STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014682	A. BUILDING: _____ B. WING _____	C 06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN BARR ORLAND PARK	14601 SOUTH JOHN HUMPHREY DR ORLAND PARK, IL 60462

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S 000	Initial Comments Facility Reported Incident of June 11, 2023 IL161150	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210 b) 300.1210 c) 300.1210 d)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. 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 are not met as evidenced by:	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 Based on interview and record review, the facility failed to ensure that a resident did not fall out of bed during staff provision of care. This applies to 1 of 3 residents (R2) reviewed for fall incidents in the sample of 12. This failure resulted in R2 sustaining lacerations on the head, requiring emergency care treatment and staples at the hospital. The findings include: R2 was admitted to the facility on April 28, 2023. R2 has multiple diagnoses which includes encephalopathy, type 2 diabetes mellitus, fibromyalgia, muscle wasting and atrophy, lack of coordination, abnormal gait and mobility, abnormal posture, and history of falling, based on the face sheet. R2's fall risk evaluation, dated April 28, 2023, showed the resident was high risk for fall. R2's side rail evaluation, dated April 30, 2023, showed, "Bilateral ½ side rails are being utilized for bed mobility and repositioning, to assist resident's independence and to serve as enabler from lying to seated at bedside during transfer. Provides a hand hold for getting into or out of bed." R2's admission MDS (Minimum data set), dated May 1, 2023, shows the resident is cognitively intact. R2's MDS shows the resident requires extensive assistance with one staff physical assist during bed mobility, dressing, toilet use and personal hygiene, and total dependence with two	S9999		

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S9999	Continued From page 2 or more staff physical assist during transfer. The same MDS shows R2 is always incontinent of both bowel and bladder functions. R2's documented weight as of June 7, 2023 was 218.8 pounds, based on the resident's weights and vitals summary. R2's fall incident report, dated June 11, 2023, showed the resident had a fall during staff provision of incontinence care. The fall incident report documented, "At approximately 9pm writer was called to room by CNA (Certified Nursing Assistant) supervisor. When entering writer observed patient laying on the floor on her back on the right side of the bed near the dresser. Writer asked staff what happened, and staff stated that she was providing toileting needs on the resident, she asked the resident to turn towards her to pull the bed pan from up under her, then she asked her to turn to her left side, when she turned, she crossed her right leg to far and slid off the bed, staff attempted to catch her but was unable to. Patient stated, "I messed up this time." The same fall incident report documented R2 sustained a laceration to the back of the head. R2's facility incident report initially reported to the State Agency on June 12, 2023 via email, showed on June 11, 2023 at approximately 9:00 PM, while the resident was receiving incontinence care from staff, R2 turned to her side, and she (R2) slid off the bed to the floor. The initial report documented two half rails were in place for positioning and bed mobility at the time of the fall incident. The same initial report showed the CNA (Certified Nursing Assistant) notified the nurse of the fall incident, and the resident was assessed and assisted by the staff. R2 did not verbalize	S9999		

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S9999	Continued From page 3	S9999		

pain, ROM (range of motion) of all extremities were within baseline, no loss of consciousness was observed, and neuro checks were initiated with normal findings. R2 sustained laceration with bleeding on the left posterior area of her head. A pressure dressing was applied to the site with ice pack to control the bleeding. R2's responsible party and physician were notified of the fall incident. R2's physician ordered for the resident to be sent out to the hospital for further evaluation and treatment. R2 was sent to the hospital via 911.

R2's final incident report was sent to the State Agency on June 16, 2023 via email. The final incident report showed, "Upon resident's return to the facility, resident noted to have two staples to the rear left side of her head."

R2's active care plan, initiated on April 28, 2023, shows the resident is at risk for falls related to current medication use, poor safety awareness, unsteady gait, pain, seizure disorder, use of narcotics and history of fall. This care plan showed multiple interventions initiated on April 28, 2023 which includes, "side rails to prevent rolling out of bed." The same at risk for fall care plan had an added intervention dated June 12, 2023 (post fall) for, "When giving patient care, please provide me 2 CNAs (Certified Nursing Assistants)."

On June 22, 2023 at 11:16 AM, R2 was in bed, alert, oriented, and verbally responsive. R2 stated she came to the facility from the hospital after a fall at home. R2 stated she was admitted to the facility to receive rehab to gain her strength, and then eventually go back home. According to R2, her stay at the facility was going well, until she had a fall that caused her to be

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S9999	Continued From page 4	S9999		

sent to the hospital due to bleeding from her head. R2 does not remember the exact date and time of her fall at the facility, but believes that it was approximately between the first and second week of June 2023. According to R2, when she had the fall incident, a female staff was attending to her. R2 could not remember what care was being provided to her, but remembered while in bed with both upper side rails raised, she (R2) was asked by the female staff to turn on her side (could not be certain which side), and when she placed one of her leg on top of the other leg to turn (could not be certain which leg), she felt a push from behind her where the female staff was, and she rolled out of the bed and fell on the floor. According to R2, "I remember seeing blood everywhere and they took me to the hospital." During the same interview, R2 was asked where she was positioned in bed before turning on her side. R2 responded she does not believe she was in the center of the bed, and commented, "I think I was closer to the side where I turned and fell, definitely not in the center." R2 added, "I know I went over the rail, I felt a push, I can't move too much in bed, and I will not throw myself off the bed." According to R2, prior to her fall (on June 11, 2023), she remembers at least two staff assisting her while in bed during incontinence care.

On June 22, 2023 at 12:36 PM, V21 (agency CNA, Certified Nursing Assistant) stated she was the assigned staff for R2 on June 11, 2023, when the resident had a fall incident. V21 stated on June 11, 2023 between 8:50 PM and 9:00 PM, R2 activated her call light and asked to use the bed pan. V21 stated she placed the bed pan under the resident, left the room for several minutes, and when R2 was ready she went back to the room to remove the bed pan. According to V21,

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S9999	Continued From page 5 after she had removed the bed pan, she noticed R2's brief was wet, so she decided to change the resident. V21 stated while R2 was on her back in the center of the bed, she provided incontinence care to the resident, while she (V21) was at the left side (towards the door) of the resident. She then instructed R2 to turn on her right side (towards the window), and while she (V21) was walking towards the right side of the resident, she saw R2's left leg overthrown, it passed the right leg that caused the resident to roll out of bed and landing on the floor between the bed and the closet/dresser by the window side. According to V21, during the entire care, including the turning/repositioning, R2's bilateral upper side rails were in place (raised). V21 stated when R2 overthrew her left leg over her right leg, it caused the resident's left leg to pass the edge of the bed, causing R2's lower body to fall out of the bed first, then her upper body followed. V21 stated, "It was very quick." By the time V21 reached the right side of the bed, R2 was already on the floor. V21 stated she had positioned R2's bed during the above mentioned care, about her waist level for easy accessibility, which according to V21 was not too high. V21 stated when R2 fell on the floor, the resident did not lose consciousness, but there was blood all over the floor especially on the head area of the resident. V21 stated she immediately called the nurse to inform of the fall, and the nurse had assessed R2. On June 22, 2023 at 2:08 PM with V2 (Director of Nursing), R2's bed was moved to simulate the same bed and room orientation when the resident had a fall on June 11, 2023, since R2 was occupying a different room at the time of this interview. R2 verbalized, "It is not easy to remember everything because it was a traumatic experience." R2 stated she remembered being	S9999		

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S9999	Continued From page 6 attended by one female staff when she fell out of bed, however, she cannot remember what care was being provided to her at the time of the fall incident. R2 stated -her bilateral upper side rails were raised, and the female staff asked her to turn on her side (was not certain which side it was). R2 remembered lifting her leg to go over her other leg (was not certain which leg) to turn on her side and felt a push from her back side where the female staff was standing. R2 stated, "I did not jump out of bed, but I felt that I was pushed out of bed. I remember, I went flying out of bed to the floor and she (referring to the female staff) was behind me." According to R2, she was not in the center of the bed when she was asked to turn on her side. R2 stated, "I know I was not in the middle of the bed. She (referring to the female staff) was on my back side, and I was further away from her, closer to the side of the bed where I turned towards." R2 also stated, "When I turned away from her (referring to the female staff) to turn on my side, I fell out of the bed." On June 27, 2023 at 9:53 AM, V20 (Nurse) stated she was the nurse assigned to R2 on June 11, 2023, and she was the staff who sent R2 to the emergency room via 911 after the fall. V20 stated she was told by V21 (agency CNA) that she (V21) was changing R2's brief, and while turning R2 to her side, R2 placed one of her leg on top of the other leg (does not know which leg), overthrew her leg to the side (does not know which specific side), and fell out of bed with both upper bilateral 1/3 side rails up. According to V20, V21 has a short stature and V21 told her she (V21) was not able to catch/reach R2 before the resident fell out of bed to the floor. V20 stated when she entered R2's room, the resident was on her back on the floor on the right side of the bed (window side),	S9999		

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S9999	Continued From page 7 between the bed and the closet/dresser. There was a pool of blood on the floor, especially on the head part of R2. According to V20, she could not determine where exactly the blood was coming from, so she applied pressure dressing on the entire head of R2 to stop the bleeding until 911 came and transported the resident to the hospital emergency room. V20 stated the staff did not move R2 after the fall, and the resident did not lose consciousness. V20 stated it was the hospital who saw exactly on which side of the head R2 had sustained the laceration. On June 26, 2023 at 3:20 PM, V19 (Physician) stated he does not know how R2 moves in bed and how many staff assistance she may need during turning and repositioning and during incontinence care while in bed. V19 stated R2 may require one or more staff assistanc,e depending on the day and the status of R2 at the time the care was being provided, as well as the staff comfort. According to V19, it is concerning R2 fell out of bed during staff provision of care, and sustaining laceration on the head because of the fall. (B)	S9999		