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
	IL6006100	A. BUILDING: ______ B. WING ______	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY PLACE	1415 WEST FOSTER AVENUE CHICAGO, IL 60640

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S 000	Initial Comments Facility Reported Incident Investigation of January 26, 2022/IL142999	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 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 each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999	Attachment A Statement of Licensure Violations	

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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.

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.

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to supervise dementia residents who are at high risk for falling, failed to ensure all residents are assessed for falls upon admission, failed to ensure safety precautions were in place to minimize the risk of injury and failed to follow their Fall Policy and Fall Risk Assessment Policy for 2 (R1, R2) of 3 residents reviewed for falls in the sample of 3 residents. These failures resulted in R1 sustaining a right hip fracture requiring surgery and R2 sustaining a dislocation of the right hip prosthesis for a recent femur fracture which required surgery.

The findings include:

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R1, a cognitively impaired, non-ambulatory, 96 year old female, was admitted over a year ago on 1/4/21 with a fractured femur that required surgery per face sheet. The Annual Minimum Data Set (MDS) dated 1/9/22, states R1 requires extensive assistance for her activities of daily living (ADLs). R1's cognition (Brief Interview Mental Score/BIMS) score is a "4" which indicates cognitive impairment. The surgery was a hip rodding in December 2021. R1 has been assessed as a high risk for falls on 1/4/22 and 10/5/21 with an unsteady gait. R1 has sustained many falls while in the facility per the care plan. R1 has had unwitnessed falls on 3/4/21 at 5 PM, 7/9/21 at 6 PM, 8/5/21 at 11:45 PM and 1/22/22 at 7:30 PM. R1's fall on 1/22/22 at 7:30 PM resulted in R1 fracturing her right femur and requiring Cephalomedullary fixation of the right femur. V6 (Registered Nurse/R.N.) and V7 (Certified Nurse Aide/C.N.A.) were the assigned staff members.

R1's care plan interventions for falls were to ensure frequent monitoring and a low bed.

On 3/9/22 at 11:17 AM, V7 stated on 1/22/22 R1 was complaining about sitting up all day and wanting to lay down so R1 was taken to her bed and laid down. V7 stated the bed was at its lowest position, not sure of the inches but low. V7 stated not to remember if there was a bed alarm but stated the corridor door is left open and the room is near the nurses' station. V7 stated there was no floor mattress or pad. V7 stated it was V6 who informed her that R1 was on the floor. V7 stated that R1 had to walk a few feet to reach the doorway which was unexpected because R1 was laid down 15 minutes earlier after being toileted.

Attempts to contact V6 (R.N.) were unsuccessful.

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The facility's report on R1's fall of 1/22/22 at 7:30 PM documents R1 was found on the floor in hallway by her door. There were no witnesses, no alarms or floor mats. R1 did have a low bed but there is no measurement as to how low the bed was positioned. R1 sustained a skin tear to right elbow and right thigh and was sent to hospital where R1 had a Cephalomedullary fixation of the right femur. R1 returned to the facility on 1/27/22 per the MDS and nurses' note. The new intervention after this fall was to provide a chair/bed alarm but this intervention had been care planned since the 3/4/21 fall investigation and care plan.

R2, a cognitively impaired, non-ambulatory, Spanish speaking, 90 year old male, was admitted on 1/13/22 with a metallic right hip prosthesis that was dislocated 2 times prior to entry to this facility per R2's face sheet and admission MDS dated 1/13/22. R2 required extensive assistance with ADLs. R2's BIMS is "8" per the admission MDS 1/13/22; but the 2nd admission MDS dated 1/19/22 (following surgery) documents a BIMS of "00" which indicates cognitive impairment. R2 sustained a fall in his room on 1/16/22 at 8 PM which resulted in R2 re-dislocating the hip prosthesis. V8 (R.N.) and V9 (Certified Nurse Aide/CNA) were assigned to R2.

R2's care plan intervention for falls are to ensure frequent monitoring and a low bed.

On 3/4/22 at 10:30 AM, V5 (4th Floor R.N.) stated the facility uses bed/chair alarms, floor mats and constant monitoring for residents at risk for falls.

On 3/4/22 at 12:15 PM, V2 (Restorative R.N.) stated that the staff will round every hour for

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S9999	Continued From page 4 frequent monitoring and the fall risk residents are in rooms closer to the nurse's station. V2 stated due to R1's unsteady gait and the ability to take a few steps, a floor mattress would not be good in R1's room. V2 stated R2 came to this facility after R2 dislocated his hip prosthesis 2 times in another nursing home and surgery was put on hold while R2 received skilled therapy here. V2 stated that R2's bed was lowered to knee height approximately 16 inches from the floor because the bed height assisted in proper hip/knee alignment when exiting the bed. V2 stated after this 3rd dislocation of the prosthesis, surgery was performed as planned. On 3/4/22 at 2 PM,V2 (Restorative R.N.) stated R2 arrived with an immobilizer on his right leg due to sustaining a fall which required surgery at another nursing home prior to entry to this facility. Asked for R2's initial fall assessment, V2 stated it should be there. The initial 1/13/22 fall assessment was blank, and it was presented to V2. V2 had no response. The facility staff failed to provide an initial fall assessment for R2. On 3/9/22 at 10:40 AM, V8 (R.N.) stated R2 was a new resident, and this was the first time she worked with him. V8 stated R2 was very restless, moving around in the bed, would not use call light, spoke Spanish mostly and continuously removed his clothing and adult brief and threw them. V8 stated not to be aware of R2's cognition but stated when the C.N.A. would say "English, English" then R2 would respond in English. V8 stated R2 was unable to walk and had an immobilizer on his right leg. V8 stated not to recall any alarm on R2 when R2 was found on the floor in his room. V8 stated R2 was x-rayed, and the fracture was dislocated again. R2 was sent to hospital where surgery was done due to	S9999		

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S9999	Continued From page 5 dislocating the metallic prosthesis in the right hip. On 3/9/22 at 11:52 AM, V9 (C.N.A.) stated R2 was always restless, agitated and removed his clothing and adult brief. V9 stated to recall a landing strip (a thin, rubberized mat) pad on the floor on R2's right side. V9 stated not to be aware that R2 was demented and that R2 kept saying "wants to go outside for a walk". V9 stated she found R2 on the floor next to his bed. Review of the facility's R2 fall incident 1/16/22 documents that R2 is oriented to self only, sustained a mechanical fall with acute right femoral neck fracture, right hemi-arthroplasty dislocated 2 times since 1/7/22. R2's right leg was extended outward with immobilizer intact along with fecal matter smeared on his left hand, left thigh and smeared on bed sheets and pillow. Bed was positioned at knee height. After this fall, a personal alarm and floor mat were applied as fall interventions. The facility's policy labeled FALLS - CLINICAL PROTOCOL documents while many falls are isolated individual incidents, a few individuals fall repeatedly. Those individuals often have an identifiable underlying cause. The staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or consequences of falling. If interventions have been successful in fall prevention, the staff will continue with current approaches and will discuss periodically with physician whether these	S9999		

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S9999	Continued From page 6 measures are still needed. The facility's policy labeled FALL RISK ASSESSMENT documents upon admission, the nursing staff and the physician will review a resident's record for a history of falls especially falls in the last 90 days and recurrent or periodic bouts of falling over time. Assessment data shall be used to identify underlying medical conditions that may increase the risk of injury from falls. Staff will evaluate functional and psychological factors that may increase fall risk, including mobility, excessive motor activity, cognition and activities of daily living. The staff and physician will collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable. (A)	S9999		