STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003875	A. BUILDING: _____ B. WING _____	C 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKPOINTE HEALTHCARE & REHAB	1223 EDGEWATER MORRIS, IL 60450

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 2178757/IL140662	S 000		
S9999	Final Observations Statement of Licensure Vilolations: 300.1210 b) 300.1210 d)6) 300.2900) d)2) 300.3100 d)2) 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 300.2900 General Building Requirements Section 300.3100 General Building Requirements d) Doors and Windows	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the safety of a resident who is known to wander. This failure resulted in the resident falling down a stairwell with her wheelchair and sustaining fractures to her clavicle and ribs. This applies to 1 of 3 residents (R1) reviewed for fall with significant injury. The findings include: R1's Electronic Medical Record (EMR) shows diagnoses of vascular dementia with behaviors, generalized anxiety disorder, and repeated falls. R1's September 7, 2021 Minimum Data Set (MDS) shows R1 has severe cognitive impairment and requires one staff physical assistance for locomotion on the unit. The same MDS shows R1 was not steady on her feet, had functional impairment of both legs, and requires the use of a wheelchair. R1's care plan for wandering (revised 01/07/2021) shows R1 "is a wanderer related to impaired safety awareness and wanders aimlessly ..." Interventions for the same date on	S9999		

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S9999	Continued From page 2	S9999		

the care plan include "Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something?..." Another intervention on the care plan showed "disguise exit: cover doorknobs and handles, tape floor ..."

R1's risk for falls care plan (revised 06/20/2019) shows she is at risk for falls related to confusion, an intervention dated 09/17/2018 shows to "encourage resident to stay in high visible areas ..." R1's care plan from an actual fall on 03/03/2020 (initiated 03/03/2020) related to poor balance, poor communication/comprehension, and unsteady gait showed an intervention from the same date as "observe for unsafe situations ..."

R1's November 13, 2021 fall/incident note from 4:51 PM showed R1 reported she "was looking for [husband's name] ... I thought he was down here." R1's Vitals note from November 13, 2021 at 7:56 PM shows R1 was admitted to the area hospital with an observational diagnosis of left distal clavicle fracture and left rib fracture.

On November 29, 2021 at 12:01 PM, V5, CNA (Certified Nurse Assistant), reported V5 was working on Saturday November 13, 2021, when R1 fell down the stairs. V5 stated around 3:30 PM, V5 helped another resident to her room and asked V4, RN (Registered Nurse), to help her with cares. V5 stated when V5 left that resident's room, V5 noticed one pole from the makeshift covid unit doorway was on the floor, and a second pole was also on the floor past the doorway, in the middle of hallway. (The makeshift doorway separated the current resident rooms from what would be covid rooms, if there had been residents with covid.) V5 stated V4

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S9999	Continued From page 3	S9999		

checked all those empty covid rooms and bathrooms, even though all the doors were closed, to see if there was a resident in any of the rooms. V5 stated V5 did not find anyone, but then could not find R1 when she checked on V5's residents.

V5 stated V5 checked the other unit for R1 because R1 liked to wheel herself all over. V5 stated R1 was kind of a wanderer, but the staff there reported they had not seen R1. V5 stated R1 would at times wander over to the other unit, and during covid, R1 would open the heavy door to leave her unit, and then open the heavy door to enter the other unit, and R1 was able to do it all by herself.

V5 stated V5 rechecked all the rooms and bathrooms again on the empty "covid unit" hall. V5 stated when V5 came all the way to the very end, V5 noticed the green light on the egress bar was flashing green (meaning the door was not armed). There was no alarm going off, but V5 opened the stairwell door and she saw R1 laying on the landing. R1's wheelchair was tipped forward, but had stopped on the second or third step of the stairs. V5 stated V5 called for the nurse (V4).

On November 29, 2021 at 1:57 PM, V4, RN (Registered Nurse), stated V4 was finishing some charting on R1's unit around 3:30 PM on November 13, 2021. V4 stated V4 assisted V5 with another resident, then stayed with the resident and talked after V5 left. V4 stated a short while later, V4 heard V5 screaming something like, "Help she fell down the stairs!" V4 stated V4 left the room and saw the covid unit curtain was collapsed and a pole in the middle of the floor. V4 stated when V4 got to the

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emergency door at the far end of the hall, R1 was holding on to the stairway railing while lying on the stair landing. V4 described V4's assessment of R1, and stated R1 told V4 R1 was looking for R1's husband. V4 stated when paramedics arrived, they placed R1 on a stretcher and R1 was transported to an area hospital.

The facility's November 19, 2021 Final Reportable of R1's fall showed R1 was admitted to a local hospital with diagnoses of a left clavicle fracture and a left rib fracture.

On November 29, 2021 at 1:57 PM, V4 stated R1 on any day can be seen wheeling herself independently on the unit. R1 will even go to the end of the hall towards the nurses' station, leave the unit, and enter the other unit on R1's floor. R1 could open the heavy metal doors by herself. V4 stated if they needed R1 and R1 wasn't in R1's room or on R1's unit, R1 could be found on the other unit. R1 was a very determined individual, and most days R1 thought R1's husband was on the other unit. V4 stated R1 was admitted to the hospital and diagnosed with a left fractured clavicle and left side fractured 8th and 9th ribs.

On November 24, 2021 at 4:29 PM, V10 (RN) reported R1 seemed to be obsessed with the plastic curtain, describing it as two poles that went from the ceiling to the floor with a zipper in the middle. V10 reported R1 was strong enough and capable of getting past the curtain and being able to open the door. R1 would go to the other end of unit past the nurses' station, open the heavy metal door, and enter the other unit on this floor.

On November 29, 2021 at 12:13 PM, V3 (Maintenance Director) reported every morning

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S9999	Continued From page 5 Monday through Friday, either V3 or V6 (Maintenance Personnel) will go door to door and press the egress bar, listen, ensure the door beeps for 15 seconds, open the door to trigger the alarm, then close the door. V3 stated, "We have to use a key and turn it to the left to turn the alarm off, and then turn the key to the right to reset alarm." V3 stated a steady green light means the alarm is armed (on), and a flashing green light means the alarm has been disarmed. "If someone opened the door without entering the code, and the door closes, but no one resets alarm, the alarm will at some point turn off, and the light will flash green until someone uses the key to reset it or turn on the door alarm. If the alarm is disarmed, the door can be pushed open without having to hold the bar down for 15 seconds. To reset the alarm, you have to turn the key to the right and then you will see a solid green light; if you turn it to the left, the alarm will be turned off and the light would flash green." On November 24, 2021 at 1:02 PM, V1 (Administrator) reported the egress bar alarms on the emergency exit doors should sound if someone goes through the door without entering the keypad code next to the door. On November 29, 2021 at 2:47 PM, V1 (Administrator) reported the doors were checked every morning by maintenance Monday through Friday, and there was not anyone assigned to check the doors on the weekends. (A)	S9999		