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
	IL6019723	A. BUILDING: ______ B. WING ______	C 07/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEERFIELD CROSSING NORTHBROOK	4101 LAKE COOK ROAD NORTHBROOK, IL 60062

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S 000	Initial Comments Facility Reported Incident of 6/22/22/IL148324	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) 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. 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	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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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.

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 300.1220 Supervision of Nursing Services

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b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to follow a resident's plan of care by not having two staff assist while providing care for a resident at risk for falls and documented to require two staff assistances with bed mobility and ADL's (activities of daily living). This failure applied to one (R1) of one resident reviewed for accidents and supervision and resulted in R1 rolling out of bed during care and then having to be emergently transferred to the local hospital's medical intensive care unit for treatment of laceration to the back of her head, which required sutures.

Findings include:

Facility incident report dated 6/22/22 at 2:30 PM

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S9999	Continued From page 3 written by V2 (Director of nursing) reads in part, "Resident (R1) is an 84-year-old long term care resident in the facility with diagnosis of morbid (severe) obesity due to excess calories, chronic diastolic heart failure, peripheral vascular disease, anxiety disorder, lack of coordination, bilateral contracture, history of falling. In conclusion, a complete and thorough investigation was conducted to include review of medical records. Resident is alert and oriented x 3, BIMS (brief interview of mental status) score 15 and she can verbalize her needs. Based on the results of the investigation and staff interviews the facility has determined that on 6/22/22, resident rolled out of bed during incontinence care, hitting her head on the floor sustaining scalp laceration with moderate amount of bleeding. CNA/certified nursing aide stated that he pivoted to reach for the incontinence pad on the bedside table next to resident's bed and was noted resident sliding off the bed. CNA attempted to hold onto resident's body but unable to break the fall due to resident's kept off the bed and landed on the floor. CNA and nurse on duty stated that prior to the incident resident was repositioned in the center of the bed. The results of the investigation have been discussed with resident and physician. All agreed with the plan of care." EMS (Emergency Medical Services) form dated 6/22/2022 at 14:32:30 (3:32 PM) reads in part, "Dispatched for 84-year-old female patient who fell from her bed. Upon arrival, EMS crew met patient in her room, patient was lying supine (on her back) on the ground and had blood pooling around the back of her head and one of the staff members was holding towels and supporting the patient's head. Patient was alert and oriented 3/3. Staff members stated they were giving the patient a bath in her bed and when the patient went to	S9999		

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roll over, she went too far and fell out of her bed. Staff stated patient fell to the floor onto her back and hit her head on the floor. Staff did inform EMS crew that patient was on blood thinners. EMS crew assisted patient to cot and performed assessment and noted patient had an injury on the right back corner of her head. The injury appeared to be approximate size of a quarter in circumference and approximate half inch laceration. Patient denied any neck pain and was complaining of having a headache. EMS crew bandaged wound and moved patient to MICU (Medical Intensive Care Unit)."

Interview with V2 (Director of Nursing) on 7/29/22 at 10:25 AM stated, "I did the fall investigation and R1's nurse was V3 (RN) and V4 was an agency CNA/Certified nursing aide. V3 told me that she was doing her rounds when V4 (agency CNA) was about to do incontinence care for R1, and she helped him put R1 to the center of the bed and then she left the room after doing so. V4 mentioned upon interview that he turned the patient to her left side, and he pivoted around to get the resident's incontinence brief when the patient rolled out of bed and on to the floor. The resident is morbidly obese so if you see her, she is hard to catch if she is about to fall." Surveyor asked whether during her investigation if she detailed whether R1 held on to anything while she was being turned, V2 stated, "Normally she could hold on to a side rail, but she does not have any to hold on to." Surveyor asked whether R1 was a fall risk, V2 stated, "She is not a fall risk. She is wheelchair and mostly bed-bound and she has not fallen before."

On 7/29/22 at 10:40 AM, R1 was observed lying atop a bariatric (wide bed) bed which was raised high above surveyor's waist level. There were no

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floor mats on either side of bed or any side rails that were up to prevent R1 from falling out of her raised bed. On the left side of the bed was a bedside table with metal rollers. Behind this table was a large oxygen tank situated beside and below the left-hand side. These were concerns as potential fall hazards.
R1 appeared disheveled and had bruising to both her arms. Surveyor asked R1 how she was feeling and asked if she remembered when she fell, R1 stated, "I'm not feeling well today. I fell not too long ago. There was this CNA that turned me when he was cleaning me up and next thing you know I rolled over out of this high bed and fell on the ground. I was bleeding a lot from my head, and they sent me to the hospital. I was in a lot of pain, and they gave me something for it. I got all stitched up, but I still have headaches now and I was sent back to the hospital just last week again." Surveyor asked if she recalled if there were one or two people helping her turn to her side during care, R1 stated, "There was only one and I only get one person most of the time."

7/29/22 at 10:55 AM V6 (RN) stated, "I'm the nurse for R1 today yes. There's one CNA (V7) for her, she's with the agency but she's currently on break." Surveyor asked about R1 and what she could tell the surveyor about her, V6 stated, "Well she's alert and oriented times three and she is able to make her needs known. She was recently hospitalized due to her having some respiratory distress issues due to her chronic heart failure and fluid overload and she just came back recently. (R1) stays mostly in her bed and we try to get her up around 11 or so for lunch and then we put her back to bed right after dinner." Surveyor asked whether R1 was considered a fall risk, V6 stated, "She is not a fall risk and she doesn't try to stand up on her own. She does

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need extensive assistance when in bed and I guess where she'd fallen out, but I think that was the first time." Surveyor asked that now that R1 had fallen (as she mentioned) whether R1 was considered a fall risk, V6 stated, "No. I don't think so." Surveyor asked if there were any other instructions provided to her to follow after R1 fell, V6 stated, "I wasn't given any instructions."

7/29/22 at 11:32 AM V3 (RN) with V2 (Director of Nursing) present, stated, "I was the nurse on duty when R1 fell from the bed. I was doing my rounds and I happened to come in when V4 (CNA/certified nursing aide) was going to provide incontinence care for (R1), so I helped prop her up and put her in the middle of the bed. I then left to finish my rounds and prepare my medications. V4 called me later and said that the patient was on the floor. I asked V4 to go get help because I saw bleeding on her head, and I also saw blood on the floor." Surveyor asked where R1 may have hit her head to determine the area of bleeding, V3 stated, "I don't really know. When I came in there was blood on the floor and I think she either hit the front or back of her head when she fell to the floor and hit the bedside table. It has metal castors, and she could have hit it but that I don't know. I just know her head was at the foot of this bedside table when I came in and saw her on the ground." Surveyor asked what kind of assistance R1 needs to safely reposition her in bed and whether she was a fall-risk. V3 stated, "She is considered a fall risk because she needs maximum assistance." Surveyor asked what she meant by maximum assistance, V3 stated, "She is difficult to turn in bed because she is obese, so she needs 2 people to turn her to her side." Surveyor asked whether she helped her aide (V4) turn R1 to her side to assist in bed mobility as per her care plan, V3 stated, "I didn't help turn her. I

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didn't help at all it was the agency CNA (V4) that turned her to left side to do incontinence care and she rolled out of bed. I left and I finished my rounds and prepared my medications."

7/30/22 at 1:47 PM V4 (agency CNA) stated, "Yes, I was the CNA that was caring for R1 when she fell. She was alert and orient x 4. When I turn her, she usually grabs on to something but she wasn't feeling well that day so she must have not grabbed on to anything when I turned her. I turned around to get her (brief) and when I turned back around, she rolled out of bed to the ground. After she fell, I ran and got the nurse and told her R1 fell, and we needed to get her up. The nurse came and she started to look at her and she was bleeding." Surveyor asked if V3 (nurse) or any other staff helped him turn R1 as per her plan of care, V4 stated, "Nobody helped me turn R1. I've taken care of R1 several times and she only need one person to turn her. That is how she has been doing it as far as I know." Surveyor asked what position the bed was in when he turned R1 to her side. V4 stated, "We have to lift the bed up high, so we are close to the patient." Surveyor asked if he saw where R1 may have hit her head on, V4 stated, "I don't know. She had her oxygen tank, and a bedside table was on the side of the bed she fell on, but she could have hit her head on the ground. I don't know. I only saw her rolling and it was too late to grab her." Surveyor asked if he was informed that R1 was at risk for falls, V4 stated, "It was never endorsed to me she was a fall risk" Surveyor asked to clarify whether anytime during his assignments with R1 if he was informed that R1 was a fall risk and/or needed 2 people to turn her in bed, V4 stated, "No. Never."

Interview with V5 (MDS/Care plan nurse) on 7/29/22 at 1:20 PM with V2 (director of nursing)

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present in the interview stated, "I do the MDS for R1 and part of the IDT (interdisciplinary team) to assist in making the care plans." Surveyor asked to describe the resident's activities of daily living (ADL's) requirements, V5 stated, "R1 has always needed extensive assist because she has right hand contracture, she has morbid obesity and she declined more after she fell." Surveyor asked what she meant by extensive assist, V5 stated, "She needs extensive assist to do her ADL's and needs 2-persons to do most of them." Surveyor asked what it meant for extensive assist x 2 for bed mobility as prescribed in the MDS, V5 stated, "It means she need at least 2 persons to turn her from side to side in bed." Surveyor asked whether the facility followed this plan of care and whether this requirement was met, V5 stated, "No we did not meet this requirement because she needed 2 people and there was only one as I was told."

Interview with V8 (agency CNA) on 7/29/22 at 2:30 PM stated, "I'm an agency CNA but I've had R1 a couple of times. She's usually not in her room when I'm here but I sometimes put her back to bed." Surveyor asked if anyone helps her put R1 back to bed, V8 giggled slightly and said, "No, that would be just me." Surveyor asked if she thought the question was funny, V8 stated, "No. I'm just saying that I take care of this entire section here and I don't normally get much help." Surveyor asked whether R1 was considered a fall risk, V8 stated, "No. Nobody told me she was. Is she?" Surveyor asked if she is provided any in-service training on anyone at risk for falls, V8 stated, "I can't say they do. They don't even tell me anything about any of the residents. I get my assignment and that's it." Surveyor asked and clarified whether at any time she started working at the facility whether the facility provided any form of training or orientation to the residents'

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care requirements, V8 stated. "No."

Interview with V9 (Advance Practice RN) on 7/31/22 at 12:46 PM stated, "I am one of the NP's that see R1 at that facility and yes I am very familiar with her. She is very alert and knows what is going on with her care. According to (R1) she fell out of her bed in the midst of patient care." Surveyor asked if she knew whether R1 was considered a fall risk. V9 stated, "No. I wouldn't consider her a fall risk. She's very alert and knows what's going on with her care but I'm not told by the facility she is at risk for falls." Surveyor asked if she knew that upon admission R1 was considered a fall risk based on her assessments and care plan, V9 stated, "I wasn't aware of that either, but I guess you can say that could be the case because she does require a lot of assistance in doing things." Surveyor asked whether she'd agreed if the facility care planned for R1 to require 2 people to assist in bed mobility whether the facility should follow that plan of care, V9 hesitated to answer but stated. "I can't really say."

Progress Note written by V9 (Advance Practice RN) on 6/23/2022 at 12:00 PM includes: "Patient seen and examined today, sitting up in bed with no signs of acute distress. When asked about recent incident, patient reports that when she was turning over during incontinence care yesterday, she rolled out of the bed and onto the floor obtaining a laceration to the head and was immediately sent to the hospital. CT head and neck were negative, and sutures were placed to the back of her head. At current, patient reports a dull headache that started since hitting her head yesterday. She endorses pain is alleviated by analgesics. No other active complaints at this time. Patient denies any chest pains, palpitations,

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shortness of breath, nausea/vomiting, fevers/chills. Appetite and bowel/bladder habits stable. Labs reviewed with cardiology. Nursing staff reports low grade fever yesterday; plan discussed with nursing staff.
Fall: CT scan head and neck negative. Laceration with sutures to right side of head. Right upper extremity hematoma. Maintain fall and safety precautions. Continue prn (as needed) analgesics. PT/OT as indicated. Generalized Weakness/Debility: PT/OT/ST evaluation/treatment as indicated. PRN pain medicine as ordered. Fall precautions in place."

MDS (minimum data set) assessment dated 5/19/22 showed R1 requiring extensive assist with a minimum of 2 person assist for bed mobility (turning and repositioning while in bed). A subsequent post-fall MDS dated 6/28/22 showed R1 to remain to require extensive assist with a minimum 2-person assist in bed mobility.

Activities of daily living care plans dated 10/11 21 reads in part, "The resident has an ADL (activities of daily living) self-care deficit related to impaired balance, limited mobility, weakness. Diagnosis: obesity, contracture right hand, ADL needs and participation vary. Interventions: ADL's: Bed mobility: total (assist) x 2 (staff). Transfer: total x 2; Walking: n/a; Toilet use: total x 2; Personal hygiene: total x 2; Bathing: total x 2. Date initiated 10/11/22. Revision on 6/29/22."

Care plans related to fall risk dated 10/11/21 reads in part, "Resident is at risk for falls. The resident has balance or walking impairments. The resident has a history of falls. The resident takes medications that may cause dizziness, loss of balance, or impair judgement. The resident has vision impairments. The resident has urinary

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S9999	Continued From page 11 incontinence, resident has bilateral artificial knees. Goal: Prevent a serious fall related injury. Interventions: Be sure call light and other personal items are in reach; check the environment for clutter or trip hazards and area is well lit; Keep bed in lowest position acceptable by the resident when the resident is in bed; 6/22/22 resident rolled out from bed and sustained laceration on the back of her head. monitor wound on the back of her head (laceration) every shift for signs and symptoms of infection; Suture removal in 2 weeks; Provide resident with wider bed. " Policy dated 3/27/21 titled "Standards and Guidelines: Falls" states in part, "It will be the standard of this facility to complete an initial assessment, on-going monitoring/evaluation of resident condition and subsequent intervention development in an attempt to prevent falls and injuries related to falls. As part of the initial assessment, the facility will help identify individuals with history of falls or risk factors for subsequent falling. On admission, the nurse should assess and document/report items such as vital signs, mental status, gait, pain, medications and active diagnoses. The staff will discuss the resident's risk factors for falling and obtain orders from the physician for appropriate fall preventative devices as is needed. The staff will evaluate, and document falls that occur while the resident is active in the facility census. If a resident sustains a fall while a resident, staff should attempt to identify possible causes of the fall. Based on evaluation of an existing fall (s) pertinent interventions will be implemented by staff such as, but not limited to: resident education if appropriate, staff re-education regarding transfer techniques and safety during ADL care, resident footwear, appropriate lighting,	S9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEERFIELD CROSSING NORTHBROOK	4101 LAKE COOK ROAD NORTHBROOK, IL 60062

(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
S9999	Continued From page 12 maintaining close proximity of frequently used items, medication reviews, toileting programs, use of hip protectors, referral to therapy for strengthening/coordination/balance, addressing medical issues such as hypotension and dizziness, discontinuing, or changing problematic medications, use of fall prevention programs that provide more frequent supervision and restraints, if warranted." "B"	S9999		