STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005144	A. BUILDING: _____ B. WING _____	C 09/08/2022

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CLARIDGE HEALTHCARE CENTER	700 JENKISSON LAKE BLUFF, IL 60044

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S 000	Initial Comments Complaint Investigations: 2216973/IL150754 2217089/IL150892 2217071/IL150868	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.690b) 300.1010h) 300.1010i) 300.1210a) 300.1210b) 300.1210c) 300.1210d)3)6) Section 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. Section 300.1010 Medical Care Policies 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 Statement of Licensure Violations	

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S9999	Continued From page 1 i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid procedures. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.	S9999		

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S9999	Continued From page 2 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 are not met as evidenced by: Based on interview and record review the facility failed to provide for a resident's safety dependent on staff for care. This applies to 1 of 3 residents (R1) reviewed for safety in the sample of 10. This failure resulted in R1 sustaining four fractured bones. The findings include: R1's Admission Record (Face Sheet) dated 9/6/22 showed R1's original admission date was 5/31/2015 with diagnoses to include: a stroke with paralysis affecting her dominant side; chronic obstructive pulmonary disease (COPD); and atrial fibrillation (A-Fib, rapid and irregular heart rate.) R1's 7/10/22 Minimum Data Set (MDS) showed she had short and long-term memory problems.	S9999		

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S9999	Continued From page 3 The MDS showed she required extensive assistance from two staff for "Bed Mobility" (turning and positioning in bed.) The MDS showed R1 was totally dependent on two staff for transfers between her bed and chair. R1's Risk for Fall care plan, dated 7/10/22, showed she was a mechanical (crane type) lift transfer, and she uses her wheelchair for mobility. R1's Patient Transfer and Referral Record from 8/30/22 showed at 8:00 AM and 9:00 AM R1 was pale and not feeling well. The record showed R1 had refused breakfast. (Record was signed by V12 Registered Nurse, RN) R1's 8/30/22 at 8:00 AM Nurse's Note showed, the nurse received R1 up in her wheelchair. The note showed R1 requested to return to bed and she was transferred by staff. (No mention of resident being pale or not feeling well.) R1's 8/30/22 at 9:15 AM Nurse's Note showed, "Resident in bed, looks pale, refused breakfast, noticed not her usual self. C/O (complains of) pain, when asked where, just pointed all over...remains pale...order to transfer resident to [local area hospital]." R1's 8/30/22 at 9:45 AM Nurse's Note showed she was transferred to a local area hospital. R1's 8/30/22 at 3:15 PM Nurse's Note showed the facility was notified by the hospital that R1 would be admitted for a left femur (thigh bone) fracture, urinary tract infection, and dehydration. On 9/1/22 at 1:10 PM, V12 RN stated she had told the day shift CNA/certified nursing assistant that R1 was not feeling well and R1 wanted to go	S9999		

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S9999	Continued From page 4	S9999		

to bed. V12 stated she did not assist with the transfer from her wheelchair to the bed. V12 stated when the ambulance personnel arrived, she was called to the room. V12 stated R1's legs were uncovered, and her left leg was turned to the side and touching the bed (externally rotated.) V12 stated, "...it didn't look right." V12 stated the right leg was externally rotated as well; however, at the time she believed it was due to R1's stroke and her right side being the affected side. V12 stated she had not noted or assessed for external rotation prior to R1's transfer. V12 stated she has worked at the facility for 10 years and has not aware of R1 ever having a fall. V12 stated R1 never attempts to get up without assistance.

On 9/6/22 at 1:35 PM, V15 Orthopedic Surgeon stated R1 had sustained 4 fractures in total: left femur, right femur, right tibia (shin), and right humerus (right upper arm bone.)

The facilities working schedule for R1's floor showed V10, and V11 Certified Nursing Assistants (CNA) worked a double shift from 3:00 PM on 8/29/22 until 7:00 AM on 8/30/22. The schedule showed V10 and V11 were the only assigned CNA's to R1's floor during that time period.

On 9/2/22 at 2:25 PM, V10 stated when she arrived for her shift on 8/29/22 R1 was already in bed, and per R1's preference, R1 was not transferred out of bed until 5:30 AM on 8/30/22. V10 stated V13 RN had assisted with the transfer the morning of 8/30/22. (On 9/6/22 at 3:10 PM, V10 retracted this statement and stated V11 had assisted with the transfer.) V10 denied any incident with R1 during her shift.

On 9/2/22 at 2:55 PM, V11 stated she was

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S9999	Continued From page 5	S9999		

assigned to the opposite side of R1's floor. V11 stated she did not see R1 until after dinner that evening. V11 stated she assisted with R1's transfer the morning of 8/30/22. V11 denied knowledge of any incident occurring during her shift starting on 8/29/22. V11 stated she was 100 percent certain V13 RN assisted with R1's transfer as well as V10 on 8/30/22. V11 stated she is not aware of R1 ever having a fall; if R1 fell, she would not be able to get up on her own; and R1 does not attempt to transfer herself.

On 9/1/22 at 12:05 PM, V13 stated R1 had no issues during the night that she was aware of. V13 stated R1 was in her wheelchair at 6:30 AM when she passed R1 her morning medication. V13 stated R1 was at her baseline. V13 stated she was certain she did not assist with R1's transfer the morning 8/30/22.

The facilities working schedule showed V7, V8, and V9 were the day shift CNA's assigned to R1's floor on 8/30/22. The schedule also showed V12 was R1's nurse.

On 9/1/22 at 11:45 AM, V9 CNA stated "...She (R1) was already up when I punched in at 7:00 AM. (V12) came up to me right after I punched in, and she said she (R1) looked pale and wanted to go to bed. She's not normally a good eater but she will eat something, that day she ate nothing (for breakfast.) I went right to (R1's) room. She was crying. She does a lot of crying, especially when she wants to go to bed, but that day she was in pain and crying more than usual. I asked her if she was having pain and she shook her head yes. I didn't ask her where the pain was, but she would not have been able to tell me if I did ask her. I put her in bed with (mechanical lift.) Normally she will move a lot during the transfer

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S9999	Continued From page 6 but that day she wasn't, and she was crying even more during the transfer which made me think she was having pain during the transfer..." V9 denied any incident or falls during his time with R1 on 8/30/22. V9 stated R1 does not attempt to get up on her own; he has never known R1 to fall; and if R1 fell she would not be able to get up without assistance. On 9/1/22 at 1:00 PM, V8 CNA stated she assisted with the transfer of R1 from her wheelchair back to bed on the morning of 8/30/22. V8 stated, "...She (R1) complained of pain but didn't say where the pain was...she was more pale that morning..." On 9/1/22 at 11:38 AM, V7 CNA stated the morning of 8/30/22 he notified V12 that R1 appeared pale. V7 stated, "She (R1) knows better than to get up on her own..." On 9/6/22 at 1:35 PM, V15 Orthopedic Surgeon stated when he assessed R1 he noted the right leg was swollen in addition to the left leg. V15 stated, R1 was found to have two fractures in the right leg. V15 stated, R1 also had significant bruising to her right arm and imaging of that arm showed a fourth fracture of the humerus bone. V15 stated, "I'm pretty certain these fractures were not due to her pathology (her diagnoses.) I could see maybe one fracture but not that many all at once. They are all acute (recent) fractures, I would say they occurred within a week of me seeing them. I don't really see a way that she could have had these fractures without having pain from the moment she got them. She does have some osteoporosis (weakening of the bone) but these fractures are not due to her pathology." V15 stated that if R1 is unable to put herself back in bed after a fall and she is unable to transfer	S9999		

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S9999	Continued From page 7 herself, "I cannot imagine any way that she would have caused these injuries to herself, and I cannot imagine a way that these injuries occurred outside the presence of staff." V15 stated, "We see this many and types of fractures on people that are in bad automobile accidents or falls from great heights, given her age it would not have needed to be that severe but would have been due to trauma. Maybe a fall from a wheelchair. It could have been a drop from a [mechanical crane type lift], if the [lift] was high enough...these injuries would have been painful from the moment they occurred." V15 stated, R1 could not have sustained this many injuries during a normal and safe transfer. The facilities Monitoring Flow Sheet for Incidents showed from 6/3/22 through 8/30/22 no documented falls for R1. R1's Nurses Notes from 4/23/22 to 8/30/22 showed no documented falls. R1's 8/23/22 weekly skin assessment showed, "skin intact." R1's August Medication Administration Record showed no documented pain for the month. R1's as needed pain medication, acetaminophen, was not documented as being given for the month of August. (A)	S9999		