STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005003	A. BUILDING: _____ B. WING _____	C 03/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSHORE ESTATES NURSING & REHAB	6125 SOUTH KENWOOD CHICAGO, IL 60637

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S 000	Initial Comments Complaint 2282313/IL144986	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.690a) 300.690b) 300.690c) 300.1010h) 300.1210b) 300.1210c)3) 300.1210d)6) 300.3240a) 300.3240b) 300.3240e) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. 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. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. 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	S9999		

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S9999	Continued From page 2 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. 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 care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. 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	S9999		

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S9999	Continued From page 3 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) These Regulations were not met as evidenced by: Based on interview and record review, the facility failed to immediately report a resident's fall and initiate assessment as defined in the facility's policy; failed to adequately investigate the root cause of the fall and provide appropriate documentation for the resident's fall. This failure affected one resident, R1 reviewed for quality of care. R1 fell by the elevator/nursing station on the fourth floor around the time of shift change	S9999		

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S9999	Continued From page 4 (approximately 3pm) on 2/25/22, and no proper documentation of R1's fall, although the fall was witnessed by nursing staff. No record of a timely physician notification until 2/26/22 at 8:35pm and no record of a head-to-toe assessment after the fall. On 2/26/22 at 8pm, R1 was "noted lethargic and barely responding to touch nor the calling of his name". R1 was sent to the hospital on 2/26/22 at 8:20 pm and expired on 3/4/22. Findings include: On 03/22/2022 at 11:58 AM, the surveyor asked V14 (CNA/Certified Nurse Assistant) if V14 was present at the time R1 fell in front of the nursing station. V14 stated, "I do remember when R1 fell straight back." V14 stated, in part, that R1 walked up to the nurse's station and was trying to get onto the elevator. The elevator was full at the time and V16 (Psych tech) who was riding the elevator attempted to tell R1 that R1 needed to wait for the next elevator because there were too many people on it at the time. According to V14, R1 kept trying to get on the elevator at which point V16 "grabbed R1 by the arms" and attempted to move R1 back. V14 stated that R1 lost his balance and fell backwards onto the floor near a cart that was sitting in front of the nurse's station. V14 stated that it didn't look like R1 hit R1's head on the floor; that R1's back took the brunt of the fall and R1 stopped his head from hitting the floor. V14 stated that 3 staff members (V14, V16, and V17-LPN/Licensed Practical Nurse) assisted R1 back up off the floor and that R1 proceeded to get on the elevator after the fall. V14 stated that this happened right before 3pm because V14 was getting ready to punch out at the end of the shift. On 03/22/2022 at 12:09 PM, the surveyor	S9999		

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S9999	Continued From page 5 interviewed R14 who was sitting in a chair in the doorway of R14's room directly across from the nurse's station in view of the elevator. When the surveyor asked R14 if R14 witnessed the incident involving R1, R14 stated, "Yes." R14 stated, in part, that R1 was trying to get on the elevator, but it was too full. R14 stated that, "One of the guys that works here grabbed (R1) by the chest and pushed (R1) out of the way. That's when R1 fell back." R14 was unable to state who the staff member was that pushed R1. R14 stated that R1 lied down on the floor for a few minutes then got up and went to R1's room. When the surveyor asked R14 if R1 hit R1's head, R14 stated that with the way R1 fell backward then R1 probably did hit R1's head. When the surveyor asked if the staff had done an assessment or any vital signs on R1 at the time of the fall, R14 stated, "Nobody checked to see if (R1) was injured." On 03/22/2022 at 12:14 pm, R15 stated that R1 was R15's roommate. When the surveyor asked if R15 had witnessed the incident involving R1, R15 stated, "No." R15 stated that R15 was in R15's room when R1 entered the room and lied down on the bed after the incident occurred. R15 stated that R1 told R15 that one of the psych techs had punched R1 in the chest and R1 fell and hit R1's head. R15 stated that R1 told staff right away that R1 was injured and that R1 was in a lot of pain, but they (the staff) just kept giving R1 pain pills. R15 stated that staff didn't come to do vital signs on R1 until later that night. R15 stated that the incident took place around 1:30-2:00 pm. R15 stated, "I had to help R1 put R1's covers on. R1 couldn't move." R15 stated that R15 can't recall if it was the same day of the incident or if it was the next day that R1 was sent to the hospital, but by that time, R1 was unconscious.	S9999		

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S9999	Continued From page 6 On 03/22/2022 at 3:47 PM, the surveyor asked V1 (DON/Director of Nursing) if V1 was notified that R1 had a fall. V1 stated, "Yes, the nurse called me, but R1 didn't report it that day." V1 stated that it was the next day or day later that R1 was complaining of R1's leg hurting. V1 stated that the doctor ordered an x-ray. When the surveyor asked where the fall took place, V1 stated, "R1 was getting off the elevator." The surveyor asked V1 what the protocol is for reporting a fall. V1 replied, "They (staff) have to call me or the ADON (Assistant Director of Nursing), do an incident report, contact the doctor, call the family, and update the fall assessment because it's a new fall." V1 stated, "At the time the nurse called me, R1 was self-reporting the fall." V1 stated that, R1 was very alert R1 would talk to V1 about everything. The surveyor asked V1 if a staff member had witnessed the fall at the nurse's station what would be the expectation of the staff member. V1 stated, "It depends on the situation. They (staff) would be expected to immediately report the fall, maybe get labs, move the resident closer to nurse's station, do head-to-toe assessment, do vital signs, interview the resident to make sure the resident is alert." V1 stated that R1 was provided education after reporting the fall. When the surveyor asked if R1 was a risk of falls, V1 stated, "No, R1 was not a risk at all for falls. I believe it was an isolated incident." The surveyor asked if V1 was aware that there was an altercation with another staff member at the time of the fall, V1 stated, "No." The surveyor asked V1 if V1 knows why V16 (psych tech) resigned. V1 stated that V16 didn't give a reason why. V1 stated, "Sometimes people take it personal when we have to look into certain things."	S9999		

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S9999	Continued From page 7 On 03/22/2022 at 4:16 PM, the surveyor asked V18 (MD/Medical Doctor/R1's Attending Physician) when V18 was notified that R1 had a fall. V18 stated, "I'm not in the system so I can't look at the note. I don't know if it was same day or next day." The surveyor asked if a resident fell backwards what is the expectation of the staff. V18 stated, "They're supposed to notify the doctor with any fall. It doesn't matter if fell backward or forward." On 03/23/2022 at 9:36 AM, the surveyor asked V1(Director of Nursing) to review footage from the camera located at the nurse's station on the fourth floor. V1 stated that V1 spoke with the Administrator (who was on vacation at the time of the investigation) regarding accessing the camera system. V1 stated that the Administrator told V1 that, "The camera system is not an advanced system and does not have the capability of rewinding back no more than seven days." On 03/23/2022 at 11:30 AM, the surveyor asked V19(LPN) to recount the day V19 worked with R1. V19 stated, "I was giving out medication when R1 called me from his room that R1's leg hurt. R1's room is close to the nurse's station. R1 was requesting pain medication. R1 tried getting up and R1 was limping. R1 said R1 fell yesterday. When I asked R1 if R1 reported the fall to anyone, R1 said that he didn't tell anybody and that he'll be ok. I told him next time tell the nurse. I educated him to report the fall in a timely manner." V19 stated that V19 called the DON that R1 was complaining of pain and unsteady gait. V19 stated, "I called the doctor to get a stat x-ray." V19 stated that the x-ray was done during V19's shift and that V19 also gave R1 a pain medication. V19 stated, "I didn't know anything after that." When the surveyor asked what R1's	S9999		

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S9999	Continued From page 8 mental status was at the time, V19 stated, "R1 was very alert and oriented x 4. I had worked with him before." V19 stated that R1 had no other complaints at that time other than the leg. The surveyor asked V19 where R1 had told V19 that he fell. V19 stated, "He told me that he fell in the elevator." The surveyor pointed out that in V19's progress note on 2/26/2022 at 12:36 pm, it says R1 fell in the elevator and then again that R1 fell in the restroom and failed to report it. V19 stated, "No. I think R1 told me he fell in the elevator." The surveyor inquired about a change of condition progress note that V19 wrote with a "created date" documented as March 18, 2022, and the effective date was February 26, 2022. V19 stated, "I got a call from the supervisor that I should lock my notes. I think it was last week. They stated that I shouldn't leave my note on the draft. March 18 was the date they told me to lock my notes." On 03/28/2022 at 10:14 am, the surveyor did a phone interview with V20 LPN. The surveyor asked V20 if V20 had gotten any report from the day shift nurse that R1 had reported a fall. V20 stated, "No, I was not aware V1 had fallen." V20 stated that R1 was not on 72-hour observation or neuro (neurological) checks. V20 added, "If I had known that he had fallen, I would have relayed that message to the doctor when R1 went to the hospital. The nurse had not charted anything." On 03/28/2022 at 3:38 PM, V18 MD was interviewed regarding falls in general and was asked if a resident fell backward and hit his head, could that cause a subdural hematoma. V18 responded, "Yeah, that can happen." When asked what other potential harm can be caused by falling backward, V18 stated that sometimes nothing happens, but other times a resident can	S9999		

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S9999	Continued From page 9 have bleeding in the brain, can break the neck or the skull depends on what the resident hit on the floor. Review of the "72 Hours Neurological Flow Sheet" shows that neuro checks were started on R1 on 02/26/2022 at 12:30 PM and were continued by V20 LPN starting at 4:15 PM until 7:15 PM. Review of the facility daily staffing sheets showed that V16 (psych tech) was scheduled on 02/25/2022 for the 3-11 pm shift on the 5th floor. V14(CNA) and V17(LPN) were scheduled on the 7 am-3 pm shift on the 4th floor. Review of V16's personnel file documents V16's last day worked was 02/25/2022 and contained a handwritten note from V16 on 03/04/2022 documenting V16's resignation. The Facility Reported Incident dated 02/27/2022 documents the brief description of the incident as: "It was reported to writer that R1 alleged that staff member was inappropriate with him." No fall was mentioned in the report. Review of R1's progress notes show no documentation of R1 sustaining a fall on 02/25/2022. The first mention of a fall was documented by V19 LPN (Licensed Practical Nurse) on 02/26/2022 at 12:36 PM. R1's Nursing Progress Note documented, in part, "R1 summoned writer to (R1's) room, upon arrival R1 reported pain to left hip, stated (R1) had a fall yesterday in the elevator. Resident stated (R1) had a fall in the restroom, R1 thought (R1) was okay that's why (R1) failed to report." The "created date" of this progress note was 03/03/2022(6 days later).	S9999		

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S9999	Continued From page 10	S9999		

R1's Nursing Progress Note written by V20(LPN) on 02/26/2022 at 8:00 pm documents, in part, "Resident noted lethargic, and barely responding to touch nor calling of his name."

R1's hospital "EM (Emergency Medicine) Resident Assessment Note" dated 02/26/2022 at 9:26 PM documented by V21 (MD/Medical Doctor) indicates that R1 presented with "Altered Mental Status." In the history of present illness, V21 documented, "Pt (patient) obtunded with only a gag reflex and intubated on arrival."

R1's hospital hand-written progress note dated 03/05/2022 at 4:48 PM from an unknown hospital employee documented, "Sent V22 (Resident physician) an email to call the medical examiner for assistance with the death certificate. V22 stated that (V22) is unsure if patient cause of death was traumatic or non-traumatic."

During this investigation, several attempts were made to speak with V22 or an attending physician at the hospital but were unsuccessful.

R1's Brief Interview for Mental Status (BIMS) dated 12/23/2021 documented a score of 14 out of 15, indicating that R1 was cognitively intact.

R14's Brief Interview for Mental Status (BIMS) dated 01/13/2022 documented a score of 15 out of 15, indicating R14 is cognitively intact.

R15's Brief Interview for Mental Status (BIMS) dated 02/17/2022 documented a score of 15 out of 15, indicating R15 is cognitively intact.

The undated facility policy titled "Incidents/Accidents/Falls" documents, in part, "It

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S9999	Continued From page 11 is the policy of the facility to ensure that any incident/accident to include falls is reported immediately to the nurse or appropriate person designated to be in charge. After the resident has had immediate attention and their safety is established, a written report will be entered into Risk Management. The facility will ensure that incidents and accidents that occur involving residents are identified, reported, investigated and resolved." Procedure includes but is not limited to: "2. In the case of a fall, the resident will have a head-to-toe assessment to include a pain assessment and assessment as to any change in their ROM (Range of Motion) ability/function. Further, residents who have an unwitnessed fall must have neuro checks (neurological checks) started and continued per policy. Neuro checks will be initiated even if the resident states they did not hit their head in an unwitnessed fall. 3 ...When possible, a descriptive statement(s) will be obtained from the resident and/or any witnesses ...11. All falls will have a site investigation by appropriate staff to define the "root cause" of the fall. This will help provide information to enable staff to roll out interventions to prevent another similar occurrence." (A)	S9999		