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 04/03/2023

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 3/5/2023/IL157565	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210d)6 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. These Requirements were NOT MET as evidenced by: Based on observation, interview, and record	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 review, the facility failed to supervise two of three residents (R1, R3) reviewed for falls. This deficient practice resulted in R1 falling and breaking her pelvis. Findings include: 1)R1's medical record (Face Sheet, Physical Therapy Notes) document R1 is a 72-year-old admitted to the facility on 03/03/2023 with diagnoses including but not limited to: Diverticulitis of Intestine, Syncope and collapse, Open angle glaucoma, Muscle weakness (generalized), Other abnormalities of gait and mobility (03/04/2023), and Other lack of coordination (03/04/2023). R1's MDS (Minimum Data Set, 03/10/2023) notes a BIMS (Brief Interview for Mental Status) of 8 denoting R1 was moderately cognitively impaired. On 04/01/2023 at 7:14 PM-7:33 PM, V3 (RN-Registered Nurse) said she was the nurse working the 7:00 PM-7:00 AM shift on 03/04/2023 when R1 fell the morning of 03/05/2023. "So, what happened, the patient (R1) had a fall. She was coming out into the hallway from her room, she was a little unsteady on her feet. She fell backwards, she hit her head on the wall. She complained of pain to her back. She was always complaining of pain, she was a hypochondriac with a psych history." When asked if R1 was a fall risk, V4 said "Oh, yeah, she was a fall risk, she was a new admit, and unsteady on her feet. I checked on her frequently, at least every hour, there should be documentation in her progress notes. I asked R1 what she was doing; R1 said she was going to the bathroom. We would monitor R1 frequently, assist with toileting needs, ensure R1 was clean and dry; we kept the call light close to R1 but she didn't use it. I'm sure she	S9999		

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S9999	Continued From page 2 was getting up on her own (to go to the bathroom), we probably didn't see her. On 03/05/2023 at 7:49 PM, Progress Note documents in part, Describe Incident in Detail: 03/04/2023 7:00 PM Resident observed in bed. No c/o (complaint) voiced. 9:00 PM All due meds given. 10:00 PM Resident assisted with toileting needs by CNA. 03/05/2023 12 MN (midnight) Sleeping in bed. 2:00 AM Resident observed walking out of room in hallway. Gait unsteady. Assisted back to bed. Instructed resident to use call light and to call nurse for assistance. 4:00 AM Sleeping on rounds. 5:20 AM Resident observed walking out of room into hallway. Gait unsteady. Observed resident falling to the floor. Resident was obsrved in supine position. "C/O (complaining of) back and stated, "I hit the back of my head. Ask resident where was she going or doing. Resident stated "I was trying to go to the bathroom." 04/03/2023 at 9:27 AM-9:43 AM via telephone, V4 (CNA-Certified Nursing Assistant) said, she was the CNA responsible for R1's care on 03/04/2023 from 11 PM-7 AM when R1 fell on the morning of 03/05/2023. V4 said R1 was a fall risk. V4 said R1 wasn't in bed at the beginning of the shift; R1 was sitting up in the dining area watching TV. Around 12 (midnight) V3 (RN-Registered Nurse) told me to put R1 back in bed. I put R1 back in bed and covered her. I don't remember toileting her; I assumed we changed her in the bed since she had a diaper on. Prior to the fall, R1 was getting up all the time on her own, we couldn't keep her sitting. We kept the bed locked in the low position, call light within reach. We encouraged R1 to use the wheelchair, but she would get up on her own all the time without the wheelchair. I don't remember a walker.	S9999		

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S9999	Continued From page 3 On 04/03/2023 at 1:18 PM-1:25 PM via telephone, V5 (PT-Physical Therapist) said, "Before I saw R1 (for physical therapy evaluation), both the nurse and the CNA said R1 kept getting up on her own and walking into the hallway. I remember when I saw her that day, on Saturday, that she kept walking by herself in the hallway; her gait was unsteady. When the session was over, I put her back to bed; the bed was locked and in the lowest position; the call light was within reach; her walker was near her bed within reach. I spoke with the CNAs and Nursing, I told them R1 needed to ambulate with the walker; the walker should be within R1's reach. I also left the door (to her room) open so that everyone could see what was going on. It was really unsafe for R1 to be left alone. She definitely needed supervision and to use the walker." On 04/01/2023 at 6:29 PM-6:31 PM, V1 (Administrator) said, R1's son informed the facility, during a care plan meeting, that R1 fell last year and broke her pelvis. V1 said the fracture found on R1's X-ray on 03/05/2023 was an old fracture from previous fall. X-ray of pelvis report of 12/02/2022, documents, under diagnoses, "Closed fracture of other parts of pelvis." X-ray of pelvis report of 03/05/2023, documents, under findings, "There are fractures of the left superior and inferior pelvic rami" and under impression, "Fractures of the left pubic rami." On 04/03/2023 at 5:27 PM-5:38 PM via telephone, V6 (Nurse Practitioner) said, she saw resident (R1) three times while at facility, the last time she believes was when R1 was discharged	S9999		

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S9999	Continued From page 4 from the facility. V6 said she is aware of the x-ray result for fall of 3.5.23 but does not know anything about x-ray results from 12.22.2022. V6 said, I would like to review the record before I give you an answer (are the fractures seen on 3.5.2023 x-rays the same fractures seen on 12.22.2022 x-ray?). V6 said she will call back within an hour; will call to speak with administrator to get x-ray results of 12.22.2022). On 04/03/2023 at 6:33 PM-6:36 PM via telephone, V6 said, "I do not have a lot of information. R1 was primarily at the facility for diverticulitis. I spoke with the Administrator (V1), he would not provide information related to R1's fall on 12.22.2022. I can't answer your question about R1's x-ray results of 12.22.2022." V7 (R1's Physician) was not available for interview. On 04/03/2023 at 4:20 PM-4:30 PM, V8 1620 (RN/ Fall Nurse) said, "fall interventions that were put into place prior to R1's fall included: call light within reach, bed in low position, answering call light in timely manner, the basic interventions you would do for anyone." 2)R3's medical record (Face Sheet) document R3 is a 75-year-old admitted to the facility on 03/23/2023 with diagnoses including but not limited to: Parkinson's disease, Fall on same level from slipping, tripping and stumbling with subsequent striking against other object, Closed head injury, and Severe dementia. R3's MDS (Minimum Data Set, 03/30/2023) notes a BIMS (Brief Interview for Mental Status) of 9 denoting R3 is moderately cognitively impaired. Progress Note of 03/23/2023 at 5:43 PM	S9999		

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S9999	Continued From page 5 documents: "Weight Bearing Status: 1 person assist" Falls Care Plan Potential (effective 03/25/2023) documents under interventions, "Assist resident in transfers and ambulation." On 04/03/2023 at 1:00 PM, R3 was observed getting out of his wheelchair, unassisted, pants sliding down partially exposing his buttocks. R3 continued to ambulate down hallway while pushing wheelchair. There were no staff in or around common area to assist or re-direct R3. On 04/03/2023 at 4:32 PM-4:40 PM, V9 (RN-Registered Nurse) said, R3 can use a walker or a wheelchair (self-propel); he's unsteady on his feet. When R3 is ambulating, it would be best if one person is assisting him. (B)	S9999		