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
	IL6007876	A. BUILDING: ____ B. WING ____	C 01/27/2023

NAME OF PROVIDER OR SUPPLIER: DOWNERS GROVE REHAB & NURSING

STREET ADDRESS, CITY, STATE, ZIP CODE: 3450 SARATOGA AVENUE, DOWNERS GROVE, IL 60515

(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 2370516/IL155506	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)6) 300.3210o) 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	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 plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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: 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 300.3210 General o) The facility shall also immediately notify the resident's family, guardian, representative, conservator, and any private or public agency financially responsible for the resident's care whenever unusual circumstances such as accidents, sudden illness, disease, unexplained absences, extraordinary resident charges, billings, or related administrative matters arise.	S9999		

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These requirements are not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide toilet assistance to prevent an unwitnessed fall; failed to follow the facility's fall protocol; and failed to assess a resident following an unwitnessed fall. These failures resulted in R1 sustaining multiple rib fractures, swelling to his right eye, and bilateral knee contusions.

The findings include:

On 1/22/23 at 12:23 PM, V12 (R1's family member) said she arrived at the facility at 8:30 AM on 1/3/23. V12 stated, "When I walked in, he was sleeping, but his room looked like a murder scene. I noticed both his knees were red and appeared bruised. There was a thick mattress on the floor beside his bed. His walker was broken and there was blood all over the room. There was drops of blood from the bed to the bathroom and a larger area of blood in the bathroom, by the toilet. It was so awful, I took pictures. Everything on his overbed table had been knocked off and was on the floor. I asked him what happened, and he told me that he turned on his call light around 3:50 AM to go to the bathroom. He said that the CNA (Certified Nursing Assistant) told him 'no, just go in your diaper.' He told me that he decided to go by himself, but lost his footing on the mattress and fell onto his walker. He had to hit that walker hard because it was broken, and he ended up with several fractured ribs. I was in tears when he told me what happened to him. I asked the CNA and nurses what happened, but no one knew anything. I waited in the room for a long time. Finally, an agency nurse came in to give him his morning medication, but she wanted no part of it. She said she didn't know anything.

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and she didn't want to be involved. By then, more of our family members had arrived and we went to the DON's (Director of Nursing's) office, but she wasn't there. Eventually, V2 (DON) came to his (R1's) room, but she said she didn't know anything about him falling. V2 told me that she had been on vacation and hadn't read her emails yet."

R1's Face Sheet dated 1/22/23 showed diagnoses to include, but no limited to: spinal stenosis, depression, generalized muscle weakness, repeated falls, osteoarthritis, overactive bladder, hypertension, dementia, prostate cancer, abdominal aortic aneurysm, difficulty walking, and unsteadiness on feet.

R1's facility assessment dated 1/2/23 showed he had moderate cognitive impairment; required limited assistance of one person for bed mobility, transfers, and toilet use; and was always continent of bowel and bladder.

R1's Admit-Readmit Screener dated 12/27/22 showed R1 was admitted from an acute care hospital for rehab. This document showed that he had dementia/cognitive impairment and a recent fractured hip. This document showed R1 was alert and oriented to person, time, and situation.

R1's Morse Fall Scale dated 12/27/22 showed R1 was at "High Risk for Falling," with a score of 95.

R1's Care Plan initiated 12/27/22 showed, "R1 is at risk for falls r/t (related to) dementia and recent fall at home... Fell on 1/3/23 and was sent to the hospital for an evaluation. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests

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for assistance... Follow facility fall protocol."

R1's Progress Notes were reviewed from 12/27/22 (admission) to 1/3/23 (transfer to the emergency room). There was no documentation of R1's unwitnessed fall by the nursing staff before 1:23 PM. At 1:23 PM, V19 (Agency LPN - Licensed Practical Nurse) charted, "Resident was picked up by local ambulance, went out to local hospital accompanied by family per MD orders for further evaluation due to unwitnessed fall."

R1's MD Progress Note dated 1/3/23 at 9:17 PM, showed, "... Patient see in follow-up today for a fall that was unwitnessed earlier this a.m. (morning). Patient with dementia cannot give history. Discussed with family had significant blood in the room as well as some swelling in the right periorbital (eye) area, has some right chest pain, and bilateral knee pain... General: chronically ill appearing, does not appear stated age... Pain to right rib area... Redness to bilateral knees... Alert, cooperative, confused, cognition deficits noted. Assessments & Plan: ...Status post fall: Potential rib injury; patient with trauma unwitnessed to orbital area; bilateral knee contusion; Because patient unable to give history and unwitnessed fall with significant mechanism evidenced by multiple injuries and blood sent here for evaluation. Further recommendation to follow. Discussed with family. Questions answered..."

The surveyor requested the facility's fall investigation and/or documentation of R1's unwitnessed fall. The facility was unable to provide the requested documentation.

On 1/22/23 at 1:42 PM, V6 (RN - Registered Nurse) said after an unwitnessed fall, the nurse

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should perform a thorough assessment and observe for injuries. The nurse should provide first aid as needed. Then call the MD (Medical Doctor), family representative or POA, and the DON. V6 stated, "If there was a lot of blood, a swollen eye, right rib pain, and bilateral knee contusions, then I would call 911. Those injuries would need immediate action. Especially if I didn't know what happened." V6 said the nurse should complete an Incident Report; document the resident assessment and interventions; and document any first aid provided.

On 1/22/23 at 1:58 PM, V2 (DON) said after an unwitnessed fall the nurse should assess the resident and provide first aid. Then the nurse should call the MD for further orders; the family/POA should be notified; and the clinical person on call should be notified. The resident assessment and the information about the fall should be documented in the EMR (Electronic Medical Record). The nurse should complete an Incident Report; initiated Post-Fall Assessments; and enter a progress note. The documentation lets everyone know what happened. I don't know why there isn't any documentation of R1's fall. V2 stated, "I went to talk to R1, and his family was very upset. The daughter told me there was blood on the floor and on his pillow. R1 told me that he got up, un-assisted, and went to the bathroom. He said he lost his footing on the fall mat and landed on his walker. He complained about pain in both his knees and his knees were red. He told me that he had bilateral knee replacements, so I started palpating areas. He complained of tenderness to his right rib area. I think he had a skin tear on his arm too. R1 denied hitting his head, but just to be safe I called V24 (MD), to get X-ray orders."

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On 1/22/23 at 8:25 PM, V17 (CNA - Certified Nursing Assistant) said he works the overnight shift (10P-6A), and he was assigned to R1 that night. V17 stated, "He didn't fall for me. I haven't had a fall on my watch for months. I think R1 fell right before I came in. I have the same routine. I come in, get report, and collect my supplies for rounds. When I walked past R1's room, he was in bed, so I didn't think anything of it. I was in R1's room around 10:30 PM and noticed all the blood. There were drops of blood on the floor from R1's bed to the bathroom. I turned on the bathroom light and there was a pool of blood near the bathroom. I was like, "WTH (what the hell)!" I told the nurses right away and they said he'd been falling all day. I took a towel a tried to sop up the blood. The nurses from the previous shift was still there and stated, "Oh, he fell." I basically was sitter with him that night. That's how I know he didn't fall on my shift. We use a lot of agency staff, so I don't know most of their names. I told the nurse that she needed to check his elbow because it was cut, and he had a few scratches on his face. I'm not sure what she did when she went in the room."

On 1/23/23 at 9:05 AM, V15 (RN) said she worked the night shift on 1/2/23 but was not assigned to R1's room. V15 said if there is an unwitnessed fall, then the nurse must do a head-to-toe assessment, initiate neuro checks according to facility protocol, and notify the MD right away. There should be documentation in the progress notes and an Incident Report completed. The nurse should describe what happened, how the resident looked, where the resident was found, and who was notified. V15 stated, "It is very important for resident safety to treat the residents appropriately 24/7. The progress notes let the care team know what is

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happening with the resident, so we can follow-up and/or continue care. If a resident had an unwitnessed fall, increased pain with breathing or laughing, and soreness to the right ribs, then that would be alarming." V15 said she was not assigned to R1's room; V21 (RN) was R1's nurse that night shift.

On 1/23/23 at 12:07 PM, V21 (RN) said she remembers R1, and he was a very nice man. R1 was in bed and slept most of the night. R1 did not tell me about the fall, but I know he didn't fall on my shift. V21 stated, "If R1 had an unwitnessed fall, then the previous nurse should have done a head-to-toe assessment. I did not receive report of any inquiries. If I had known, then R1 would have been on neuro checks and more frequent assessments. I don't know the nurses name, she was agency. She should have been the one to complete the Incident Report and document R1's fall."

On 1/23/23 at 3:44 PM, V22 (RN) said she was familiar with R1. V22 stated, "I think he fell twice that same night. One of the agency nurses had R1 and she didn't do anything. V17 (CNA) came to me and said that there was blood on R1's floor and his elbow was bleeding. R1 wasn't assigned to me, but I went in to check on him. There was blood all over the room. There was blood over by the window, which was 15 - 20 feet across his room. I told the agency nurse about it, and she said that he was found on the floor mat, next to his bed earlier in the shift. I was in his room around 10:30 PM with V17 (CNA). The agency nurse came down but was overwhelmed. R1 had a skin tear to his elbow. I don't know if the agency nurse did anything. When I told her about the blood in R1's room, the agency nurse replied, 'I didn't know he fell again. I can't do 2 falls in 1

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shift!' I asked her if he could get out of bed, and she said she didn't know. The agency staff doesn't know anything about these residents, and they don't seem to know how to use the EMR (Electronic Medical Record). I'm not surprised there isn't any documentation. The communication is poor, and care can be disconnected because we have so much agency staff right now. V17 (CNA) was the one that asked if we could put a dressing on R1's skin tear, but the agency nurse didn't want anything to do with it. They don't want to be responsible for anything. I placed the dressing on R1's arm and left. I had my own assignment to take care of. I wouldn't be surprised if the agency CNA told him to go in his diaper, either."

On 1/23/23 at 2:23 PM, V20 (Agency CNA) said she had been taking an assignment regularly at the facility since September. V20 stated, "I remember R1, he was big sweetie. He used a walker and had a wheelchair. R1 could go to the bathroom with a 1 person assist. Basically, we were just there to keep him steady. He did really well. R1 would turn on his call light when he needed to go to the bathroom. He was continent but needed help to get to the bathroom. He would only try to get up by himself if someone wouldn't help him. I came in at 6 AM that day (1/3/23). I get report then start my rounds. He usually likes to sleep in a little bit, so his daughter made it to the room before I did. She expressed that he had a skin tear on his arm, and it was bleeding. She said she wasn't too sure what happened. I told the nurse and went back to check on him. He told me that he turned on his call light, to go to the bathroom, around 4 AM. He said that the CNA wouldn't take him to the toilet and told him to go in his diaper. R1 said that he tried to go to the bathroom himself but fell. he said he broke his

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walker. I could see the broken walker and a sharp part that had blood on it, where he probably cut his arm. He said he crawled to the bathroom. R1 said he yelled for help in the bathroom, but no one came, so he crawled back to bed. I did notice that his knees were really red. He was complaining of some pain to his right abdominal area when he laughed, talked, and sat up. That was a new pain for him. I told the nurse. I believe V6 (RN) did an assessment and said R1's knees were really red. R1 told her that's because I was crawling on the floor. There were little droplets of blood on the floor and in the bathroom, probably from his arm. The blood had dried up, so I had to call housekeeping to come clean it up. The walker was up against the wall, and I could see that it was broken. There was a thick mattress next to his bed. I'm sure that was hard for him to walk on. He was able to tell me what happened, but he wasn't sure who the CNA was that told him to go in his diaper. The CNA probably knew he had a diaper on and that's why they just told him to go in it. I was so surprised because he is one of the easiest residents to transfer."

On 1/27/23 at 11:17 AM, V16 (CNA) said she was working the day shift on 1/3/23. V16 stated, "I remember R1 telling me that he fell. He said that someone refused to take him to the bathroom, so he went by himself. He looked frustrated and irritated. This was around 6:30 - 7 AM. R1 had a scratch on his elbow. I told the nurse about it, she was an agency nurse, I don't know her name. I believe she did go and check on him. I remember he was very upset and so was his family. The whole situation with R1 was just not okay. He is an easy transfer, that's why I'm so confused that this happened. No one should refuse to take a resident to the bathroom and tell them to go in their diaper. That's just awful. R1 was able to tell

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S9999	Continued From page 10 us when he needed to go to the bathroom and was rarely incontinent." On 1/27/23 at 12:07 PM, V19 (Agency LPN) said she only worked one day at the facility and that was enough. V19 stated, "I don't remember R1 by name, but I remember the incident. Nobody told me anything about a fall in report. But the family said that R1 turned on his call light overnight and staff refused to take him to the toilet, so he took himself. He crawled to the bathroom and back to bed. His knees were red, and his elbow had a skin tear. I had no part of the fall, and I didn't want any part of it. R1 was part of my assignment that day (1/3/23), but I didn't want to get involved in that mess. The family was very upset, so I excused myself from that too. They were getting pretty loud. I gave R1 his medications and got out of there. I apologized to them because of the negligence of the previous shift. I won't ever go back there." On 1/27/23 at 11:28 AM, V2 (DON) said R1 reported that he fell during the night, but was unsure of the time. V2 stated, "I spoke with the night shift staff and they said he didn't fall during their shift. They said he fell on the previous shift (2P-10P). The evening staff said they had no recollections of any falls and they had been in his room. I have no idea if V24 (MD) was notified of the fall before I called him. I'm not sure the exact time, just that it was before noon on 1/3/23. I should have been notified of R1's fall. They call or text me all hours of the day and night, but I didn't receive anything about this. The nurse should have called R1's POA and MD too. They did not follow the fall protocol and procedure. I didn't see anything charted about the fall or notifications that were made."	S9999		

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On 1/27/23 at 3:13 PM, V24 (MD - medical doctor) said R1 was a recent admission. V24 stated, "I don't remember all the specifics, but I think it was an unwitnessed fall. It was pretty bloody. Clinically I thought he was at his baseline. Because of the unknown mechanism of injury and the multiple injuries, I sent him out to the hospital to be evaluated. He had rib pain. I wasn't sure if he hit his head. He was cleaned up by the time I got to the facility. I sent him to the emergency room, but he did not return to the facility. I'm not sure what time I was notified of R1's fall. It was in the morning of 1/3/23, but I would have to check my archives and I'm not sure if they go back that far." The surveyor requested V24 his phone/text archives and report the time he was notified. V24 did not call to provide the information.

The facility's undated Assessing Falls and Their Causes Policy showed, "The purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall... General Guidelines - 1. Falls are a leading cause of morbidity and mortality among the elderly in nursing homes... 4. Residents will be assessment upon admission and regularly afterward for potential risk of falls. Relevant risk factors must be addressed promptly... After a Fall: 1. If a resident has just fallen or is found on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities. 2. Notify a licensed nurse to evaluate the resident for potential injury. 3. Obtain and record vital signs as soon as it is safe to do so. 4. If there is evidence of injury, provide appropriate first aid and/or obtain medical treatment immediately. 5. If an evaluation rules out significant injury, help the resident to a comfortable sitting, lying, or standing

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(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
S9999	Continued From page 12 position, and document relevant details. 6. Notify the resident's attending physician/practitioner and family in a appropriate time frame. a. When a fall results in a significant injury or condition change, notify the practitioner immediately. b. Provide first aid/treatment as appropriate, notify EMS and/or arrange transport to the Emergency Department for further evaluation/treatment as needed and/or ordered... 8. Document the presence/absence of observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility; and any changes in the level of responsiveness/consciousness and overall function. Note the presence or absence of significant findings. 9. If the resident hit their head or the fall was unwitnessed, complete and documented neurological checks per facility protocol and/or physician order. 10. Complete an incident report for resident after the fall occurs. The incident report form should be completed by the licensed nurse with input from other staff as appropriate and submitted to the Director of Nursing Services. Defining Details of Falls: 1. After an observed or probably fall, clarify the details of the fall, such as when or where the fall occurred and what the individual was trying to do at the time the fall occurred. 2. After an unwitnessed fall, document observations of the resident's location, position, and possible environmental factors. 3. Observe to see if care plan interventions were in place at the time of the fall... Identifying Causes of a Fall or Fall Risk: 1. Immediately begin to try to identify possible or likely causes of the incident... 2. Evaluate possible chains of events (trends/patters) or circumstances preceding a recent fall, including: a. Time of day of the fall; b. Time of last meal; c. What the resident was doing; d. Whether the resident was standing, walking, reaching, or transferring from one position to another; e.	S9999		

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
	IL6007876	A. BUILDING: ______ B. WING ______	C 01/27/2023

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S9999	Continued From page 13 Whether the resident was among other persons or alone; f. Whether the resident was trying to get to the toilet; g. Whether any environmental risk factors were involved... g. Whether there is a pattern of falls for this resident. 3. Continue to collect and evaluate information until the cause of falling is identified or it is determined that the cause cannot be found. 4. As indicated, the attending physician/practitioner may examine the resident or may initiate testing to try to identify causes. 5. Consult with the attending physician/practitioner or medical director to confirm specific causes from multiple possibilities. When possible, document the basis for identifying specific factors as the causes. 6. If the cause is unknown but no additional evaluation is done, the physician/practitioner or nursing staff should note why... Documentation - When a resident falls, the following information should be recorded in the resident's medical record: 1. The condition in which the resident was found... 2. Assessment dated, including vital signs and any obvious injuries. 3. Interventions, first aid, or treatment administered. 4. Notification of the physician and family, as indicated. 5. Completion of a falls risk assessment per facility protocol. 6. Appropriate interventions taken to prevent future falls. 7. The signature and title of the person reporting the data. Reporting - 1. Notify the following individuals when a resident falls: a. The resident's family; b. The Attending Physician/Practitioner (timing of notification may vary, depending on whether injury was involved); c. The Director of Nursing Services and/or licensed nurse. 2. Report other information in accordance with facility policy and professional standards of practice." (A)	S9999		

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