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
	IL6002521	A. BUILDING: ____ B. WING ____	C 05/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOBSON PLAZA	120 DODGE AVENUE EVANSTON, IL 60202

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S 000	Initial Comments Investigation of Facility Reported Incident of April 1, 2023/IL158528 Investigation of Facility Reported Incident of March 27, 2023/IL158343	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	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	S9999		

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.

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:

1. Based on interview and record review, the facility failed to have effective, resident-centered, fall interventions in place to prevent a fall and failed to adequately supervise a resident at risk for falls. This failure applied to one of one (R6) resident reviewed for falls with injury and resulted in R6 sustaining a fall, then being subsequently transferred to local hospital with diagnosis of right femur fracture and had to undergo surgery for repair.

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S9999	Continued From page 2	S9999		

2. Based on interview and record review the facility failed to ensure that one resident (R2) was properly assisted during repositioning in bed. This failure resulted in R2 sustaining bruises to both right and left upper arms and right hip requiring emergent transfer to a local hospital and being diagnosed with right femoral fracture.

Findings include:

1. R6 is a 92-year-old female, originally admitted to the facility on 5/26/22. R6 has medical diagnoses that include displaced Intertrochanteric fracture of right femur, repeated falls, orthostatic hypotension, unspecified dementia, Parkinson's disease, difficulty in walking, other lack of coordination, abnormal posture, and muscle weakness. Most recent fall risk assessment completed 3/3/23; is at risk for falls.

Review of R6's comprehensive care plan includes the following focus areas:

R6 has a deficit in ADL performance r/t dx of dementia with behavioral disturbances ...Symptoms include cognitive impairment, short attention span, generalized weakness, poor ability to follow directions and occasionally resisting caregiver assistance. Recently readmitted from hospital s/p ORIF (Open Reduction and Internal Fixation). On PT/OT therapy. Now requires total assist with all ADLs other than extensive assist with bed mobility and personal hygiene and supervision with eating. Walk in room and corridor did not occur.
Date Initiated: 04/13/2023
Revision on: 4/25/2023

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S9999	Continued From page 3	S9999		

R6 is confused and disoriented and has been noted with occasional restlessness and anxiety by staff. She often sits in front of the nursing station so that staff can keep their eyes on her. Since her recent fall, she is unable to get up by herself ...
Date Initiated: 04/13/2023
Revision on: 04/24/2023

R6 exhibits cognitive impairment secondary to dx of dementia current cognitive with behavioral disturbances. Consequently, she has problems with decision-making, insight, logic, calculation, reasoning, planning and judgment. Strengths and abilities include recognizing family members and being able to verbalize, see and hear. She had been seen every 2 weeks by in-house psychologist, but he discharged her on 3/24. He noted that she was unable to respond to simple questions and just nodded her head at times.
Date Initiated: 04/13/2023
Revision on: 04/25/2023

Facility submitted final incident report dated 3/30/23, which reads: "On 3/27/23, at approx. 7AM, this resident (R6) who has Parkinson's and ambulates with a walker, impulsively stood, and started to ambulate without her walker, causing her to lose her balance. Bump to R side forehead. X-ray of R hip results received, 4:18PM, identifying R femur FX with varus angulation."

Nurse Progress Note written on 3/27/23 at 7:50 by V14 (Registered Nurse/RN) reads: resident fell in floor, she ambulated without walker and assist, per resident she want to go to washroom, resident have bump in the right side of the head, applied ice pack in the bump are and took VS, bp 149/70 pr 68 rr 19 O2 sat 91 called NP (Nurse Practitioner) with order neuro check for 72 hours called daughter (name) to made aware re:

Illinois Department of Public Health

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S9999	Continued From page 4	S9999		

incident [sic]

Hospital record for admission on 3/27/23 includes:

HPI: ...(R6) presented after unwitnessed fall at SNIF. In ED was found she has right hip fracture with plan for ORIF this afternoon. Hx taken partially from patient but mostly from daughter as pt (patient) has baseline cognitive issues. Pt states she tried to get up and likely go to bathroom but she fell although she does not remember how she fell and was fall associated with any pre-syncopal sx like LH, dizziness, CHEST PAIN etc.; Daughter states that mom has hx of orthostatic hypotension and takes meds for it and is supposed to get slowly with help from sitting to standing positions; per daughter, she was told by SNIF that she had unwitnessed fall- likely tried to get up from chair and staff heard the fall- unclear how long was on floor; also she possible bumped her head-head CT and neck CT were done and negative; Per daughter she has frequent UTIs and she just recently finished course of Bactrim 3/17-3/24. Pt has hx of TAVR, but per daughter no recent complaints of SOB, DOE, SP, dizziness, syncope although she has been having frequent falls, attributed to orthostatic hypotension. No recent reported abdominal pain, n/v/diarrhea; no reported black or tarry or bloody stools or other bleeding; She is only taking aspirin 81 mg and no other blood thinners; Pt currently only complaining of R leg pain with any movement 'Denies fevers, chills, HA, LH, dizziness, CP, SOB, palpitations, cough, abdominal pain/n/v/diarrhea, urinary sx ...[sic]

Review of systems documents ...Neuro: A/O x3, moving extremities spontaneously except protective of R leg movement due to pain ...

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S9999		S9999		

Continued From page 5

XRAY FEMUR MIN 2 VIEWS RT
Result Date: 3/27/2023
IMPRESSION: Acute intertrochanteric fracture through the proximal right femur, as above. The remainder of the right femur and bony pelvis are intact.

XRAY PELVIS
Result Date: 3/27/2023
IMPRESSION: Acute intertrochanteric fracture through the proximal right femur, as above. The remainder of the right femur and bony pelvis are intact ...

4/29/23 at 6:17 AM, V14 (RN) stated that she was passing meds on the other side of the hall when R6 fell, and they heard the chair alarm but couldn't get to her on time. I assessed her and she said her pain was 100%. I gave her Tylenol and an ice pack for her head. Didn't send her out to the hospital right away because the NP wanted to wait for the x-ray.

4/30/22 at 12:22 PM, V14 (RN) stated that she called the NP after R6 fell and also called the portable x-ray company because the x-ray was ordered STAT; all before she left that morning, so she ended up staying until about 8:30 AM. V14 added that the NP was worried about a fracture, that's why she ordered the x-ray and (NP) said don't move (R6). V14 was asked if she endorsed to oncoming nurse that the resident should not be moved, and she stated that she told the oncoming nurse about the fall and told her that R6 could use an ice pack.

4/29/23 at 11:50 AM, V17 (RN) stated that she has worked at the facility for more than two years. On 3/27/23, when she came in at the start of

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S9999	Continued From page 6	S9999		

shift, the previous nurse told her that R6 had fallen because she had gotten up from sitting on the chair. V17 proceeded to state, I remember (previous nurse) said that R6 fell and got a bump. I asked (nurse) if she called the family and NP. I think she said that she called. I know that I called the NP and asked if we should send her out. She said we should monitor her ...

4/28/23 at 12:58 PM, interview with V4 (Certified Nursing Assistant/CNA) stated that she has worked at the facility for 23 years and usually works on the first floor. When asked about R6, V4 stated that R6 requires extensive assistance with everything. She was able to walk with her walker independently but not in the hall. R6 needs a lot of reminders, and she can be impulsive when in her wheelchair. She can use her call light, but she's not really alert. She is more confused in the afternoons. I was not here when she fell.

Observed R6's room on 4/29/23 at 7am with V12 (Registered Nurse/RN) who confirmed that R6's bed alarm was not connected and on her bed. V12 pulled the bed alarm out from R6's dresser and it was disconnected; V12 stated that staff put it away when they get her out of bed in the morning.

V19 (Nurse Practitioner/NP) was interviewed on 4/29/23 at 10:28 AM regarding R6's fall on 3/27/23 and stated, I got a call early in the morning and they said that it looked like she had bumped her head a little bit. I told them to monitor. Then, they called (shortly after) and said she was complaining about pain. I ordered an x-ray. I think she already had some Tylenol, and then I ordered a Norco as well. They are pretty good about calling as soon as they found out. It

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S9999	Continued From page 7	S9999		

was a STAT Xray. Within four hours. Sometimes (x-ray company) comes the next day. They do notify if it's over four hours. In that case, we would send them to the ER without the x-ray, but this was not the case. Depends on how fast the ambulance service is. If it's more than a couple hours, I would say 911. I wasn't there so I don't know. I think she has Tylenol on order, just in case. If she is verbally saying she is in pain or having a hard time with repositioning, then I rely on the nurses to let me know. If she was at rest and not confirming pain (it's possible). When we knew she had the fracture then I ordered the Norco.

Facility policy was provided (dated 6/2014), titled, Policy Regarding Unusual Occurrences, reads:

OVERVIEW:
This facility is committed to maximizing each resident's physical, mental and psychological wellbeing. While preventing all unusual occurrences is not possible, it is this facility's policy to act in a practical manner to identify and assess those residents at risk for incidents and accidents, plan for preventive strategies, and facilitate as safe an environment as possible. All resident unusual occurrences shall be assessed, and the resident's existing plan of care shall be evaluated and modified as needed. The facility's Quality Assurance Committee and/or Safety committee shall review the information collected from all resident unusual occurrences for possible changes in facility practices and procedure.

Policy:

FALLS
1. Fall Prevention Activities for ALL Residents Upon Admission:

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S9999	Continued From page 8 o During the admission assessment process, ALL residents shall be assessed for the potential for falls, using the Falls Risk Assessment portion of the Safety Assessment Tool. Fall assessments shall include, at a minimum, a history of previous falls, contributing factors, gait and balance activities, medications, need for supervision and/or assistive devices. o For residents who have been identified at risk for falls, the interdisciplinary plan of care shall include initial interventions including supervision and/or assistive devices as necessary. o The effectiveness of each resident's care plan as it relates to falls prevention shall be evaluated and modified at least quarterly. o Falls Risk Assessments shall be completed at least quarterly and updated if necessary. 2. Facility Response to All Resident Falls o For each resident fall, an Unusual Occurrence Report Form shall be completed. If necessary, a new Fall Risk Assessment shall be completed, and the resident's plan of care shall be updated if additional care interventions are indicated. o Each resident fall shall be documented in the resident's clinical record. Documentation shall include time and location of fall (if known), any other facts necessary to describe the fall, any injuries, any care provided, any other descriptive information needed to describe the fall, neurological checks for possible head injuries and all outcomes related to the fall. o As part of the investigative process, interviews may be conducted. o If resident is cognitively intact, have them fill out the "Resident Interview Regarding the Fall". o A copy of the Unusual Occurrence Report Form shall be sent to the facility's Administrator, DON/Designee, and Risk Management Coordinator.	S9999		

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S9999	Continued From page 9	S9999		

o The resident's responsible party and attending physician shall be notified of the fall, the cause and circumstance, and any outcomes related the fall.
o If a resident fall results in a serious injury, as defined by IDPH licensure regulations, the facility shall contact by phone or fax, the State Department of Public Health within 24 hours to notify official of the incident. (Reference the Unusual Occurrence Report Form) and any related outcomes.

3. Quality Improvement Measures for Resident Falls
o The Risk Management Coordinator/DON shall be deemed responsible for the collection of all Unusual Occurrence Report Forms and any other pertinent data. This person will fill out the Internal Quality Assurance Analysis Unusual Occurrence Report. Additionally, this individual shall be responsible for the on-going study of resident falls and related outcome measurements.
o Data collected on the resident falls shall be provided to the Administrator, the Safety Committee, and the facility's Quality Improvement Committee.
o The facility's Quality Improvement Committee shall be responsible for analyzing the data collected on resident falls and for making recommendations regarding possible changes in the facility's environments or practices.
o Based on recommendations from the Quality Improvement Committee, facility-specific staff training shall be provided for all appropriate staff.

Unusual occurrences other than falls ...

2. R2 is a 90-year-old female originally admitted on 1-11-2023 with most recent readmission on

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S9999	Continued From page 10	S9999		

4-5-2023 with medical diagnosis that include and are not limited to: repeated falls, unspecified dementia, major depressive disorder, and joint replacement surgery.
Per Minimum Data Set (MDS) dated: 3-16-2023 Functional status reads: R2 needs extensive assistance: staff provide weight-bearing support of two persons physical assistance for transfers.

4-28-2023 at 4:30pm, V6 (Registered Nurse/RN) said on 3-31-2023 at about 4:00am V6 heard a noise from R2's room. I do not know where the noise came from or where it was coming from. I went to the room to see what was going on, I saw that R2 was in bed in the middle of the bed, but her legs were over the footboard and telling me: "I am going to get ready because I need to go to school, and I need to see my parents." I called for help and V7 (Certified Nurse Assistant/CNA) came to the room and assisted me to pulled R2 in the bed. I was in one side and V7 was in the other side of the bed, we put our hands under the armpit and pulled her in bed. At about 6:00am when V4, morning CNA, came into R2's room, R2 complained of pain to the right hip. I asked R2 what had happened and R2 told me I was in the floor, and two ladies came and helped me to get in bed. When I assessed R2, I noticed R2 had some bruised areas: right hip and under the armpits in both upper extremities, right and left, I think we (V6, V7) caused the bruises when we pulled her up in bed.

4-28-2023 at 12:10pm, V4 (CNA) said that on 3-31-2023 at 6:00am, I started my rounds and R2 was complaining of pain to the right leg. R2 said that morning that two people lifted her up from the floor after she had a fall. I told the nurse (V6) that was working, and she went to the room to check R2. She had some bruises to the right hip and

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S9999	Continued From page 11	S9999		

under the arms. I cleaned R2 and keep her in the bed.

4-29-2023 at 5:50am, V7 (CNA) said, on 3-31-2023 I was called by V6 (RN) to come to the room immediately because she needed help. I came into R2's room and I saw that R2 was at the bottom of the bed in the mid-section with her legs over the footboard trying to get out of the bed. V6 told me I am going in this side, I went to the other side, and we grabbed R2 from under the arms to pulled her in bed. At 6:00am the morning CNA (V4) came and reported to the nurse that the patient had multiple bruises to both under arms and on the right hip area. I did not see any bruises before. I know we are supposed to be using the draw sheet to pull the patients in bed to avoid causing any injuries.

4-28-2023 at 12:10pm, V4 (CNA) said, when I repositioned R2 we used the draw sheet to make sure we repositioned the patient and before we do it, we make sure to ask the patient to put her arms in the chest like giving herself a hug.

4-29-2023 at 8:56am, V2 (Director of Nursing/DON) said when a patient is repositioned in bed, we need to make sure to use the draw sheet to pull the patient up in bed and repositioned, we are not to pull the patient by holding them from under the armpits.

4-29-2023 at 1:00pm, V16 (Regional Director) said, my expectation is that when a complete care resident is repositioned the staff need to use the draw sheet for repositioning and pulled up in bed.

R2's record review reads on 4-1-2023 at 11:27am, R2's right hip observed to be slightly

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S9999	Continued From page 12 swollen, new order received to transfer R2 to the hospital for evaluation. At 12:59pm, R2 left the facility via local ambulance to the local emergency room. Local hospital report dated: 4-1-2023 at 14:16 (2:16pm) reads; XR femur right 2+ views, impression: Mildly displaced right femoral subcapital fracture with foreshortening and coxa vara angulation. V2 (Director of Nursing/DON) presented undated policy title: transfer and mobility policy. (A)	S9999		