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
	IL6005375	A. BUILDING: ______ B. WING ______	C 01/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN BARR LIEBERMAN	9700 GROSS POINT ROAD SKOKIE, IL 60076

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S 000	Initial Comments Complaint Investigation #2290586/IL142748	S 000		
S9999	Final Observations Complaint Investigation #2290586/IL142748 STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 300.1810c)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 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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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.

Section 300.1210 General Requirements for Nursing and Personal Care
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
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.

Section 300.1810 Resident Record Requirements

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S9999	Continued From page 2 c) Record entries shall meet the following requirements: 3) Medical record entries shall include all notes, orders or observations made by direct resident care providers and any other individuals authorized to make such entries in the medical record, and written interpretive reports of diagnostic tests or specific treatments including, but not limited to, radiologic or laboratory reports and other similar reports. These regulations were not met as evidenced by: Based on observation, interview and record review, the facility failed to provide adequate supervision and assistance devices to prevent accidents; failed to implement fall interventions consistent with the resident ' s care plan and current professional standards of practice; failed to train staff on fall preventative measures and monitoring of cognitively impaired residents in order to eliminate the risk of an accident; and failed to conduct a comprehensive root cause analysis of each fall to prevent further falls. These failures affected 3 (R2, R3, R4,) of 3 residents in the sample assessed as high risk for falls and with history of falls. These failures caused all 3 residents an emergent transfer to the hospital; R2 with head trauma and surgical staples, R3 with a hip fracture and R4 with rib fracture. Findings include: 1. R2 is a 70-year-old with diagnoses listed in part with diabetes, unsteadiness on feet, repeated falls with history of falls. On 1/25/22 at 10:35 AM, R2 was observed in bed in a hospital gown, a blue tarp-like sheet with	S9999		

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S9999	Continued From page 3 straps and buckles was bundled underneath R2 as he laid sleeping and with his left leg dangling from the bed. V15 (LPN) who was found in the alternate hall where R2 resided stated, "I take care of "C" and "D" wings." Surveyor asked what the blue tarp was surveyor saw on various residents, V15 stated, "Oh you probably saw the sling to transfer the resident to the chair or wherever." Surveyor asked if residents are allowed to sleep on them overnight, V15 stated, "I don't think so but I know they keep the sling there so they can easily transfer them (referring to residents) back to bed." Later the same day at 1:25 PM, R2 was again observed in his bed lying under the blue tarp-like lift sling V15 identified. R2 appeared on his back and with sheets that had dried blood stains still on them. V22 (Dementia coordinator) was asked to come in and view R2 with surveyor. V22 stated, "That's (R2) he is a fall risk and very confused. I think that is a sling under him. I see the blood and I know he fell recently. I don't know who the c.n.a. is for (R2) but let me go find her." Surveyor asked what the facility did to prevent R2 from falling, V22 stated, "We try to monitor him frequently and we remind him to use his call light." Surveyor asked if R2 was able to use his call light, V22 stated, "(R2) is pretty confused but probably not but we try to come in often to check on him." V22 left the room and returned with V17 who stated, "Yes (R2) is my resident. I was about to transfer him to his chair that's why the sling is under him. Surveyor asked about the blood stained sheets, V17 stated, "I haven't changed him yet but after I transfer him to the chair I will do that." Surveyor asked if R2 was provided lunch, V22 stated, "I think so but I was with another resident." Surveyor asked if R2 was a fall risk resident and if so, what instructions were provided to her	S9999		

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regarding R2, V22 stated, "Yes he is a fall risk. We try to watch him a lot and I check on him a lot. "

A facility fall incident report written by V3 (director of nursing) reads in part, "Type of incident: Unwitnessed fall with injury. On 1/18/22 at approximately around 4:15 PM, resident was observed sitting on the floor in the hallway with wheelchair beside him. Resident is alert, oriented x 2. Resident stated, "I stand up, lost my balance and fell." Head to toe assessment done, noted with laceration on occipital area of the head with minimal bleeding. Pressure dressing applied, remained on the floor with staff. Ordered to send out via 911 to emergency room. At around 3:30 AM of 1/19/22, resident returned to facility with staples on occipital area of head."

A facility form dated 1/24/22 titled "Post incident investigation" written by V9 (restorative nurse) reads in part, "Unwitnessed fall without injury. Approximately 2:30 PM, social worker (V22) reported that resident is on the floor in the hallway. Resident did not press call light in room or call for assistance. Resident did not use wheelchair or rolling walkers. Upon arrival resident was observed sitting on the floor."

A witness statement written by V22 (social worker) contradicts V9's investigation which claimed that R2 did not use a wheelchair or rolling walker or was anywhere near a call light in the hallway for resident to use. V22's statement reads, "Writer observed (R2) on 1/18/22 approximately around 4:15 PM (not 2:30 PM as per V9's report) was sitting in his wheelchair and then stand up from his wheelchair in the common area and went back of the wheelchair to grab the handles and then took a fall. Writer immediately

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notify the nurse on duty."

On 1/28/22 at 1:45 PM, V9 was questioned about the irregularity of her written reports of R2's fall, V9 stated, "Whenever someone is sent out to the emergency room and has a head injury with staples put in them, that would be considered a fall with injury. I can't explain why I wrote two reports about R2 but I think he fell twice that day. As far as showing that there was no injury, that's wrong because there was an injury, sorry for that."

On 1/28/22 at 1:00 PM, surveyor asked the social worker about the statement he made pertaining to R2's fall, V22 (social worker) stated, "I saw R2 and all that was happening from the corner of my eye and that's what I wrote in my statement about what I saw." Surveyor asked to clarify his written statement about R2 sitting in this wheelchair, then stood up to walk behind his wheelchair whether he tried to intervene to prevent R2 from falling, V22 stated, "I tried running to him to catch his fall, but I didn't get there in time." Surveyor asked to clarify if he did as he stated, why this was not on his witness statement, V22 stated, "I don't know. I just witnessed the part when (R2) stood up and walk behind his wheelchair." Surveyor asked if there were any call lights within reach in the common area where R2 was sitting, V22 stated, "No, there are not."

A fall log provided to surveyor by facility showed R2 previously fallen twice on 11/11/21 and again on 1/18/22. This same form erroneously showed no injuries were sustained including the fall on 1/18/22 when R2 was sent out emergently to the hospital for head trauma and was provided staples to stop the bleeding.

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Fall care plan dated 1/25/22 reads in part (but not limited to), "(R2) is at risk for falls related to diagnosis, history of falling and daily use of antidepressant. Interventions: I have periods of forgetfulness. I would like staff to frequently reorient me to my surroundings; keep call light within reach when in bedroom or bathroom; bed alarm, chair alarm, floor mats."

MDS (minimum data set) assessment dated 1/31/22 showed R2 with a BIMS (Brief Interview for Mental Status) score of 8 showing moderate cognitive impairment. R2's ADL scores for bed mobility and toileting use requires maximum assistance with a minimum 2-person staff assist. R2's transfer ability showed totally dependent on staff participation to transfer from bed to wheelchair with a minimum 2-person staff assist."

2. R3 is an 82-year-old with diagnoses listed in part with anxiety disorder, diabetes, vascular dementia, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side.

A facility incident report dated 1/24/22 written by V3 (director of nurses) read in part, "At around 1 PM of 1/24/22, resident complained of left upper leg pain. Facial grimacing noted upon assessment. Head to toe assessment done. No visible injury noted. Resident is alert oriented x 1 and unable to give description of pain. Resident has no history of fall or any incident prior to complaining of pain. At around 7:50 PM, nurse on duty received resident's x-ray result with impression of acute left sided intertrochanteric (hip) fracture. MD made aware to send out resident to hospital for evaluation."

On 1/25/22 at 1:40 PM, surveyor went to R3's room which was located on the furthest corner

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away from the nursing station. R3's room was vacant with an empty bed raised up over surveyors waist. V13 (LPN) asked surveyor who he was looking for. V13 stated, "Oh (R3) is in the hospital. She fell last week and has a fracture so she is not back. Surveyor asked if he knew the resident, V13 stated, "Yes, she usually stays in bed. She's very confused and I think she was on isolation that's why she's on this floor." Surveyor asked whether R3 was able to follow commands, V13 stated, "No she's too confused." Surveyor asked if R3 was considered a fall risk, and if so what he did to prevent her from falling, V13 stated, "She is a fall risk and we kept her call light next to her and reminded her a lot to use it and check on her a lot." Surveyor asked how someone very confused (as mentioned) could use or be reminded to use a call light, V13 stated, "I just check on them often."

A fall care plan dated 10/23/21 reads in part, "(R3) is at risk for falls related to: generalized weakness related to multiple complex/chronic medical diagnosis; Cognitive deficits such as poor safety awareness/judgement, inability to call for assist, decreased comprehension, impulsivity, memory deficits; medication side effects; impaired mobility, unsteady gait and poor standing balance, utilizes a wheelchair for locomotion. Interventions: Instruct to avoid sudden position changes to prevent orthostatic hypotension, provide health teachings on safety and fall prevention, anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance."

3. R4 is an 88-year-old resident with diagnosis of dementia, major depressive disorder, heart failure, unsteadiness on feet and history of falling.

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S9999	Continued From page 8 A facility incident report written by V3 (director of nursing) wrote, "Unwitnessed fall with injury. Date of incident 1/22/22 at 7:10 PM. Location of incident: hallway. On 1/22/22 at around 7:10 PM, nurse on duty observed resident sitting on the floor on the hallway close to her room. Resident is alert oriented x 2, confused and forgetful as baseline. Resident complaints of pain on the groin area, pain scale of 7 out of 10. Doctor ordered for stat x-ray on left hip. On 1/23/22 at around 1:30 AM, resident was observed restless, uncomfortable, and complaints of severe pain on left rib care area. Dr. notified with order to send to hospital for evaluation. At around 8:30 AM, nurse made a follow up. Resident admitted at hospital with diagnosis of left rib fracture. On 1/23/22, V9 (restorative LPN) wrote a facility witness statement from V26 (c.n.a.-certified nursing aide) that read, "Date of incident 1/22/22. I was assigned to (R4). I saw her on rounds when I arrived on shift at 3:15 PM. Resident was sitting in wheelchair in common area. She was being supervised by myself and the nurse. She was very restless and attempted to stand. I would redirect her by reminding her to sit in her chair. At 4:30 PM, dinner was given to resident. At 5 PM, she remained in common area being supervised between nurse and I. Around 6:30 PM, I saw that the resident was in common area sitting on the floor. " On 10/29/22 at 3:15 PM, interview with V26 (c.n.a.) stated, "I worked for the agency and just started full time here. The day I came in at the start of my shift (R4) was on her wheelchair, so me and the nurse we did our normal rounds and she was in the TV room and we were just putting eyes on her because she was high risk for falls. When I saw her before that, she was agitated and	S9999		

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she kept putting her feet off the wheelchair and so I kept trying to put her feet back on the wheelchair foot rests and told her to watch TV After dinner, she was still there in the TV room and I was trying to take care of other residents. Then another resident used a call light and I went to that resident to see what he wanted and that is when I heard (R4) scream for help. When I got there (R4) was sitting on the floor and I went to get the nurse. The nurse came and checked her and asked if she was okay and she examined her. Surveyor asked if there were any alarms heard that alerted her before R4 fell to the floor, V26 stated, "No sir, I did not hear any alarms because there no alarms on the wheelchair. I was not told she was supposed to have one and nobody told me about that." Surveyor asked whether anyone from the facility informed her of what fall precautions were to be used for R4, V26 stated, "The time (R4) fell was only the second time I took care of her. Nobody told me anything about her or what we do with her." Surveyor asked if the facility trained her on who the residents were that were at risk for falls and what to do to keep them safe from falling, V26 stated, "No, I am just given my assignment and I normally am on a different wing than R4 and I'm not told of that by my nurse." Surveyor asked if there was anyone assigned to the TV to monitor R4, V26 stated, "No."

Fall care plan dated 1/16/22 reads in part (but not limited to): (R4) high risk for falls related to dementia. Interventions: bed alarm to alert staff when resident attempts to get out of bed unassisted so staff can assist resident and prevent falls; Chair alarm to alert staff when resident attempts to get out of chair unassisted, so staff can assist resident and prevent falls; I prefer to keep the bed in the low position for

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S9999	Continued From page 10 safety; Please provide floor mats/floor pads at my bedside; Make sure my call light is within reach and encourage me to use it for assistance as needed." MDS (Minimum data set) assessment dated 1/23/22 showed R4 with BIMS (Brief interview for mental status) score of 5 denoting severe cognitive impairment. R4's functional status for activities of daily living showed she required extensive assistance with minimum 2-person assist with bed mobility and transferring from one surface to another. On 1/27/22 at 2:00 PM V4 (Regional nurse consultant) was made aware that surveyor had requested documents starting on 1/25/22 and was only being provided signed witness statements and other documents today (1/27/22). V4 apologized and stated, "I will let the higher-ups know." On 1/27/22 at 3:00 PM V23 (executive director) was asked again whether her team provided all the documents requested by surveyor pertaining to all the fall investigations the facility conducted as various documents were being provided piece-meal to surveyor days later, V23 stated, "We provided everything we have." On 1/27/22 at 3:25 PM, interview with V25 (medical director) stated, "I am (facility's) medical director and I am told of the falls they have and I know there are a lot. We are trying everything possible to try to prevent falls there. I'm alerted on all the falls and I try to attend all the fall meeting we have there to discuss the preventative measures we are trying. I'm aware of the increased amount of falls happening and we just	S9999		

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S9999	Continued From page 11 try to do the best we can do. The part of the problem is that there are new and younger nurses there and they are learning and that just takes time. My goal is to try to give the staff more confidence in their abilities to manage these problems that they are having. That is part of the problem, their confidence." Surveyor asked whether he was questioning the skill level of nurses to manage the falls, V25 stated, 'Well perhaps. There are many new and young nurses I see there and they just need to develop more and this takes time. The falls happening there are not new and we have been trying to solve the problem for many months now." Surveyor asked whether there was a staffing concern he had with the facility, V25 stated, "No, I see many of the department heads working and the director of nursing and the NP are all there to try to help. The issue is more the new staff as I mentioned. There are more staff that come and they need to be trained to handle multiple problems not just falls." Facility policy dated 7/28/21 titled "Fall Occurrence" reads in part (but not limited to): "It is the policy of the facility to ensure that residents are assessed for risk for falls and interventions are put in place to prevent them from falling. A fall risk assessment from will be completed by the nurse or falls coordinator upon admission, readmission, quarterly, significant change, and annually. Those identified as high risk for falls will be provided interventions to prevent falls. If a resident had fallen, the resident is automatically considered as high risk for falls. An incident report will be completed by the nurse each time a resident falls. The falls coordinator will review the incident report and may conduct his/her own fall investigation to determine the reasonable cause of fall. The nurse may immediately start	S9999		

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S9999	Continued From page 12 interventions to address falls in the unit." (A)	S9999		