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
	IL6000012	A. BUILDING: ______ B. WING ______	C 03/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA CARE CLIFTON	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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 Facility Reported Incident March 15, 2022/IL145213	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1010 h) 300.1210 b) 300.1210 d)3)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 300.1010 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 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1 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. 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow the current standard of practice for one of three residents (R1) when the facility did not immediately assess a change in condition to R1's right knee that included: swelling and R1's knee no longer being	S9999		

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contracted. This failure resulted in R1 going seven days without receiving diagnostic testing of R1's right knee. X-rays performed seven days after the change in R1's right knee appearance revealed an acute or subacute fracture of the distal femur with considerable impaction/shortening deformity for one of three residents (R1) reviewed for Injuries of Unknown Origin on the sample list of three.

Findings Include:

On 3/29/22 at 9:45 am, R1 was lying in bed with a brace to the right leg that went from mid-thigh to the lower calf. R1 was not able to say why R1's leg was in a brace.

R1's MDS (Minimum Data Set) dated 3/7/22 documents R1 has severe cognitive impairment.

R1's undated Final Abuse Investigation Report documents on 3/15/22 at approximately 1:50 pm, V1 (Administrator) was notified of an Injury with Unknown Origin. R1 was found to have swelling by R1's knee, an x-ray was conducted and revealed a distal femoral fracture. This Investigation contained witness statements from staff who had cared for R1 in the days prior to R1 being diagnosed with a fractured femur. Included in these witness statements were statements from V11 (Certified Nursing Assistant/CNA) and V7 CNA. V11's statement documents V11 noticed R1's knee to be red and swollen on 3/8/22. V7 CNA's statement documents V7 noticed R1's knee was "swollen and no longer contracted" and that V7 reported the findings to V20 (Agency Licensed Practical Nurse/LPN) as well as V6 LPN but does not document the day that V7 noticed the change.

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S9999	Continued From page 3 On 3/29/22 at 12:00 pm, V7 stated V7 doesn't recall what day it was that V7 noticed R1's leg to be swollen and no longer contracted. V7 explained it was between 5:00 am - 5:30 am when V7 went to put R1's pants on during morning cares that V7 noticed R1's right leg was no longer contracted, and the knee was swollen. V7 stated "normally (R1) is very hard to get dressed due to contractures but (R1's) leg was actually really loose." V7 explained V7 reported the change to R1's nurse, an African American Agency Nurse, {later identified as V20 Agency LPN} but V20 refused to look at it. V20 "said that (R1) was "very discriminating and doesn't like black people", so V7 then asked V6 (LPN) to look at R1's leg. V7 stated V6 (LPN) was busy at the time but stated V6 would go assess R1. V7 explained that R1 is very contracted, and this was a "big change." The facility Nursing Daily Schedule dated 3/7/22 - 3/15/22 was reviewed and the 3/9/22 Nursing Daily Schedule documents this is the only day that V6 (LPN) and V20 worked together, working 6:00 pm (3-9-22) - 6:00 am (3-10-22). Therefore, the day that V7 noticed R1's knee to be "swollen and no longer contracted" was the morning of 3/10/22. On 3/29/22 at 12:12 pm, V11 (CNA) stated V11 doesn't remember the exact day V11 noticed R1's right knee swollen and no longer contracted but "it was one week prior to us finding out it was broke." At the time, there was no redness, but R1's leg was "loose, not contracted anymore." V11 stated V11 reported it to the agency nurse, "I (V11) don't know her name, but she was a petite African American." {later identified as V20 Agency LPN). V11 stated V20 did not check it out but did say V20 had already told another nurse about it.	S9999		

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S9999	Continued From page 4 "It was a crazy situation. (R1) is always very contracted and it {leg}wasn't. It was really loose." V11 stated it was "a big change that needed reported" because V11 didn't know what happened to cause it. R1's Progress Notes dated 3/14/22 documents R1 is noted to have a swollen right knee. V22 Physician notified and ordered received to order a mobile X-ray for tomorrow. This was the first documentation of R1's change in knee condition in R1's medical. R1's right knee X-ray dated 3/15/22 documents, "there is an acute or subacute appearing fracture" at the distal femur, with considerable impaction/shortening deformity. On 3/29/22 at 12:25 pm, V3 ADON (Assistant Director of Nursing) stated V3 doesn't remember the exact day V3 found out about R1's fractured leg but getting R1 an X-ray was on our "honey do list that the DON (Director of Nursing) gives us" due to R1 having "issues with (R1's) leg, (R1's) knee was swollen." V3 explained R1's legs are generally always contracted and "it wasn't." V3 stated V3 would expect staff to update the Physician and POA (Power of Attorney) "with that kind of change." V3 also stated, with R1's change in condition being "that extreme", "it should have been reported to either the DON (Director of Nursing) or myself and Administrator at the time, not just the nurse." V3 ADON (Assistant Director of Nursing) stated V2 DON (Director of Nursing) completed most of the interviews regarding this investigation and those were centered around the staff that provided care to R1 around the time the injury was reported {3/15/22}, which was 7 days after the changes in R1's knee was noticed {3/8/22} by V11.	S9999		

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On 3/30/22, V1 Administrator confirmed V1 did not find out about the changes to R1's knee until 3/15/22, 7 days after the change was first witnessed and reported to the nurses: V6 LPN and V20 Agency LPN. V1 also stated, the nurses should have assessed and documented R1's change in condition on the 3/8/22, and if they felt it was a "big change" they should have reported it to the Physician.

The facility Abuse Prevention and Reporting Policy dated December 2021 documents "An injury should be classified as an "Injury of Unknown Source" when both of the following conditions are met:" the source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or location of the injury." If the injury is classified as an "Injury of Unknown Source", the procedures and time frames for reporting and investigating abuse will be followed. This policy also documents, employees are required to report any incident, allegation or suspicion of potential abuse to the administrator immediately, and nursing staff are responsible for reporting the appearance of suspicious bruises, lacerations, or other abnormalities as they occur.

"A"