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
	IL6001051	A. BUILDING: ______ B. WING ______	C 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRMONT CARE	5061 NORTH PULASKI ROAD CHICAGO, IL 60630

(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 FRI of 10/2/2022/IL151462	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.120d)6 300.1220b)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 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	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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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:

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.

These Requirements were NOT MET as evidenced by:

Based on interview and record review, the facility failed to provide proper bed mobility assistance

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for turning in bed to avoid physical harm to one (R1) of four (R1, R2, R3, R5) residents reviewed for resident injury. This failure resulted in R1 sustaining injuries of an acute comminuted fracture of the left proximal humerus extending from the humeral diaphysis through the humeral neck and involving the humeral head.

Findings include:

R1's Face Sheet documents, in part, R1's diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, contracture left hand, contracture left ankle, contracture right ankle, reduced mobility, muscle weakness, difficulty in walking and cognitive communication deficit.

R1's Minimum Data Set (MDS), dated 9/16/22, documents, in part, that R1's Brief Interview for Mental Status (BIMS) score is a "99" which indicates that R1 was unable to complete the interview. R1's Staff Assessment for Mental Status indicates that R1's Short-term and Long-term memory is a "1" for "Memory problem" and that R1's Cognitive Skills for Daily Decision Making" is a "2" for "Moderately impaired - decisions poor; cues/supervision required." R1's Functional Status for Activities of Daily Living (ADL) Assistance documents, in part, "Bed mobility - how resident moves to and from lying position, turns side to side, and positions body while in bed" with a Self-Performance code of "4" for "Total dependence - full staff performance every time during entire 7-day period" and Support code of "3" for "Two + (plus) persons physical assist." R1's Functional Abilities and Goals for Mobility documents, in part, "A: Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on

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S9999	Continued From page 3 the bed" is coded as "1" for "Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity." R1's Bladder and Bowel Status for "Urinary Continence" documents, in part, a code of "3" for "Always Incontinent (no episodes of continent voiding)," and for "Bowel Continence" which is documented as a code of "3" for "Always Incontinent (no episodes of continent bowel movement)." R1's Care Plan, dated 2/1/21, documents, in part, a focus of "ADL: Resident requires assist with: Bed mobility ... Related to: Limited mobility, Poor Cognition, Difficulty making needs know ... Due to diagnoses: " ... AMS (Altered Mental Status), left hemiparesis and right gaze preference. Moderate large right temporo-parietal stroke" with an intervention of "provide assistance with repositioning in bed." R1's Care Plan, dated 2/26/21, documents, in part, a focus of "Bed Mobility Program: Resident with impaired bed mobility as evidence by: Difficulty in repositioning self in bed ... Related to: weakness, debility, poor cognition and easily gets tired/poor endurance." No goals or interventions exist for this focus. On 10/24/22 at 12:47 pm, V3 (Registered Nurse, RN) stated, "I (V3) am familiar with (R1). (R1) is oriented times one, only to (R1's) self, confused and bed bound. (R1's) left side, (R1's) not able to move it, not at all." On 10/24/22 at 3:23 pm, V3 (RN) stated, "CNA's do the (incontinence brief) changing and turning." V3 stated, R1 speaks in Korean and understands English, but "(R1) can't communicate back to you	S9999		

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in English."

R1's Left Humerus (2 + views) X-ray results, dated 10/2/22 at 7:57 pm, documents, in part, "Impression: Acute comminuted fracture of the proximal humerus extending from the humeral diaphysis through the humeral neck and involving the humeral head." R1's Left Shoulder (2 + views) X-ray results, dated 10/2/22 at 7:53 pm, documents, in part, "Impression: Comminuted acute fracture, of the proximal humerus including the proximal humeral diaphysis extending through the humeral neck and into the humeral head at the level of the greater tuberosity."

Facility documents dated 10/1/22 (Saturday) and titled "(Facility) Staff Daily Assignment," document, in part, that for the CNA "room assignments" for R1 were as follows: 7:00 to 3:00 pm shift with V20 (CNA); 3:00 pm to 11:00 pm with V8 (CNA) and 11:00 pm to 7:00 am with V7 (CNA).

On 10/25/22 at 1:28 pm, V20 (CNA) stated that V20 was R1's CNA on 10/1/22 for the 7:00 am to 3:00 pm shift and that V20 was assigned as R1's CNA the "one time." V20 stated, "(R1) is a total, basically. I (V20) have to do everything for (R1)." V20 stated that V20 did not get R1 out of bed during V20's shift on 10/1/22. When asked about V20 providing incontinence care for R1 in bed, V20 stated, "I (V20) lay (R1) flat. Turn (R1) left and right and left. Did by myself (V20's self). (R1) didn't do anything (to help)." When asked how is V20 to know how many persons are needed for bed mobility assist like a 1 person assist versus 2 persons assist. V20 stated, "It depends on the weight. If the resident is real heavy, I (V20) will get someone else."

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S9999	Continued From page 5 On 10/24/22 at 5:25 pm, V8 (CNA) stated that V8 was R1's CNA on 10/1/22 for the 3:00 pm to 11:00 pm shift and that V8 was assigned as R1's CNA "a couple of times a month ago." V8 stated, "(R1) can't move very good. Had a stroke. (R1) is confused and can't talk very good." V8 stated, V2 (Director of Nursing, DON) and V3 (RN) had spoken to V8 after V8's care of R1 on 10/1/22. V8 stated, "I (V8) told them (V2, V3) that I (V8) changed (R1's) (incontinence brief) and at that time, (R1) was in a cranky mood." V8 stated, "I (V8) was able to change (R1) by myself. (R1) was like (R1) doesn't want be bothered. (R1) was telling me (V8) that (R1) didn't want to be changed. (R1) was very cross. I (V8) told (R1) that I (V8) have to change (R1) because (R1) was wet, so (R1) don't want skin to be broken." V8 stated, "(R1) can't turn by (R1's) self. The right side of (R1's) bed was open (to the room). Left side of (R1's) bed was against the wall. To turn (R1), I (V8) push (R1) by the shoulder and under (R1's) arm with one hand and take (R1's) hip part with other hand and turn (R1's) towards the wall." V8 stated, "When I (V8) am turning (R1) towards me (V8), I (V8) am on the right side of the bed. I (V8) take under (R1's) left arm. I (V8) am putting my (V8's) one hand under (R1's) arm pit but not directly on (R1's) shoulder blade. I (V8) have to be very careful. Some residents have osteoporosis." When asked if R1 had spontaneous movement of R1's left arm, V8 stated, "I (V8) didn't work much with (R1). (R1) didn't move (R1's) left arm. (R1's) paralyzed. I (V8) move (R1) towards me (V8) on right side of bed. I (V8) reached over (R1's) body and under (R1's) left arm with my (V8) left hand and move (R1's) hips with right hand." When asked if V8 used the draw sheet to turn R1 in bed, V8 stated, "Very seldomly do I (V8) use it (draw sheet) to turn side to side. I (V8) don't use that (draw	S9999		

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S9999	Continued From page 6 sheet)." On 10/24/22 at 5:12 pm, V7 (CNA) stated that V7 was R1's CNA on 10/1/22 for the 11:00 pm to 7:00 am shift and that V7 is usually assigned as R1's CNA. V7 stated, "(R1) is total care. (R1) is in and out a little bit but mostly alert. (R1) speaks some English and understand it when I (V7) speak to (R1). (R1) talks to me (V7), if (R1) don't want something or is in pain." V7 stated, "(R1) is bed bound on the night shift. I (V7) change (R1's incontinence brief). Clean (R1). Do everything for (R1)." When asked about V7 performing care for R1 in bed on 10/1/22 from 11:00 pm to 7:00 am, V7 stated, "I (V7) did do my rounds. (R1) will say apayo. Apayo means pain (in Korean). If you turn (R1) too hard, (R1) will let you know. (R1) had (R1's) gown on and could see (R1's) arm was hurt." V7 stated, "It was on my (V7) last rounds at 4:30 am (10/2/22). I (V7) go to push to (R1) over. (R1) likes to have (R1's) moments when (R1) doesn't want to be bothered. With (R1's) good hand (right hand), (R1) can swipe at you." When asked about the 4:30 am rounds on 10/2/22, V7 stated, "I (V7) went to change (R1). I (V7) told (R1), I (V7) have to change you. We had to pump (oral) fluids in you. When I (V7) turned (R1), (R1) said apayo. I (V7) turned (R1) by myself. I (V7) usually get somebody. (R1's) a 2 person (assist)." V7 stated, "If we have help, then I (V7) use 2 people. Using the pad to turn (R1). Bed side rail is up. As soon as I (V7) touched (R1), (R1) said apayo. I (V7) lifted up (R1's) gown and saw a bruise on left arm." V7 stated that R1's bruise was observed on the upper and outer part of R1's left arm. When asked to describe R1's left arm bruise, "Red bruise. Burgundy color. Size of small plum or apple." On 10/26/22 at 3:15 pm, V9 (Nursing	S9999		

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S9999	Continued From page 7 Supervisor/RN) stated that V9 was R1's assigned nurse on 10/1/22 from the 7:00 pm to 7:00 am shift. V9 stated, "(R1) stays in bed. (R1's) full assistance." V9 stated that on 10/2/22 "around 5:30 am," V7 (CNA) informed V9 about R1's left upper arm bruise. This surveyor asked V9 when did V9 document the assessment R1's left arm bruise, and V9 stated that V9 "corrected" the documentation on 10/11/22; however, V9 originally documented R1's progress note "on 10/2/22 around 8:00 am. V9 stated, "(R1) couldn't turn by (R1's) self in the bed." When asked V9 if V9 has assisted with turning R1 in bed, V9 stated, "No, I (V9) haven't helped (R1) turn. Usually, the CNA will assist with turning." When asked V9 how many persons are needed for bed mobility for R1, V9 stated, "I think one person." When asked how can V9 find out how many persons are needed for R1's bed mobility, V9 stated, "The computer system (electronic medical record, EMR) at the top which assigns on (resident's) wrist band. On (resident's) wrist band, it specifies a '1' or '2' which depends on how many staff are needed." V9 stated that CNAs can see how many persons are needed to turn a resident on the resident's wrist band and in "their CNA charting." When asked if a resident's wrist band signifies a '2' for 2-person assistance, how is that '2' generated for that resident, and V9 stated, "They are evaluated by the rehab restorative nurse." When asked what's the importance of following the restorative nurse's assessment for a resident for bed mobility, V9 stated, "It's for the safety of the patient." When asked what effect to the resident is if the resident was assessed as a 2 person assist for bed mobility and then a 1-person assist was provided instead, V9 stated, "The instructions are there and (we) have to follow the instructions from the evaluation by restorative to prevent; it's for the	S9999		

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S9999	Continued From page 8 safety of the patient." In R1's Progress Notes, dated 10/11/22 at 11:41 am with type of note as "Correction", V9 (Nursing Supervisor/RN) documented, in part, "Notified by CNA (V7) while rendering patient care, resident (R1) complained of left upper arm pain. Assessed resident arm noted upper arm swelling with bluish discoloration of the skin. Resident verbalized pain 6/10 (6 out of 10) scale." On 10/25/22 at 10:09 am, V12 (Restorative Nurse) stated that V12 performs restorative assessments on residents at admission and quarterly to "put in the amount of care that we think is needed for them transferring and bed mobility, and the amount of staff that is needed for the patient." V12 stated, restorative assessment is documented in the EMR where nursing staff can identify how many staff are needed for bed mobility. V12 stated that if the restorative assessment for bed mobility is assessed for 2 person bed mobility, then staff must "have two people to assist the patient during bed mobility." V12 stated that V12 performed R1's 9/15/22 restorative assessment. V12 stated, "(R1) is totally dependent. Pretty much a total assist. (R1) can move right arm. Bilateral legs cannot move. Left arm, the tenacity is stiff." When asked to describe the 2-person assist for bed mobility, turning a resident side to side, V12 stated one staff member will stand on each side the resident's bed. V12 stated, "You would use the draw sheet to turn the patient." V12 stated, the staff members would encourage the resident to hold onto the bed rail if possible and that the staff member (who is on the side of the bed where the resident is turned) would then "hold with the draw sheet if they (resident) can't hold the side rail." V12 stated, the same staff member	S9999		

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would then hold onto the resident while the staff member behind then turned resident "gently lowers the draw sheet" to perform care. V12 stated that this process would be repeated to roll the resident in bed to the opposite side. V12 stated that staff will "roll (resident) side to side using the draw sheet. Not physical movement of the body; use draw sheet." When asked what the purpose of a draw sheet is for in bed mobility, V12 stated, "It helps with bed mobility, so you don't touch the patient or injure the patient by touching their body when pulling their body up." When asked about a 1 person assist for bed mobility, V12 stated the resident must be "actively participating in bed mobility. You wouldn't use a 1 person assist if the resident is not actively able to participate in bed mobility." When asked if R1 is able to participate in bed mobility, V12 stated, "No, (R1) total assist. (R1) needs 2 person assist." V12 was asked if V12 would expect nursing staff to use a 1-person assist when V12 has coded that resident for a 2-person assist, and V12 stated, "No. It could cause injury to the resident and cause injury to yourself (staff)." When asked if V12 would expect nursing staff to turn a resident side to side in bed without using a draw sheet, V12 stated, "No, a draw sheet must be used to turn side to side in bed." When asked if V12 would expect the nursing staff to go under a resident's arm pit to turn a resident in bed, V12 stated, "Never. Never are they (staff) to go under someone's arm."

In R1's "Restorative Functional Assessment," dated 9/15/22, V12 (Restorative Nurse) documented, in part, that R1's functional assessment type was "Quarterly" with R1's cognitive status as "Alert, Confused, Oriented to person, and Forgetful." V12 documented, in part, R1's "Bed Mobility: Repositions self in bed: Self

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Performance: 3=Extensive assistance. Repositions self in bed: Support Needed: 3=2 + (plus) person physical assistance. Turns to right side: Self Performance: 3=Extensive assistance. Turns to right side: Support Needed: 3=2 + person physical assistance. Turns to left side: Self Performance: 3=Extensive assistance. Turns to left side: Support Needed: 3=2 + person physical assistance."

In R1's "Restorative Program Quarterly Notes," dated 9/15/22, V12 documented, in part, "(R1) requires total dependence with ADLs."

R1's Skin Risk Assessment Tool, dated 9/17/22, documents, in part that R1's "Range of Motion Extremity Mobility" is scored as at "4" which is "Immobile-passive ROM, unable to reposition self."

On 10/25/22 at 10:31 am, V13 (CNA Scheduler/CNA) stated that CNAs can look in the EMR, look at the resident ID band or ask a nurse to find out how many staff are needed for bed mobility. V13 stated that a 2-person assist is listed on the ID band, and the "person assist is determined by the restorative assessment." V13 stated with a 2-person bed mobility assist, the 2 staff members will "turn with the pull (draw) sheet." V13 stated, "If you push on (a resident's) body, you could injure them or bruise them. Pull sheet is more supportive."

R1's Physician Order Activity Detail Report, documents, in part, a readmission order, dated 9/30/22, for "Apply ID (Identification) Bracelet."

On 10/25/22 at 3:50 pm, V2 (DON) stated that CNAs would find out in the EMR, from the nurses or from the resident's ID band about how many

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S9999	Continued From page 11 staff are needed to perform a resident's care. V2 stated a "2 person assist" would be listed on resident's ID band. V2 stated, "It's visible and goes with the restorative nurse's assessment." V2 stated, "I expect my CNA staff to look at the (resident's) ID band to see what assistance level is needed." When asked what the effect is of turning a resident who is coded as a 2-person assist and staff performs bed mobility with 1-person assist, V2 stated "An accident could happen if they (staff) don't follow what they are supposed to follow. Accident can mean, injury or fall." V2 stated that with bed mobility for a 2-person assist when positioning a resident in bed, staff are to use the draw sheet to turn the resident side to side in bed. On 10/27/22 at 1:23 pm, when asked if V2 would expect the nursing staff to move or turn a resident in bed by placing their hand or arm under a resident's arm pit to move the resident, V2 stated, "No." V2 was asked why not that process. V2 stated, "The mechanism can injure the resident or the staff. It's not the proper way of doing it." On 10/25/22 at 3:24 pm, V14 (Nurse Practitioner) stated, "(R1's) total care." When asked if V14 is expecting that nursing staff follow the restorative assessment for R1 for a 2-person assist in bed mobility, V14 stated, "Well, yes. I (V14) am assuming that they (staff) are doing what they are supposed to be doing." V14 stated with R1's X-rays showing osteopenia, "With care provided, it is possible with care that a fracture could happen." However, V14 stated, "If (R1) is rolled in bed and (R1's) arm gets tucked under the hip, a fracture could have occurred." Facility policy undated and titled "Mobility Policy: Bed Mobility; Transfer; Ambulation," documents,	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRMONT CARE	5061 NORTH PULASKI ROAD CHICAGO, IL 60630

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S9999	Continued From page 12	S9999		

in part, "Policy: All residents will be assessed on admission and quarterly, or more often as change of condition warrants it, for their mobility. A program will be developed based on the individual resident's needs. This program will be reflected on the interdisciplinary care plan and consistently carried out by staff. Purpose: To be able to establish baseline mobility function of resident. To be able to assess and address resident's mobility needs. To be able to assist resident reach highest level of functioning in mobility. To be able to preserve function in mobility ... To promote safety. To minimize deterioration in mobility within the limits of normal aging and/or recognized disease process ... This policy and procedure covers bed mobility ... Procedure: 1. Upon admission, the nurse will assess resident's ability to move as part of functional assessment ... 2. When mobility is triggered for required further assessment, the nurse will complete the further assessment utilizing the designated functional assessment ... 7. Functional assessment in relation to mobility will be completed quarterly ... utilizing the MDS and supplemental assessment tool."

Facility policy dated September 2021 and titled "Repositioning," documents, in part, "Purpose: The purpose of this procedure is to provide guidelines of resident repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed- or chair-bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents. Preparation: 1. Review the resident's care plan to evaluate for any special needs of the resident ... 3. Repositioning is critical for a resident who is immobile or dependent upon staff repositioning ... Steps in the Procedure: Repositioning the

Illinois Department of Public Health

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S9999	Continued From page 13 Resident in Bed: 1. Check the care plan, or the communication system to determine resident's specific positioning needs including special equipment, resident level of participation and the number of staff required to complete the procedure." Facility policy dated September 2021 and titled "Restorative Nursing Services," documents, in part, "Policy Statement: Residents will receive restorative nursing care as needed to help promote optimal safety and independence. Policy Interpretation and Implementation: 1. Restorative nursing care consists of nursing interventions ... 3. Restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's care plan." Facility policy titled "Activities of Daily Living (ADLs), Supporting" and dated March 2018, documents, in part, "Policy Statement: Residents will (be) provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Policy Interpretation and Implementation: ... 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming and oral care); b. Mobility (transfer ...) c. Elimination (toileting) ... 5. A resident's ability to perform ADLs will be measured using clinical tools, including the MDS ... e. Total Dependence - Full staff performance of an activity with no	S9999		

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S9999	Continued From page 14 participation by resident for any aspect of the ADL activity. Resident was unwilling or unable to perform any part of the activity over entire 7-day look-back period. 6. Interventions to improve or minimize a resident's functional abilities will be done is accordance with the resident's assessed needs, preference, stated goals and recognized standards of practice." Facility Job Description, titled "Certified Nursing Assistant" and undated, documents, in part, "Position: Certified Nursing Assistant ... Position Duties & Responsibilities: 1. Follows daily assignments per charge nurse. 2. Keeps residents dry and clean ... 3. Performs personal care such as baths, showers, oral hygiene, skin care and hair care on assigned residents ... 11. Answers call lights in a timely manner regardless of the assignment to ensure safety and proper service to residents ... 18. Provide for resident's physical, psychological, social, safety and other needs. Actively works towards the promotion of Improved Quality of Life. 19. Perform nursing care according to the established facility standard." (B)	S9999		