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
	IL6009625	A. BUILDING: _____ B. WING _____	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF SKOKIE, THE	9000 LA VERGNE AVENUE SKOKIE, IL 60077

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S 000	Initial Comments Annual Licensure and Certification Survey F 689 G cited	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1 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. 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 300.3240 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 Regulations were not met as evidenced by: Based on observation, interview and record review the facility failed to develop fall prevention interventions to include supervision to reduce or prevent the risk of falling for 1 resident (R55) reviewed for supervisions and fall preventions. This failure resulted in R55 having multiple falls with injury resulting in treatments at the local hospital for nasal bone fracture, non-displaced fracture of the third cervical vertebra, and injury to	S9999		

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S9999	Continued From page 2 right upper extremity. Findings include: On 4/27/21 at 10:00am, R55 is up in the wheelchair in the corner of her room doing coloring using her left hand. She is alert and oriented to self but does not speaks English. She has right arm sling which not properly placed. The sling is not supporting the right elbow. She has right arm bandage which is loose and falling. She does not have 1:1 supervision/sitter. Her room is 3 rooms away from the nursing station. On 4/27/21 at 11:30am, Heard R18 (R55's roommate) yelling for help for R55 in the hallway. Observed R55 on the floor on her right side in front of her wheelchair with V2 DON (Director of Nursing) and V17 Restorative Aide /Certified Nurse Assistant (CNA). Surveyor left the room for the staff to assess R55. R55 was sent out to the hospital for evaluation via 911. On 4/27/21 at 4:49pm Telephone interview with V4 Family member stated that he is concern of R55's frequent and numerous falls since admissions. He is notified of fall incidents occurred but was not informed of plans to prevent from falling. R55's medical diagnosis listed in part as: Muscle wasting and atrophy, Fracture of nasal bone, Difficulty walking, Unsteadiness of feet, Abnormality of gait and mobility, Lack of coordination, Encephalopathy, Age related osteoporosis. R55's admission Fall assessment dated 2/19/21 score of 10 indicated high risk for fall. R55's Fall incident reports indicated:	S9999		

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S9999	Continued From page 3 4/27/21- 11:15am R55 was sitting on her bedside wheelchair coloring an activity book with no concerns. Around 11:30am writer (V2 DON) rushed to R55's room after roommate called for help in the hallway. Observed R55 sliding slowly away from her wheelchair and falling o her right side with her forehead hitting the floor. Noted mild jerking movements on her upper body and a loss of consciousness for 5 seconds. R55 unable to give description. Head to toe assessment was done. No visible injuries noted. Neuro vital signs intact. Breathing well, no apparent distress. No incontinence, changes in ROM or complaint of pain. R55 became responsive after 5 seconds and was able to answer simple yes/no questions. 911 paramedics came and evaluated R55. Primary Care Physician notified and gave order to send to Emergency Room hospital for further treatment and evaluation. V4 Family member notified. Post incident investigation dated 4/27/21 completed by V8 Restorative Nurse indicated : Unwitnessed fall with injury. 4/27/21 at 11:15am. R55 was observed sliding slowly from her wheelchair and falling on her right side with her forehead hitting the floor. R55 was noted with mild jerking movement on her upper body and a loss of consciousness for 5 seconds. Interventions to address incident: R55 will have a sitter and will be moved to a room closer to the nurses' station for close monitoring. R55 will continue to get skilled therapy for PT/OT and restorative exercise for upper and lower extremities strengthening. R55 will continue to have bed/chair alarm to alert staff for unassisted transfer. Will refer to Physician to obtain and monitor lab/diagnostic work to check blood levels. Hospital discharged instruction dated 4/27/21 indicated: Diagnosis: Closed head injury, initial encounter; Other closed nondisplaced fracture of	S9999		

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third cervical vertebral, initial encounter.
Facility sent initial incident report to IDPH on 4/28/21 .
R55's fall assessment dated 4/27/21 score of 20 indicated high risk for fall.
4/17/21 Fall incident report- At 12:30am R55 pulled the call light and CNA responded to the call light. R55 was sitting on the edge of her bed and she requested CNA to take her to the washroom. CNA was getting the wheelchair to R55, meanwhile R55 became restless and stood up from her bed and resident lost her balance and fell on the floor. R55 hit her face on the floor and started bleeding from her nose and mouth. Nurse applied pressure to her nose and cold pack to control bleeding. Neuro check initiated. 911 called immediately.
Post incident investigation dated 4/17/21 completed by V8 Restorative Nurse indicated: Unwitnessed fall with injury. 4/17/21 at 12:30am, R55 requested CNA to take her to the washroom at around 12:30am, became restless and stood up from her bed and lost her balance, fell on the floor, hit her face on the floor. Alert and oriented x 1, confused, difficult to redirect, with impaired cognition. Interventions to address incident: R55 will have a sitter for close monitoring. R55 will have a sitter for close monitoring. R55 will continue to use a bed/chair alarm to alert staff for unassisted transfer. R55 will continue to get skilled therapy for PT/OT. On 4/22/21 Sitter discontinued as indicated in care plan.
Hospital discharged instruction dated 4/17/21 indicated: Diagnosis: Closed head injury, initial encounter; Closed fracture of nasal bone, initial encounter; Elbow injury, right, initial encounter.
Facility sent final incident report to IDPH indicated: Final investigation/Conclusion: Based on staff and resident interview, there was no abuse that took place. R55 was witnessed

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attempting to stand independently, lost balance and fell forward. R55 sustained a fracture to her nasal bone and came back with a sling on her right arm due to questionable fracture on the right elbow. X-ray as performed on 4/22/21 confirmed no fracture of dislocation on the right elbow. R55 was taken to hospital on 4/17/21 and was sent back to the facility that same day. Denies any pain. Care plan updated and interventions in place.
R55's Fall assessment dated 4/17/21 score of 17 indicated high risk for fall.
3/14/21 Fall incident report- 1:45pm Nurse was at the nursing station documenting when a staff member approached and stated that R55 was on the floor, immediately the nurse rushed to the R55's room and observed her laying on the floor in a prone position. Bleeding noted from both of her nostrils. R55 unable to give description. Nursing assessment done. Vital signs done. Pressure applied to the nostrils, ice pack, applied to control bleeding. 911 called per facility's protocol. R55's primary care physician notified. R55's emergency contact notified. DON made aware.
Hospital discharged instruction dated 3/14/21 indicated: Diagnosis: Closed fracture of nasal bone, initial encounter.
Post incident investigation dated 3/15/21 completed by V8 Restorative Nurse indicated: Unwitnessed fall with injury. 3/14/21 at 1:45pm, Resident was observed by staff laying on floor in prone position beside her bed. Alert and oriented x 1, confused, difficult to redirect with impaired cognition. Interventions to address incident: R55 will place by the nurses' station once up in the chair for close monitoring. R55 will continue to have bed/chair alarm to alert staff for unassisted transfer.
R55's Fall assessment dated 3/14/21 score of 21

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indicated high risk for fall.
2/23/21 Fall incident- 12:21pm R55 was observed on the bathroom floor laying with her head on the floor. The roommate said she fell backwards and hit her head on the floor. Resident unable to give description. Head to toe assessment done, noted minimal bruise with mild bleeding on the back of the head. ROM (Range of Motion) within baseline. 911 called. R55 is alert and oriented x 1. Confused and forgetful. Vital signs checked and recorded as T-97.9, RR-18, BP-117/72. R55 was assisted by 2 staff back to her bed via Hoyer lift. Pressure applied on head with gauze. Primacy care Physician notified and sent R55 to hospital. POA (Power of attorney) and DON notified.
Post incident investigation dated 2/23/21 completed by V8 Restorative Nurse indicated: R55 was observed in the bathroom floor, laying with her head on the floor. Alert and oriented x 1, confused and forgetful, R55 requires assistance in all her ADLs (toileting), should be in wheelchair for locomotion. Per roommate, she fell from the back and hit her head on the floor. Interventions to address incident: Sent to hospital for evaluation. R55 will use an ultra-low bed and bed/chair alarm upon return from the hospital to alert staff for unassisted transfer. R55 will be picked up for skilled therapy (PT/OT/ST). Requested for Fall assessment after fall incident on 2/23/21. No document given.
R55's Fall Care Plan initiated 2/23/21 indicated: 3/15/21- R55 will stay at nurses' station once up in chair for close monitoring. 4/17/21- R55 will have a sitter for close monitoring. She will continue to use bed/chair alarm. 4/22/21- Sitter discontinued. She will continue to get therapy for PT/OT and also with Restorative program/exercise for UE (upper extremity)/LE (Lower extremity) strengthening.
Care plan intervention was not implemented. On

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S9999	Continued From page 7 4/27/21, R55 fell in her room. She is not placed by nursing station once up for close monitoring as indicated in her care plan dated 3/15/21. On 4/28/21 at 9:54am, Observed R55 up in wheelchair in the corner of her room with right arm sling not properly placed. The right elbow is not supported with the sling. V5 Resident Escort stated she is sent to watch her 1:1 since 7:30am. R55 has medical appointment today. On 4/28/21 at 10:15am, V6 Activity Aide translated conversation with R55 and R18. R55 stated that she has pain in her both arms. She stated she stood up and the wheelchair moved, and she fell. R18 (R55's roommate) stated that R55 dropped her coloring pen, she tried to stand and pick it up. She instructed her not to stand up, but she does not listen to her . She called for help. Both R55 and R18 stated it happened during lunch time. On 4/28/21 at 12:13pm, V7 Therapy Supervisor/Occupational Therapist stated that she has treated R55 for occupational therapy for Certification period of 2/22/21 to 3/23/21 and 4/20/21 to 5/19/21. She did her initial evaluation on 2/22/21. She needs minimal assist for ADLs except toileting and bathing she needs moderate assistance for 1 person. Per record review, she lives with family at home. She ambulates with walker at home with supervision. She is high risk for fall due to poor cognition and impaired safety awareness. She had a fall incident on 2/23/21. After each fall incident Restorative nurse informed therapy to evaluate for changes in functional mobility. She was seen by PT and OT on 2/25/21. She is ambulating 20-30ft with minimal assist. No changes in assistance for hygiene and grooming. She had another fall on	S9999		

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3/14/21 causing nasal bone fracture. She was seen by PT and OT on 3/17/21. No changes in mobility. On 3/19/21, she added to her goal of locking her wheelchair because V8 Restorative nurse reported that from previous fall investigation indicated that R55 stood up without locking her wheelchair that causes her to fall. She was recertified for skilled therapy services for 3/24/21 to 4/22/21. R55 had another fall on 4/17/21 causing fractured right elbow. She was re-certified again on 4/20/21 to 5/19/21. R55 demonstrated significant functional decline after the fall resulting in fracture in RUE (right upper extremity) and inability to use RUE for assistance in functional mobility. She was progressing toward goals prior to fall but due to limited use of RUE, she is now requiring more assistance. Her functional assessment decline in the following areas: Bed mobility (from contact guard assist to moderate assistance), Transfer (from minimal assist to maximum assist), Ambulation (from walking 60 feet with minimal assist to 5 feet maximum assist). Hygiene to moderate assist. Toileting (from minimal assist to maximum assist). Dressing (from minimal assist to moderate assist).
R55 remains a high risk for falls. She (V7) has not spoken to a family member of R55 regarding her progress or decline due to recent falls. She stated that usually nursing staff talk to the family. R55's therapy notes for 3/19/21 indicated goal upgrade: R55 will demonstrate ability to lock brakes with moderate assist and 75% verbal cues for initiation of tasks. Certification period 4/20/21 to 5/19/21 Physical therapy updated plan indicated: Summary of skilled services Patient progress: R55 demonstrates significant functional decline s/p fall resulting in fracture in RUE and inability to use RUE for assistance in functional mobility. R55 was progressing towards goals prior

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to fall but due to limited use of RUE, she now requires more assistance. Bed mobility- Moderate assistance, Transfers- Maximum assistance and Ambulation- Maximum assistance.

On 4/28/21 at 12:48am, V8 Restorative Nurse/Fall Coordinator stated that a Fall assessment is done upon admission and after each fall incident. V8 does the Fall investigation and root- cause analysis. V8 updated the resident's individualized care plan based on root cause analysis to prevent from future falls. Care plan meeting with resident (if applicable) and family member to discuss plan of care to prevent future falls. V8 stated she spoke with R55's brother but did not document. V8 cannot recall date of conversation. She stated that she does need to call the family member for new fall prevention intervention after each fall. She stated that she updated R55's care plan after each fall. The sitter was discontinued on 4/22/21 but resident remains on therapy for PT/OT and Restorative program/exercises for UE (Upper extremities) /LE(lower extremities) strengthening. V8 did the fall investigation incident yesterday and implemented new interventions. She stated that fall could be prevented by providing a sitter and moving closer to the nursing station. V8 stated that she has not called or spoken to family regarding new interventions. Review R55's POS and care plan indicated that she is on AROM (active range of motion) program for bilateral upper and lower extremities. Nursing Rehab log indicated that from 4/17/21 to 4/27/21 AROM was done to both upper extremities. R55 has right arm sling due to right elbow injury secondary to fall incident on 4/17/21. She stated that she has not updated the POS (Physician order sheet) and care plan. AROM cannot be done on right upper

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arm due to fracture and need to be immobilized. V9 Restorative Aide only performed it on Left upper arm. Review of R55's Restorative program log dated 4/27/21 done at 12:10pm for both walking and AROM. R55 had fall incident on 4/27/21 at 11:15am in her room and was sent out to the hospital. She stated that V9 RA did the exercises in the morning but documented in the afternoon.

On 4/29/21 at 9:43am, Follow up request to V1 Administrator and V2 DON documents requested for R55 and policies from yesterday including the 1:1 monitoring log for R55. She stated she will ask V8 Restorative Nurse.

On 4/29/21 at 10:29am Observed R55 up in wheelchair in the corner of her room with right arm brace. V5 Resident Escort/Sitter at bedside stated that the ortho doctor applied it yesterday when they went for medical appointment. She stated that she is assigned to monitor R55 today since 7:10am. Observed 1:1 monitoring log every hour binder started on 4/28/21 at bedside. V6 Activity Aide translated conversation with R55. R55 stated that she has pain on both arms but more pain on right upper arm and rubbed her right upper arm.

On 4/29/21 at 1:50pm Interview with V8 Restorative Nurse at 2nd floor Nursing station. She stated that she did not have the monitoring log for R55 for 4/17/21 to 4/22/21, she just started the monitoring 1:1 log yesterday. Asked V8, for the list of residents on high fall risk or residents on fall prevention program in the unit to communicate with the staff. She stated she does not have the list on the unit but it's in her office. Requested copy of policy of fall prevention program. She stated the V2 DON has the policy.

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S9999	Continued From page 11 On 4/29/21 at 2:08pm, Follow up request for R55's documents and Facility's policy on fall prevention program. She stated they don't have Fall prevention program policy. That corporate only gave her a Fall occurrence policy. On 4/29/21 at 2:15pm Telephone interview with V10 Pyschiatrist, she stated that she has been seeing R55 regularly since admission. She is aware that she is high risk for falls and has multiple episodes of falls. She is not aware that 1:1 supervision/ sitter was discontinued on 4/22/21 as indicated in care plan. She is not aware that R55 has another fall on 4/27/21. She has not spoken to R55's family member and R55's Primary Care Physician. She stated fall could be prevented if she is on 24-hour supervision/1:1 monitoring /sitter. She is very impulsive. If they continue the 1:1 supervision/sitter she could be monitored, watched closely and fall could be prevented. R55's progress notes indicated V10 Psychiatrist visits and documentation on the following dates: 3/15/21- Plan: 12. Fall precautions: she fell over the weekend and was sent to the hospital, found to have nasal fracture, she has to see ENT in this regard. Fall precaution per facility protocol. PT, OT to improve strength, frequent visit by staff and call light within reach. 3/22/21- Plan: 12. Fall precautions: she fell over the weekend and was sent to the hospital, found to have nasal fracture, she has to see ENT in this regard. Fall precaution per facility protocol. PT, OT to improve strength, frequent visit by staff and call light within reach. 3/29/21- Plan: 12. Fall precautions: she fell over the weekend and was sent to the hospital, found to have nasal fracture, she has to see ENT in this regard. Fall precaution per facility protocol. PT,	S9999		

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S9999	Continued From page 12 OT to improve strength, frequent visit by staff and call light within reach. 4/12/21-Plan: 12. Fall precautions: denies any pain in the nasal fracture area. Fall precaution per facility protocol. PT, OT to improve strength, frequent visit by staff and call light within reach. 4/19/21- Plan: 12. Fall precautions: Recurrent fall, fall precaution per facility protocol. She has sitter. Patient suffers from right arm fracture, no records available for review. Sling and ortho appointment on 4/28/21 she also has auto laryngology consult for recent nasal fracture. 4/26/21- Plan: 12. Fall precautions: Recurrent fall, fall precaution per facility protocol. She has sitter. Patient suffers from right arm fracture, no records available for review. Sling and ortho appointment on 4/28/21 she also has auto laryngology consult for recent nasal fracture. Facility's Fall Occurrence policy revised date 8/5/2020 indicated: Policy statement: it is the policy of the facility to ensure that residents are assessed for risk for falls and interventions are put in place to prevent them from falling Procedure: 8. The Fall coordinator will add the intervention in the resident's care plan Facility's Care plan policy revised date 8/5/2020 indicated: Procedures: These will be periodically reviewed and revised by a team qualified person after each assessment. (B)	S9999		