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
	IL6008825	A. BUILDING: ______ B. WING ______	C 09/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN BARR SOUTH LOOP	1725 SOUTH WABASH CHICAGO, IL 60616

(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: 2287131/IL150942	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b)5) 300.1210d)6) Section 300.610 Resident Care Policies 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. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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. These regulations were not met evidenced by: Based on interview and records review, the facility failed to provide adequate and sufficient care for 1 resident (R2) in a sample of 4 residents (R1, R2, R3, R4) reviewed for falls. This failure resulted in R2, a resident who requires two person-assist for bed mobility falling out of bed and sustaining a femur fracture. Findings include: R2's Face Sheet documents resident is a 84 year old with diagnoses including, but not limited to: History of Falling, Spinal Stenosis, Lumbar Region Without Neurogenic Claudication, Acute	S9999		

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Respiratory Failure with Hypoxia, Encephalopathy, Unspecified Chronic Kidney Disease, Unspecified Transient Alteration of Awareness, Adult Failure to Thrive, Acute Kidney Failure, Unspecified Obesity, Unspecified Acute Embolism and Thrombosis of Unspecified Deep Veins of Unspecified Distal Lower Extremity, Presence of Unspecified Artificial Knee Joint.

Facility's Final Reportable (8/17/22) regarding R2's documents in part: On 8/13/22, certified nursing assistant (C.N.A) was providing ADL (activities of daily living) care to R2. Upon turning R2 to the left side, R2's legs and lower body begin to slide off the bed. To prevent R2 from falling to the floor, C.N.A. lowered R2 to the floor while calling for help. R2 complained of left knee pain and prn (as needed) pain medication administered. Doctor notified and ordered R2 to be transferred to the hospital for further evaluation. On 8/17/22 the facility received clinical updates and R2 was noted to have a left periprosthetic distal femur fracture.

On 09/14/2022 at 9:50 am, V2 (director of nursing) stated, "R2 sustained a fall on 08/13/2022 resulting in a femur fracture. R2's fall occurred while a certified nursing assistant was providing ADL care at R2's bedside. The C.N.A. tried to prevent R2 from falling, however, was not successful. R2 had all fall preventative measures in place as per R2's care plan. If a 3 is coded on a resident's MDS for bed mobility, the resident requires at least two CNA or staff members to provide care."

On 09/14/2022 at 12:05 pm, V4 (physical therapy director) stated, on 07/16/22 physical therapy picked R2 up post fall incident (R2 had a fall at

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the facility on 7/15/22). R2 remained at previous baseline of two-person max assist with transfers and bed mobility.

On 09/15/2022 at 10:04 am, V7 (fall prevention coordinator) stated, "R2's second fall occurred on 08/13/22. R2 was in bed, getting ADL care and R2 was positioned properly in the bed. While R2 was getting the care R2's leg dropped over the side of the bed. R2's top leg dropped over R2's lower leg and dropped over the side of the bed. With R2's leg dropping like that, the leg made R2 start sliding out of the bed because R2 has bilateral lower weakness. The C.N.A. who was providing care to R2, went around to the other side of the bed to try and prevent the fall. The C.N.A could not prevent the fall, and instead ended up guiding R2 to the floor. The CNA was not able to prevent the fall, so she guided her to the floor and called for help, staying with R2 the entire time. The floor mats were already at R2's bedside. R2 sustained a left peri-prosthetic distal femur fracture. Due to the density of R2's bones, arthritis and R2's age and previous fractures, R2 sustained a femur fracture. The impact of R2 being led to the floor could have resulted in R2 sustaining a femur fracture. R2 complained of pain and aches in R2's left leg and R2 was sent out to the hospital. In order to implement other post fall interventions, we had to wait till R2 returned from the hospital so that we can assess her, however, R2 never returned.

On 09/15/2022 at 2:17 pm, V3 (restorative director) stated, "Prior to the first fall that took place on 07/15/2022, R2 required extensive assistance with almost everything. R2 required assistance from 2 or more staff members for ADL care and bed mobility. When R2 was receiving ADL care on 08/13/2022, the day that the second

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fall occurred, R2 required 2-to-3-person assistance. When R2 was receiving ADL care due to a bowel movement or bed bath, R2 should have had two CNA's present at bedside for R2's safety. The reason why R2 needed the presence of two CNAs while getting cleaned is because R2 would not be able to help because R2 required extensive assistance. R2 was assessed as being a 3, which means that R2 required the assistance of 2 or more CNAs. I think the assistance of 2 CNAs would have been sufficient. R2 was not able to perform anything independently."

On 09/15/2022 at 2:44 pm, V9 (certified nursing assistant) stated, "I was giving R2 a full bed bath when I noticed that R2's legs started to slide off the side of the bed. I scurried to the other side in an attempt to lessen the impact of R2's fall, while at the same time calling for help. A nurse did arrive and did a full assessment, and we used a mechanical lift to get R2 back into the bed. I was the only C.N.A. that was present while I was giving R2 a bed bath. To my knowledge, R2 was one person assist for bed mobility. R2 requires extensive care, but R2 is a one person assist. I have given bed baths alone to R2 in the past. On 08/13/2022, the day R2 fell was not the first time I have given R2 a bed bath by myself. I was not aware that R2 was assessed as needing the assistance of two or more CNAs for bed mobility. If I was aware that R2 scored a 3 on the MDS for bed mobility, I would not have been giving a bed bath to R2 by myself. I was only aware that R2 required a two-person transfer, that is why I never transferred R2 without a second person. I only remember that R2 was a two person assist for transfers, but I was not made aware that R2 required at least two people for bed mobility, as I have done a bed bath for R2 by myself on many occasions."

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S9999	Continued From page 5 On 09/15/2022 at 3:12 pm, V10 (certified nursing assistant) stated, " R2 required two-person assistance for bed mobility and transfers. I never cared for R2 by myself because R2 was too heavy and too difficult to care on my own. It was not safe to care for R2 by just one person. I never did R2's ADL care by myself I always requested another C.N.A. because R2 was difficult to deal with not only because of R2's increased weakness, but because R2 was sundowning as well." On 09/16/2022 at 12:14 pm, V11 (primary physician) stated, "If the resident is listed on the MDS as two-person assist, R2 should get help from two people. I saw R2 multiple times in the facility. If this resident is assessed as needing assistance from two people, then two people should have been assisting R2 to prevent falls and injury. Having two people assisting a resident who is scored as requiring two people increases the resident's safety." Minimum Data Set Section G (MDS) (dated 04/22/2022) scored R2 as (3) requiring 2-to-3-person physical assistance for bed mobility. M.D.S (dated 07/23/2022) scored R2 as (3) requiring 2-to-3-person physical assistance for bed mobility. Fall Care Plan (dated 07/16/2022) notes R2 is a high risk for falls related to limited mobility, unsteadiness, generalized weakness, decreased sitting stability increased bilateral lower extremity weakness and most recent falls. Fall Risk Assessment (dated 07/15/2022) prior to fall incident on 08/13/2022 scored R2 as (17) a high risk for falls.	S9999		

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Post Fall Investigation (dated 08/15/2022) documents R2 sustained a witnessed fall on 08/13/2022. The investigation documents that the root cause of the fall was due to increased bilateral lower extremity weakness now affecting stability when turning side to side in bed. Resident also failed to identify edge of bed, leading to poor position, destabilizing resident and she was unaware to correct/compensate D/T (due to) weakness.

Progress Note (dated 08/13/2022 at 4:43 pm) documents, "Resident is a/o x 3. Complaining of left knee pain. E. ambulance services pick up resident by stretcher and she was taken to R. hospital with 2 attendants. Son at bedside."

Fall Occurrence Policy (revised 05/17/2022) states that it is the policy of the facility to ensure that residents are assessed for risk for falls, that interventions are put in place and interventions are reevaluated and revised as necessary.

(A)