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
	IL6000046	A. BUILDING: ____ B. WING ____	C 06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDOLORATA VILLA	555 MCHENRY ROAD WHEELING, IL 60090

(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 Complaint Investigation 2293933/IL147088 Facility Reported Incident of 5/1/22/IL146585	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210 b)5) 300.1210 c) 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	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 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. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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 These requirements are not met as evidenced by: Based on observation, interview and record review the facility failed to safely conduct a resident transfer who required extensive assistance with a minimum two-person assist for 1 (R1) of 3 residents reviewed in the sample; and failed to follow facility fall prevention care plan and guidelines. This failure resulted in R1 being emergently transferred to the hospital's emergency department where he was diagnosed with a hip fracture and head laceration.	S9999		

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Findings include:

R1 is an 86-year-old male admitted to the facility on 07/26/2021 with diagnosis including but not limited to Muscle Weakness, Parkinson's Disease, Repeated Falls, Difficulty Walking, Atrial Fibrillation, and Dementia.

MDS (Minimum Data Set) dated 02/02/2022 under section C, R1 has BIMS (Brief Interview of Mental Status) score of 6 indicating severely impaired cognition.

MDS (Minimum Data Set) dated 08/03/2021, 10/27/2021, 01/21/2022, and 02/02/2022 under section G, all showed R1's functional status for transfers required extensive assistance with minimum two-person staff assist to transfer from bed to chair.

Care plan dated 02/28/2022 showed R1 was at risk for falls with interventions: keep call light within reach, encourage use of call light, low bed, physical therapy referral, and side rail for repositioning.

Fall risk assessment dated 04/28/2022 showed R1 at very high risk for falls.

Alternate fall risk assessment dated 05/01/2022 showed R1 remained at a very high risk for falls.

On 6/1/22 at 10:25 AM, surveyor observed R1 sitting in the common area in the reclining chair. R1 was transferred to the room for an interview. There were no fall mats noted on the floor or anywhere stored in the room upon entrance to R1's room and a leaf sign (indicating fall risk) posted by R1's room number. Surveyor asked if R1 remembers what happened on 05/01/2022,

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S9999	Continued From page 3 R1 stated that he doesn't remember what happened; however, he recalls that he had a leg fracture around that time. Surveyor clarified which leg was affected, R1 pointed to the left leg. On 6/1/22 at 12:00 PM surveyor interviewed V3 (RN, Registered Nurse). Surveyor asked about the fall sustained by R1 on 05/01/2022, V3 stated, "R1 fell around 7:00 AM while V4 Certified Nursing Aide (CNA) was trying to get him ready for breakfast. R1 usually needs two-person assist or standing mechanical lift. V4 explained that she was trying to get R1 ready by herself, while she was changing his clothes, she realized he was too heavy, and R1 started to slide off the bed. V4 attempted to lower the bed while R1 was sliding off the bed. I wasn't in the room at the time of an incident. When I came in R1 was sitting on the dresser leaning to the left and his head was leaning against the dresser. R1 is on blood thinners, so I made a full assessment to look for any bleeding, I also checked neurological function and range of motion, I didn't notice any changes." Surveyor asked how many people does R1 require for transfers, V3 stated, "R1 always requires two-person assist, he is considered a fall risk resident." Surveyor clarified what does an image of a leaf posted by the R1's room number mean, V3 stated, "I don't know what that is". Surveyor's asked V3 to accompany them to R1's room to look at the fall mats in question. Upon arriving in the room, V3 searched for the mats that were to be used for R1 but could not find any mats used or stored anywhere in the room. V3 stated, "I'm sorry but I cannot find any floor mats, but we are supposed to use them for R1." Surveyors clarified whether mats were stored anywhere on the unit, V3 stated, "No we don't have storage area for the mats, they would be folded up against the wall ready for use or in the	S9999		

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closet."

On 6/1/22 at 12:20 PM surveyors asked V2 (Director of Nursing) information pertaining to the leaf symbolism observed on various rooms and for fall prevention guidelines. V2 indicated she was not aware of the leaf symbol used by the facility, however, was aware the leaf symbol referred to fall risk residents. V2 was able to provide policy and procedures pertaining to falls but could not find any information regarding the leaf symbol. Surveyors asked how long she was in her position, V2 stated, "Over 2 years."

Progress note dated 05/01/2022 at 10:50 AM completed by V3 (RN) reads in part, "At 07:10 AM, care partner reported that R1 fell on to the floor during transfer from bed to wheelchair. She (V4) realized that resident is heavy and not safe to transfer, so she just assisted him to sit on the floor, but his head hit the wood drawer. Immediately went to the resident's room with another nurse. R1 observed sitting on the floor leaning to the left side. Head to toe assessment done. Observed skin laceration on the left side of the head. Informed MD and she advised to send resident to emergency room hospital for further evaluation and treatment. Resident complained of pain to the left hip and desaturated to 88%. 911 called, R1 picked up at 8:08 AM and transferred to the hospital."

Interview with V4 on 6/1/22 at 11:30 AM stated, "I was R1's CNA that day he fell but I didn't know this resident (R1) at all, and it was my first time working with him when he fell. I was on orientation from this other CNA. I can't recall her name, but she didn't really tell me much about (R1). I was trying to transfer him from bed to wheelchair close to beginning of my shift (6:30

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am) and his feet got stuck on the wheelchair. He was really, really, heavy and he started to fall, and I tried to keep him from falling, but like I said he was heavy so I kind of lowered him to the ground, but he dropped to the ground, and he hit his head on the furniture and was bleeding. He looked like he was in shock or something when he was on the ground, so I shouted to the nurse (V3), and she came right away, and I know she checked him out and they sent him to the hospital. I found out later he had a fracture and I felt bad because no one helped me get this man (R1) out of bed. I didn't know he was a fall risk, and no one told me anything about R1 or any of the residents." Surveyor asked what fall preventative measures she was instructed use with R1 and other residents under her care? V4 stated, "I don't know what they do for people who are fall risk because I normally do private duty, that's my regular job. I was not even given instructions on anything for this man (R1). I was just given an assignment, that's it." Surveyor asked if the Director of Nursing (V2) called her to investigate the fall, "I never got any call from anyone from the facility, in fact you are the first person (referring to surveyor) that has called me about the fall." Surveyor asked again whether anyone from the facility including the Director of Nursing, Administrator or any other staff left a message or tried calling her to interview and investigate about R1's fall? V4 stated, "No."

Interview with V5 CNA on 6/1/22 at 10:30 AM stated, "I'm agency, I just came in to get the call light because (V2-DON) said to get the call light. I don't know these residents well but what's your question?" Surveyor asked which residents were considered fall risk, V5 stated, "Like I said I don't know these residents well, I'm agency and I've only worked here a couple of times." Surveyor

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asked if anyone from the facility informed her of who the residents that are at risk for falls, V5 stated "No, they don't tell us anything, they just tell us which section we have and that's it." Surveyor asked if the facility in-serviced (training) her on fall prevention, V5 stated, "No."

On 6/1/22 at 2:00 PM Surveyor interviewed V7 (Physician). Surveyor asked if V7 remembered the fall that R1 suffered on 05/01/2022, V7 stated, "Yes, I remember, R1 was sent to the hospital after he fell where he was diagnosed with hip/femoral fracture. I don't know the details of the fall. The facility said that R1 accidentally fell, and I just gave them an order to send him to the emergency room. R1 was hospitalized for few days to get evaluated by an orthopedic specialist; however, the decision was made not to perform a surgery. R1 is unsteady due to his Parkinson's disease. He is also very confused and has dementia. R1 is only able to follow very simple directions and he cannot hold himself standing up." Surveyor clarified if someone with Parkinson's disease who is confused and unsteady would be safe to transfer with one-person assist, V7 stated, "R1 would probably benefit from two-person assist. Parkinson's disease residents are not stable and it's safer to have two-person assist while performing transfers with them."

Interview with V6 CNA on 6/1/22 at 2:20 PM stated, "Yes, I have R1 today, I put him back to bed." Surveyor asked about the one floor mat observed beside R1's right side, V6 stated, "I don't know, I was told by the nurse (V3) to make sure it was there". Surveyor asked why there was only one fall mat on one side of the bed and not the other side, V6 stated, "I don't know why." Surveyor asked what would prevent R1 from

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injury if he fell on the other side of the bed without a mat, V6 stated, "I guess you're right, but I was just told to put the mat on this side (pointing to R1's right). Surveyor asked if R1 was considered a fall risk, V6 stated, "I guess so because of the fall mat." Surveyor asked what other interventions R1 was placed on to keep him safe from falls? V6 stated, "I don't know." Surveyor asked if she received any in-service training to keep her residents safe from falls, V6 stated, "I was not told anything about any of the residents except to get them up and answer call lights."

On 06/01/2022 at 2:53 PM, Surveyor interviewed V8 (RN, Registered Nurse). Surveyor asked if he is familiar with R1, V8 stated, "R1 is alert and oriented to himself, he requires one-person assist, and is on pureed diet. He is a fall risk due to his Parkinson's Disease. R1 had fracture of the left hip, I readmitted him on 05/04/2022. I was also present at the time of the incident on 05/01/2022. V3 (RN) called me for help when R1 fell. I went to the room, V3 was already there, R1 was sitting on the floor. His head was leaning against the dresser. V3 checked his vital signs and assessed him. R1 had laceration on his head due to the fall, I didn't see any other injuries. We put him back into the bed with mechanical lift. V4 was assisting R1 that morning." Surveyor asked what fall precautions were utilized for R1, V8 stated, "We are using quarter (length) bed rails to have him something to hold on to; keep bed in low position; frequent monitoring as often as hourly; we are also utilizing a fall mat on the right side of the bed; and orienting residents to use the call light." Surveyor clarified why only one mat was used on the right side of the bed, V8 indicated that he doesn't know why. Surveyor asked about the meaning of the leaf symbol outside R1's bed, V8 stated, "I'm not aware of the

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S9999	Continued From page 8 leaf posted by the R1's room or what it means." Hospital emergency room record reads in part: Admit dated 5/1/22 Discharge dated 5/3/22. HPI (history of present illness): (R1) is an 86-year-old with medical history significant for Parkinson's disease, hypersensitivity lung disease, hypertension, atrial fibrillation on blood thinners, history of deep vein thrombosis ... with mostly wheelchair bound living at a nursing home into hospital after having witnessed fall while being transferred to wheelchair. (R1) had impact on left side and was noted to have left subcapital fracture of the left femoral neck. Ortho was consulted and he was admitted for further management." Facility progress noted dated 05/04/2022 at 2:47 PM completed by V8 (RN) reads in part, "R1 arrived on 05/03/2022 at 6:25 PM from the hospital. On continuous oxygen, two liters per minute. Resident readmitted with diagnosis of closed fracture of the left hip with routine healing." Facility policy dated 10/01/2012 titled "Falls and Fall Risk-Managing policy reads in part, "It is the policy of the community that based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risk and causes to try to prevent the resident from falling and trying to minimize complications from falling. The staff, with the input of attending physician, will identify appropriate interventions to reduce the risk of fall. Staff will identify and implement relevant interventions to try to minimize serious consequences of falling" (A)	S9999		

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