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
	IL6001051	A. BUILDING: ___ B. WING ___	C 10/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRMONT CARE	5061 NORTH PULASKI ROAD CHICAGO, IL 60630

(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 FRI of 9/12/2022/IL151838 FRI of 9/19/2022/IL151845	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)3 300.1210d)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	S9999	Attachment A Statement of Licensure Violations	

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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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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 Requirements were NOT MET as evidenced by: Based on observations, interviews and review of records, the facility failures are as follows: Failed to follow policy to assess before transferring the resident. As a result, resident (R2) sustained left lower leg wound with multiple stiches. Failed to provide required assistance according to	S9999		

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assessment to a resident (R1) who sustained left arm (humerus) fracture after being transferred from bed to wheelchair.
Failed to use gait belt for 2 residents with history of multiple falls that requires extensive assistance during transfers (R4 and R5). Per care plan, R4 fell on 6/6/2022 and sustained hematoma in the head.
And failed to provide 2-person assist extensive assistance on bed mobility for 2 residents (R1 and R4).
Failures applies to 4 out of 4 residents (R1, R2, R4 and R5) reviewed for accidents, hazards, falls and resident injuries.

Findings include:

R1 is 83 years old with medical diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. R1's brief interview of mental status dated 9/20/2022 scored 13. Per assessment, R1 ' s cognitive status is intact. And that R1 needs 2-person extensive assistant on transfers and bed mobility. R1 ' s most current Fall Risk Assessment dated 9/5/2022 was 10 which means that R1 was high risk for falls.

On 10/11/2022 at 1:38 PM, R1 said, "It was during a CNA (Certified Nursing Assistant) transfer that I slipped. I did not fall but I slipped. A CNA was helping me transfer. Yes, it was only 1 CNA who helped me. Because if they used gait belt on me, I only need 1 CNA. Or else I need 2 CNA. When I slipped. Yes, I slipped, I cannot do much because my left foot was paralyzed (points at her left leg. R1 was seen with left leg immobilizer). She pulled me up. Then I was able to lay on the floor. I slipped because the floor was

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S9999	Continued From page 3 slippery. The CNA was holding on to me, and I heard (R2 was performing a cracking sound). I said to the CNA, that my left shoulder had a popping or cracked sound. Yes, I am sure, there was only 1 CNA during that time that helped me. After the cracking sound, I felt pain right away (R1 was grimacing). And was telling her that I have pain. I ' m sorry, I don ' t know the name of the CNA. Yes, my arms still hurting. Oh yes, I can say it hurts often very much. I am not sure if I received pain medicine." On 10/12/2022 at 12:45 PM, V2 (Director of Nursing) said, "It was R1's son that called me, that R1 told her that she (R1) had a pop on her shoulder. R1 was on a wheelchair that time because she (R1) was being transferred from bed to wheelchair. I went to R1 and assessed her shoulder. She (R1) complained of pain during movement. So, I notified the Nurse Practitioner/NP or doctor and X- Ray was done here at the facility. After I received the X-Ray result that showed R1 had a sub-acute fracture of her left humerus. I think it ' s right here (pointing on her left upper arm)." V2 was informed that R1 said it was only 1 CNA that was helping her during transfer. V2 said, "I was informed that there were 2 CNAs helping R1. V7 (Certified Nursing Assistant) and another CNA. But I was not there, so I did not see them transferring." V2 was asked why the name of the CNA that helped V7 was not mentioned on the report. V2 said, "V7 was assigned to R1 and not the other CNA. I did not include the other CNA statement because the other CNA was not assigned to R1. I can't remember when R1 saw V16 (Orthopedic Doctor), but I think it was earlier than 10/12/2022 or 9/15/2022 (referring to the notes by V12 (Licensed Practical Nurse)."	S9999		

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On 10/12/2022 at 1:50 PM, V13 (Restorative/Licensed Practical Nurse) said, " Transfer means that a resident is from one place to another like wheelchair to bed or vise-versa. Extensive Assist means that assistance given includes weight bearing assistance. Bed mobility means that resident is moving while on bed left to right. Like when changing a resident taking of her shirt and putting her gown. Yes, that is bed mobility. With regards to R2, R3 and R5, I just made their fall assessments yesterday. Although I back dated their assessment on the past dates. I understand that fall assessments are important in determining the status of resident risk of fall. And it will help with planning their care to prevent fall. Yes, I also understand that it must be on resident ' s chart so that nurses on the floor can access the fall assessment and will know if a specific resident is at risk for falling. "

On 10/13/2022 at 3:11 PM, V7 (Certified Nursing Assistant) stated that she was the staff that transferred R1 from bed to wheelchair after changing her clothes. V7 confirmed that she changed R1 by herself. And that she does not know that R1 has left-sided weakness and needs 2-person extensive assistance on bed mobility. Further stated that none of the staff including nurses informed her of R1 ' s ability while on bed. V7 said, " Yes, I changed her (R1) by myself. R1 was on laying on the bed so I changed her by myself. I did not know that R1 has left side weakness and needs 2-person to help her change. "

V16 (Orthopedic Doctor) was paged twice but did not call back.

R1 ' s progress notes dated 9/13/2022 for 9/12/2022 (late entry charting) reads: " during

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transfers to wheelchair, R1 called family and claimed that she heard a popping sound on her left shoulder and complains of pain on the site." On 10/13/2022 at 9:24 AM, V2 stated that there was no thorough pain assessment done after she was informed by the son that R1 (his mother) called complaining of pain. R1 ' s September 2022 Medication Administration Record (MAR) where pain assessment scheduled every shift shows that pain range 0-10 was left blank although it was signed by nurses on the floor. Medication Administration Record (MAR) reads: Monitor for pain every shift. Pain Intensity are as follows: 1-3 mild pain, 4-6 moderate pain and 7-10 severe pain. V2 said, " Yes, there should be a numeric number that should reflect on the MAR in that section. I will check if they assessed R1 for pain but as for now I cannot tell you. " Per the same MAR, R1 has an order for 2 pain medications: Norco 5 MG - 325 MG tablet to give every 12 hours for pain which does not reflect that it was given for the whole month of September. And Acetaminophen 325 MG to give 2 tablets every 6 hours as needed which was never given on the day R1 sustained left arm fracture 9/12/2022. And was not given until 9/13/2022 6:55 AM. V2 said, " It seems that is showing on the MAR. Yes, that is the way it was documented. I will look unto it. I will check if they were putting notes on R1 ' s pain. " At 1:05 PM V2 returned, and no notes were presented. Review of R1 ' s progress notes for the month of September shows no documentation of pain on the left arm due to fracture was addressed.

R1 ' s Clinical Records are as follows:
X-Ray Result on the left shoulder dated 9/13/2022 document that R1 sustained left humerus subacute fracture.

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R1 ' s Care Plan on Activities of Daily Living/ADL dated 5/23/2021 documents that R1 needs assist on Bed Mobility. Provide 2-person assist with transfer. No pain management was documented on R1 ' s full most current care plan other than medicate as needed for pain/discomfort.

Orthopedic Consultation Report is as follows: V16's (Orthopedic Doctor) Physician progress notes dated 9/14/2022 : R1 was being evaluated for left humerus pain present for a couple of days ago. R1 states the nursing staff tried to lift her up and she heard crack. R1 resides at nursing home facility after a stroke from a year ago which affected her entire left side. Per V16's diagnoses, R1 sustained closed fracture 3-part proximal end of left humerus.

R2 is 84 years old with medical diagnosis of laceration on left lower leg and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. R2's brief interview of mental status dated 9/26/2022 scored 15. Per assessment, R2 ' s cognitive status is intact. And that R2 needs 2-persons extensive assistant on transfers and bed mobility. R2 ' s most current Fall Risk Assessment dated 10/11/2022 backed dated to 9/19/2022 by V13 (Restorative/Licensed Practical Nurse) was scored as 7 which means that R2 was high risk for fall.

On 10/11/2022 at 1:20 PM, R2 said, " It happened about 2 weeks ago when I first came here. They were transferring me from wheelchair to bed that my left leg was caught. There are 2 of them (staffs) present but only 1 of the staff helped me. And I don't think she knows what she was doing. The lady saw my leg that was caught and did not respond. The other staff was just looking. When my leg was caught. I told them but I did not

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know if they hear me. Or my English was not good. "

On 10/11/2022 at 2:00 PM, with R2 ' s consent, V10 (Licensed Practical Nurse) was requested to open dressing wrap of R2's left leg. On the wrap was dried light yellow mixed with red brownish dried fluid (removed was) seen on the wrap gauze. Wound was still with stitches and swelling on the left side. V10 said it was approximately 6 inches. V10 said he was not sure if his measurement was accurate.

On 10/12/2022 at 11:27 AM, V8 (Nurse Supervisor/Licensed Practical Nurse) stated that she did the incident report of R2. And that R2 sustained abrasion about 10 inches long on left leg or shin because of the transfer. V8 said, " I was working as the floor nurse and helping with admission. The CNAs (Certified Nursing Assistant), V14 and V9 and another CNA, V15 was present. V14 got my attention and said R2 was bleeding on her leg. When I went inside the room, I saw R2 was on the bed already, I said what happened she was bleeding on the leg. I grabbed gloves and placed a cloth. R2 was alert and oriented, I called V19 (Wound Nurse) and V18 (Nurse Practitioner). V18 was an in-house Nurse Practitioner, and he took over. V14 said they really don't know what happened during transfer from wheelchair to the bed. V14 told her to stand up and 3 of them (V14, V9 and V15) helped R2. I did not see them transferring R2, there was no nurse present during transfer of R2. I was not inside the room , for the actual transfer of R2. When I asked R2, she said that she bumped her leg on the bed. R2 came from another nursing home. She (R2) was accompanied by the driver. It was not an ambulance but medicar. When a new admission

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comes, the nurse should be there and assess the patient for transfers. R2 was not yet assessed by any nurse when they transferred her to bed. During this time, we have not assessed R2 yet. Including how she (R2) can transfer from wheelchair to bed. Yes, I agree that it would be safer if the nurse assessed the resident first before transferring the resident. And it will also be safer for the nurse to be present during transfer. I don't know if they transferred her with 2-person assisting. But if R2 said that only one of them transferred then I feel bad to R2. R2 is alert and oriented she can tell you what happened. As to gait belt, it is like a part of their uniform and must be used with all transfers. V9 should have placed a gait belt to R4 and R5 when transferring them to bed. " R2 ' s progress notes dated 9/19/2022 by V8 admission notes reads in part that R2 ' s weight bearing status was left blank during admission.

On 10/12/2022 at 12:25 PM, V9 (Certified Nursing Assistant) stated " I was called by V14 (Certified Nursing Assistant) and asked me to help her transfer R2 to bed. I am not familiar with R2. I saw her with the lady that was driving a car like an ambulance. I never saw her before or took care of her before. V14 did not inform me how to transfer her. And I was not informed by any nurse how to transfer R2. I don't know if she can stand on her own. But we were able to let her stand. After we transferred her to bed. I saw a lot of blood on the floor. And then I saw her leg with wound and skin flap. V14 called V8 and I just left the room."

On 10/12/2022 at 12:45 PM, V2 (Director of Nursing) said, "When a CNA (Certified Nursing Assistant) transfers any resident they must use a

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gait belt. V9 should have used the gait belt during transfers of R4 and R5. As to R2, nurses on the floor must inform the CNA about resident's ability to transfer because they are the one receiving report. I understand what you mean, since R2 was new admit. Nursing staff was not familiar with her ability to transfer. And CNA's does not assess but nurses. Nurses should have instructed the CNAs on transferring R2."

On 10/14/2022 at 12:28 PM, V14 (Certified Nursing Assistant) confirmed that she was assigned to R2 and helped R2 transfer from wheelchair to bed. V14 said that she was not familiar with the resident ability to transfer because it was the first time the R2 came in the facility. V14 said, " That was the first time I met R2 because she was a new resident. I do not know her ability to transfer, or she has left side weakness. It was only during transfer that I noticed she was weak on one side. Nobody told me how she transferred. I agree, it would be safer if I was given instruction how to transfer R2. Or I knew that she (R2) was weak on her left side. "

Facility wound care notes and assessments dated 9/21/2022 documents that R1 sustained skin tear with a length of 16 centimeters, 0.1 centimeters width and 0.1 centimeters depth. Hospital assessment dated 9/20/2022 documents that R1 sustained traumatic tibial anterior wound with a length of 15 centimeters, 3 centimeters width and 0.1 centimeters depth with 16 sutures.

R2 ' s care plan for mechanical lift dated 9/22/2022 documents that R2 requires the use of Hoyer lift for transfers related to weakness. And that R2 needs 2-persons assist from caregivers.

On 10/11/2022 at 12:40 AM, V9 (Certified Nursing

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Assistant) was seen wheeling R4 on her wheelchair then entered a room. Upon entering the same room, writer saw R4 was already in bed. V9 said she just transferred R4 on bed because both R4 and R5 who was sitting on her wheelchair next to a bed wants to go back to bed right away after lunch. V9 was seen changing R4 by taking off her shirt and putting a gown. Turning R4 from left to right. V9 was asked if she usually performs transferring and changing R4 by herself. V9 replied, " Yes. " V9 then left the room and took multiple trays out of multiple rooms. At 1:32 PM, after 52 minutes of leaving R5 sitting on the wheelchair on the bedside, V9 was seen transferring R5 from wheelchair to bed holding on the back of R5's pants with her right hand and with her left hand holding R5 ' s upper left arm. During this time R5 was in standing position. When V9 saw the writer entering the room, V9 put back R5 on the wheelchair. V9 said, "Oh I need to find something." V9 left the room and after few minutes came back with gait belt wrapped around her waist. V9 said, "I forgot my gait belt from another room. I did not use my gait belt when I transferred R4 to bed earlier. I know I need to use my gait belt all the time when transferring resident. I think both R4 and R5 only need 1-person assist but with gait belt in all transfers."

R4 is 99 years old with medical diagnosis of repeated falls. R4 have history of multiple falls per care plan. Per the same care plan, R4 recently fell on 6/6/2022 and sustained hematoma in the head. R4 was transferred to the hospital due to fall. R4 ' s most current Fall Risk Assessment dated 6/7/2022 was scored 17 which means that R4 was high risk for fall.

R5 is 71 years old with medical diagnosis of

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hemiplegia and hemiparesis following cerebrovascular disease affecting right dominant side. R5 has history of multiple falls per care plan. Per the same care plan, R5 has seizure disorder due to history of head trauma and has seizure medications. Per transfer care plan review date 10/12/2022, R5 needs gait belt during transfers. R5 ' s fall care plan dated 10/21/2019 documents that R5 is high risk for falls due to following factors: R5 has unsteady gait with foot drop, has balance impairment especially on standing. R5 has unsafe/unpredictable behaviors - tries to stand, transfer, walks alone in spite constant reeducation and reminders. R5 has history of traumatic brain injury resulting to memory and mental impairments, impaired judgment, changes in attention, cognition, impacting ability to comprehend. R5 has hemiplegia and taking anticonvulsant medication and antidepressant. R5 has prior history of falls. And R5 is impulsive and diminished safety awareness, poor recall and judgment. R5 ' s most current Fall Risk Assessment dated 10/11/2022 backed dated to 8/3/2022 by V13 (Restorative/Licensed Practical Nurse) was scored 7 which means that R5 was high risk for fall.

Per Fall Assessment Instructions, if score is 6 or greater, the resident should be considered at HIGH RISK for potential falls.

Facility's policy on safe lifting and movement of residents not dated, in part reads:
In order to protect the safety and well-being of staff and residents, and to promote quality of care, this facility uses appropriate techniques and devices to lift and move residents. Manual lifting of residents shall be eliminated when feasible. Nursing staff in conjunction with the rehabilitation staff, shall assess individual residents' needs for

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S9999	Continued From page 12 transfer assistance on an ongoing basis. Fall Occurrence Prevention Policy dated as revised on 8/16/2021 in part reads: This facility is committed to minimizing residents falls and/or injury so as to maximize each resident's physical, mental and psychosocial well-being. It is this facility's policy to act in a proactive manner to identify and assess those at risk for falls, plan for preventative strategies, and facilitate a safe environment as possible. Under fall prevention protocol: Assessment, a fall risk assessment form will be completed on all residents upon admission, readmission, quarterly, annual, post fall and on significant change of condition. It includes a fall history and a list of risk factors. The main purpose of which is to prevent injury from falls. (See Fall Risk Assessment). Under Fall Investigation Report, Fall Investigation Report shall include the following: Witness and Staff Interviews. Admission Assessment and Follow Up: Role of the Nurse policy dated 12/2021. In part reads: The purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan and completing required assessment instruments, including Minimum Data Set. Under steps in the procedure, conduct supplemental assessments (following facility forms and protocol) including. Activity level, Fall Risk Assessment and Functional Assessment- ability to perform Activity of Daily Living ADLs. (B)	S9999		