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
	IL6001184	A. BUILDING: ______ B. WING ______	C 09/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRITISH HOME, THE	8700 WEST 31ST STREET BROOKFIELD, IL 60513

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S 000	Initial Comments Facility Reported Incident of August 8, 2023 IL163449	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)3) 300.1210 d)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 resident to meet the total nursing and personal care needs of the resident.	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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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.

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to properly position a resident (R1) in bed to prevent the resident from falling out of bed onto the floor, failed to properly assess R1 after his fall incident and prior to moving the resident post fall, and failed to follow facility policy by leaving resident unattended during fall event. These failures resulted in the resident being sent out emergently to a local hospital in pain, and R1 was diagnosed with dislocation to his right hip which required surgical intervention. This failure affected one (R1) of three residents reviewed for accidents.

Findings include:

R1's electronic medical record indicated resident admitted to the facility on 08/04/2023, was discharged on 08/08/2023, and readmitted on

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08/25/2023. R1 has a past medical history not limited to dislocation of right hip, encephalopathy, acute and chronic respiratory failure, acute osteomyelitis of right ankle and foot, hypotension, and peripheral vascular disease.

R1's care plan, dated 08/04/2023, reads, "resident is at risk for falls related to gait instability and poor balance."

R1's Minimum Data Set (MDS) Section G for functional status, dated 08/08/2023, indicated R1 requires two-person assist for bed mobility, which includes turning side to side and body positioning in bed.

R1's incident report, dated 08/08/2023, indicated R1 was being changed by (V4) a male certified nursing assistant (Certified Nursing Assistant/CNA) when R1 "kept pulling on side rail and was hanging out of the bed". R1 was told to stop pulling on rail, but "did not listen", and was then in a kneeling position on the floor. When the CNA (V4) walked around the bed, R1 fell face forward. R1 was sent to a local hospital emergently via ambulance. Page three of this same report, indicated R1 was lying in bed on his side and was holding on to the side rail when R1 "unexpectedly and unpredictably dangled his legs beyond the edge of the mattress", and with the forward momentum of his legs, slid out of bed onto his knees then subsequently "let go of the side rail and slid the rest of the way to the floor". (V4) CNA called out for help and the nurse immediately went to assist and "completed a full head to toe assessment", where she observed a skin tear to his right arm and R1 complained of pain rated "6/10" on a numerical scale. R1 was emergently sent to a local hospital for further evaluation and treatment per physician's orders.

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R1 was admitted to the hospital and diagnosed with "right hip dislocation with no acute fracture".

R1's progress note, dated 08/08/2023 created by V5 (Registered Nurse), indicated R1 had a fall incident and sustained a skin tear to his right arm, but V5 was "unable to assess (R1) fully as paramedics in room (R!) on to stretcher". Note continued with, "(R1) denies pain", but was requesting to go to hospital.

R1's hospital records, printed on 08/25/2023, indicated while in hospital, R1 had two unsuccessful attempts at a closed reduction to his right hip and had an open reduction procedure to his right hip with orthopedics on 08/11/2023.

On 09/01/2023 at 11:32 AM, R1 said on day of his fall incident, "I fell". R1 then said a male staff member, V4, was helping him get into bed, when he began slipping out of his arms, and almost fell to the floor. R1 added he "kept slipping and sliding out from the male aide's (V4) hold", was face down when his hands went down to the floor. R1 then said the male aide, V4, was trying to hold the rest of his (R1) body up, but eventually his whole body ended up on the floor. R1 added he had "pain all over, and he (V4) could not get me up from the floor, so the paramedics came and took me to the hospital."

On 09/01/2023 at 2:44 PM, V4 (Certified Nursing Assistant/CNA) said as far as he knew, R1 was a two-person assist for transfers in and out of bed but to provide care; it was okay with one person. V4 then said while providing care to R1 on day of incident (08/08/2023), he used the turning pad underneath R1; pulled it towards him to turn R1 onto his side. V4 added after he had turned R1 onto his side, he noticed that the resident "was a

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little too close to the edge of the bed". V4 (CNA) said R1 became anxious because he was on the edge, and he was unable to calm him when his legs then went over the side of the bed. V4 added he tried to hold on to R1 from the opposite side of bed, but was unable to, and R1 then slid out of bed to the floor onto his knees while he was holding on to the side rail with his arms. V4 then went over to R1's side (right side) of the bed, and tried to hold his upper body up so that R1 would not completely go onto the floor. He added R1's call light wasn't working, so he walked over to the other bed and pressed the call light, and when he returned to R1's side, he was face down on the floor and was "hollering". V4 said he didn't notice any injury to R1 other than bleeding from his right arm. After the nurse (V5) assessed R1, he and another aide used the mechanical lift to get R1 off the floor and back onto bed, while the nurse left to make phone calls, then returned approximately ten minutes later and said R1 was being transferred out. V4 (CNA) did not indicate if the nurse (V5) assessed R1's range of motion to his lower extremities and whether they could move R1. When asked why he didn't initially reposition R1 away from the edge of the bed when he saw that R1 was close to the edge, V5 said "I don't know, I should have repositioned him, but everything just happened so fast".

On 09/01/2023 at 3:01 PM, V5 (Registered Nurse) said on day of incident at approximately 6:30 AM, V4 (CNA) was providing care to R1, when he came out of the room, informed another aide (V8), who informed her R1 was on the floor. When she walked into R1's room, she observed the bed to be waist level high, and R1 was face down on the right side of bed on the floor between the bed and wall. V5 saw blood on the floor, then asked R1 if he had hit his head. She

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indicated R1 said no, but it looked like he did in her opinion, so she left the room due to observing the blood, and R1 didn't complain of any new pain. When asked if she assessed R1's range of motion to lower extremities, V5 said it was communicated to her R1 was sitting on the floor, but that was not how she observed R1 to be, and she knew that R1 needed to be transferred out to the hospital emergently. V5 said after calling 911 along with R1's physician and family, she went back to his room, and R1 was in bed. V5 said she did not verbally instruct the aides to transfer R1 from the floor back into to bed. She added R1 did not complain of any hip pain, just the chronic pain to his right heel, which he had received scheduled pain medication for at approximately 6:00 AM. V5 added she didn't recall when the last fall in-service was, and a resident's level of care is communicated during shift to shift report that is done by both nurses and aides.

Reviewed first floor report sheet provided by V2 (Assistant Director of Nursing/ADON) indicated R1 is a assist of one, with activities of daily living and bed mobility which is documented within his Minimum Data Set (MDS) Section G-functional status.as a two-person physical assist.

On 09/02/2023 at 10:26 AM, V2 (Assistant Director of Nursing) said her expectations for nursing post fall is for a "staff member to stay with the resident to prevent further injury, and for the nurse to do a full head to toe assessment to determine level of injury and if resident requires further evaluation. The aides are not to move the resident until the nurse completes an assessment and determines whether there is any injury or not. Staff should refer to a resident's chart regarding their level of care and assistance."

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On 09/02/2023 at 12:40 PM, V8 (Certified Nursing Assistant) said while leaving another resident's room, she saw R1's call light on and V4 (CNA) standing in R1's doorway saying he needed something, but she couldn't hear what it was. She added while heading towards R1's room, V4 began walking towards her and said, "(R1) is on the floor". V4 then said when she entered R1's room, R1 was in between the bed and the radiator almost in a fetal position, saying "please help me". She saw some blood on the floor, but was unsure where it came from. V8 then left the room and went to get the nurse (V5). Upon entering R1's room, the nurse began looking for injury and asking him questions, but said she did not personally see the nurse assess R1's range of motion because she was moving things about room out of the way. After the nurse left to make the phone calls, R1 was asking to get off the floor, so V4 got the mechanical lift and they got R1 up off the floor. V8 added the nurse (V5) did not directly instruct them to get R1 up. When asked when the last in-service on fall policy and procedures was that she had attended, V8 (CNA) said they are frequent and mandatory; believes the last one was a week ago, but she does not recall when the last in-service was prior to R1's fall.

Reviewed bed mobility policy labeled "turning resident on side away from you" last revised October 2010 that reads:
"Purpose: provide comfort to the resident, to prevent skin irritation and breakdown, and to promote good body alignment.
Preparation: review the resident's care plan to assess for any special needs of the resident
Steps in the procedure:
5. slide both your arms under the resident's back to his/her far shoulder.

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6. slide the resident's shoulders toward you on your arms.
7. slide both your arms under the resident's buttocks.
8. slide the resident's buttocks toward you.
9. slide both arms under the resident's feet and ankles.
10. slide the resident's feet toward you.
11. cross the resident's arms over his/her chest.
12. cross the resident's leg nearest you over the leg farthest from you.
15. place one hand on the resident's shoulder nearest you.
16. place your second hand under the resident's buttocks.
17. gently turn the resident away from you"

Reviewed fall-clinical protocol policy, revised March 2018, that reads:
"Assessment and Recognition:
2. the nurse shall assess and document/report the following:
a. vital signs
c. musculoskeletal function, observing for change in normal range of motion, weight bearing, etc.
e. neurological status"

Reviewed fall prevention in-service agenda and attendance logs that showed V4 (CNA) attended on 07/23/2023 and 08/24/2023.V8 (CNA) attended on 08/24/2023. V5 (RN) was not listed on either attendance logs.

(A)