STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007371	A. BUILDING: _____ B. WING _____	C 01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON PARK HEALTH CARE CTR	6141 NORTH PULASKI ROAD CHICAGO, IL 60646

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S 000	Initial Comments FRI of 12/16/2022/IL154609 & Complaint Investigation: 2380474/IL155465	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 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 plan. Adequate and properly supervised nursing	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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 were not met as evidenced by: Based upon interview and record review, the facility failed to implement the fall prevention interventions plan of care according to resident's assessment. This failure affected one resident(R2) of three residents reviewed for falls. As a result, R2 fell from the bed to the floor and sustained a blunt force injury to the neck. R2 was later pronounced dead after the paramedics arrived at the scene of the accident. Findings include: On 1/23/23 during this investigation, V2(Director of Nursing) presented the facility's incident investigation of R2's fall event and the Police Report Case number, with the written statement from V13(Agency CNA/Certified Nurse Assistant).	S9999		

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S9999	Continued From page 2 The report states that R2 was DNR (Do Not Resuscitate) and was pronounced dead at 7:18pm. V13's statement states in part: On 12/16/22 around 6.30-6:45pm, I went into the room to feed (R2). I got inside the room with his food tray and discovered he was covered in a lot of loose bowel movement which was diarrhea. I left the tray and went to get supplies to clean him first before I feed him. I got the bowl of warm water, soap and wash cloths. I started with his hands first because he had it all over his hands, and then continued to give him a full bath down the perineal area. I did the front first, and then turned him to clean the back, as soon as I turned him, it happened so fast, he fell over on the floor on the other side of the bed with his head and face down. I rushed over and called but he did not talk but had a pulse and was breathing. I ran out called the nurse and other staff for help. The nurse took his vitals, he was still breathing and had a pulse. We called the ambulance, and they came and took over. R2's records reviewed include but are not limited to the following: Fall Risk Evaluation dated 11/20/22 shows a score of 21(high risk for falls). MDS (Minimum Data Set) section G with target date 12/13/22 shows that R2 needs extensive assistance with two persons for bed mobility, transfer, personal hygiene and toilet use. MDS section C does not record any BIMS (Basic Interview for Mental Status) score for R2 due to history of Traumatic Brain Injury and Dementia. Care Plan dated 9/28/22 states that R2 is at high risk for falls related to medical diagnoses; Intervention states to make more frequent rounds and ensure that resident is properly positioned in bed to prevent resident from sliding. Another	S9999		

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S9999	Continued From page 3 intervention dated 7/13/22 states to use wedge cushion to provide for positioning in bed to prevent R2 from sliding from bed. Care plan dated 12/9/2016 states that R2 has an ADL (Activities of Daily Living) self-care performance deficit related to medical diagnoses; Intervention states that R2 requires extensive two staff participation to reposition and turn in bed. POS (Physician Order Sheet) dated 2/12/2022 states: Admitted to Hospice with Late Effect CVA (Cerebrovascular Accident). Progress notes dated 12/16/22 at 6:45pm written by V3(RN/Registered Nurse) states: Writer was alerted by assigned CNA. Resident was observed on the floor inside the resident's room in left side lying position. Immediately assessed resident together with another nurse. Neuro-check initiated. Resident not responsive to verbal and tactile stimulation. Resident is DNR (Do Not Resuscitate). Observed with eyes and mouth open. Head to toe assessment done. No bump, no open skin alteration noted on the head. No skin discoloration observed. Vital signs taken and noted to be, BP 127/82 P 18 R 18 T 97.5. Unable to read Sp02(oxygen saturation) using a pulse oximeter. Writer asked what happened, per assigned CNA, she was giving the resident a bed bath when he slid off the bed. On 1/23/23 at 1:35pm, V2 was interviewed regarding the fall event. V2 stated "It happened during dinner tray pass on a Friday evening, close to change of shift. The CNA was from the agency and was supposed to ask for assistance to care for (R2). V3(RN/Registered Nurse) was the nurse. The night nurse(V4/RN) that came in at 7pm no longer works here but I will give you the phone number for all of them."	S9999		

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S9999	Continued From page 4	S9999		

V2 added, "This CNA has been here several times and she knows the rules about getting assistance before transfer or bed bath, for residents that require 2 persons assist. We orientate every agency CNA about each resident that they will care for." At this time, V2 proceeded to show the surveyor letter "H" that stands for mechanical lift transfer/2 persons assist, and the star sign that stands for fall risk, written by R2's name post that was at the door.

On 1/23/23 at 12:35pm, V3(RN) was interviewed. V3 stated "It was during dinner tray pass; I was called to the room, and I saw (R2) on the floor. We called 911 and assessed and took the vital signs. The paramedics came within about 5 minutes, and they took over. They did not get any pulse and no breathing." Inquired from V3 about R2's level of assistance needed for bed bath or incontinence care; V3 stated that R2 requires 2 persons for incontinence care or bed bath. V3 explained "When we have an agency CNA who is not familiar with the resident, we go from room to room of all the residents assigned to her to give orientation and information about transfer, assistance, and feeding the resident. I gave the CNA all the information. Also, at the door by the name of the resident, the information is there to show that the resident needs 2 persons for assistance. This CNA did not ask for assistance. We do room rounds and a tour of the section that the CNA will have."

On 1/25/23 at 10:29am, V12(Medical Director/R2's Physician) was interviewed regarding R2. V12 stated "It's a sad case for everyone here. (R2) has been very sick for over fifteen years and he was on hospice, and DNR (Do Not Resuscitate). The nursing home took good care of him, and he bounced back, and we

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S9999	Continued From page 5 took him off hospice. But after the stroke, he became very sick and the plan was to put him back in hospice again, and then, this happened." The surveyor inquired from V12 if the fall could have been prevented if the CNA had asked for assistance. V12 responded, "Well, that is the policy, that two persons should care for him, maybe the fall could have been prevented, but he could also have died an hour later because of his serious medical condition. We don't know if he was having another stroke during the care that could make him fall over. You know when someone driving has a heart attack or brain bleed and crashes and dies, we don't know if the heart attack or stroke happened and cause the accident or if the accident resulted in the heart attack or stroke. I'm not saying that was what happened, but we don't know. When a patient is on blood thinner, the brain can bleed also." Inquired from V12 about the possible injuries from a fall that could lead to death, V12 stated "If a patient falls, the main concerns are head and neck injuries; major injury to the neck area or brain bleed could happen." R2's document POLST (Practitioner Order for Life-Sustaining Treatment) dated 4/6/22 signed by R2's Daughter/Surrogate Decision Maker states: Do Not Attempt Resuscitation (DNR). R2's Death Certificate signed by Medical Examiner/Coroner on 12/20/2022 states in #24: Cause of Death (a) Blunt Force Injury of Neck; (b) Fall. #35 states that R2 broke his neck due to fall. Several unsuccessful attempts were made to contact V13 and V4 for more information. Facility's Fall Policy dated 8/3/2016 with latest revision date 5/17/2022 states in part: It is the	S9999		

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S9999	Continued From page 6 policy of the facility to ensure that residents are assessed for risk for falls, that interventions are put in place, and interventions are reevaluated and revised as necessary. Those identified as high risk for falls will be provided fall interventions. An interim Falls Care Plan may be started but a Falls Care Plan is necessary and required after the State required MDS was done. Facility's CNA Job description dated 05/20/2022 states in #7: Must be knowledgeable of individual care plans and support the care planning process by providing supervisors with specific information and observations of the guest's needs, preferences and report any behavioral changes. (AA)	S9999		