncoming shift by participating in walking rounds and documenting appropriately on calendar for upcoming needs ... consistently follows the policies and procedures of the facility."<br>(A) | S9999 | | |