

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/10/2023
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NAME OF PROVIDER OR SUPPLIER NORRIDGE GARDENS	STREET ADDRESS, CITY, STATE, ZIP CODE 7001 WEST CULLOM NORRIDGE, IL 60634
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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
S 000	Initial Comments Complaint Investigation 2373758/IL159533	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	S9999	<p>Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>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.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>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:</p> <p>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.</p> <p>These Requirements were Not Met as evidenced by:</p> <p>Based on interview and record review, the facility failed to assist a resident to the toilet, resulting in the resident transferring herself and falling. The fall resulted in a fractured left hip which required surgical repair.</p> <p>This applies to 1 of 3 (R4) residents reviewed for falls.</p> <p>Findings include:</p> <p>On May 9, 2023, at 10:03 AM, R4 was observed</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>in bed with a surgical incision on her left hip.</p> <p>The hospital records dated April 27, 2023, at 1:31 PM show a history and physical documenting the following: "[R4] is complaining of [left] hip pain after the fall. In the ED [Emergency Department], she is noted to have [left] hip femoral neck fracture. Plan is for OR (Operating Room)."</p> <p>On May 9, 2023, at 10:40 AM, V16 (RN/Registered Nurse) said she was assigned to R4 on April 26, 2023. V16 said R4 was a high fall risk. V16 said she had toileted R4 and gotten her back to bed when R4 said she wanted to use the restroom again. V16 said R4 would often say her bladder was still full after urinating and would request to be taken back to the toilet or commode. V16 said she instructed R4 to urinate in her incontinence brief and left the room. V16 said she was later called by another staff member as R4 was found on the floor between her bed and bedside commode. V16 said there was urine in the bedside commode. V16 said R4's fall was not witnessed and R4 complained of pain on her left side. V16 said at baseline, R4 had no issues with her mentation and would insist on using the bedside commode.</p> <p>On May 9, 2023, at 10:55 AM, V32 (Activity Aide) said on April 26, 2023, she was doing her rounds and saw R4 on the floor on the left side of her bed. V32 said she notified V16 (RN) that R4 had a fall. On May 9, 2023, at 12:33 PM, V32 said R4 does not like urinating in her incontinence brief and preferred to go to the toilet in the bathroom or on the bedside commode. V32 said all the staff taking care of her know she does not like to urinate in the incontinence brief.</p> <p>On May 9, 2023, at 11:55 AM, V30 (PT/Physical</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>Therapist) said R4 prefers using the toilet and would not go in the brief. On May 9, 2023, at 11:56 AM, V31 (OT/Occupational Therapist) said if R4 was just toileted and requested to be toileted again, she would have taken the resident to the toilet or bedside commode, as R4 required assistance with toileting and ambulating.</p> <p>On May 9, 2023, at 10:14 AM, V28 (NP/Nurse Practitioner) said R4 had an unwitnessed fall on April 26, 2023, at 4:30 PM, and resulted in R4 requiring surgery for a fracture of the left hip. V28 said R4 did not have any injuries prior to the fall.</p> <p>When R4's progress notes were reviewed, a stricken-out progress note written by V16 on April 26, 2023, at 10:35 PM showed: "received resident in bed in her room. She requested assistance for her to use bedside commode but explained that she can urinate in her diaper and will change her in the room. Resident insisted to stand and use bedside commode. Upon assessment resident was conscious and coherent, however resident verbalizes pain whenever her extremities were examined. Resident was lying on the floor until 911 arrived."</p> <p>On May 9, 2023, at 4 PM, V1 (Administrator) said if a resident needed to go to the toilet, the staff has to take the resident to the toilet.</p> <p>The hospital records dated April 26, 2023, at 3:46 PM documents the following: "89-year-old female to ED [Emergency Department] via EMS [Emergency Medical Services] from [facility] with complaints of left hip pain after unwitnessed fall from commode. [Patient] was on commode in room when staff heard a fall and walked in to find [patient] awake and alert on floor. [Patient] has complaints of left hip pain and cannot straighten</p>	S9999		
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S9999	Continued From page 4 out left leg." An X-ray of the left hip showed the X-ray was indicated due to the fall, and the impression was "Displaced subcapital fracture of the left femoral neck." The EMR (Electronic Medical Record) showed R4 was admitted to the facility on December 31, 2022. R4 had multiple diagnoses including osteoarthritis of both knees, spinal stenosis, spondylosis, chronic kidney disease, need for assistance with personal care, difficulty in walking, and reduced mobility. R4's April 3, 2023, MDS (Minimum Data Set) showed R4 was cognitively intact, required extensive assistance for bed mobility, transferring, dressing, toileting, and personal hygiene. The MDS showed R4 was occasionally incontinent of urine and always continent of bowel. The facility's Urinary Continence and Incontinence revised March 2020 shows the staff is to assist the resident with his or her toileting needs at least every 2 hours and as needed. The assistance may include but is not limited to checking and changing if incontinent or assist the resident to the toilet as needed. (A)	S9999		