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 |
|---|---|---|---|
| | IL6009856 | A. BUILDING: _____ B. WING _____ | C 03/22/2024 |

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| WENTWORTH REHAB & HCC | 201 WEST 69TH STREET CHICAGO, IL 60621 |

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| S 000 | Initial Comments<br><br>Complaint Investigations:<br>2481602/IL170266<br>2482076/IL170874 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violationss 1 of 1:<br>300.610a)<br>300.1210b)<br>300.1210d)3)6)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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 | S9999 | | |

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| S9999 | Continued From page 1<br>care needs of the resident.<br><br>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:<br><br>3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.<br><br>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.<br><br>These Regulations are not met as evidenced by:<br><br>Based on interviews and records review the facility failed to ensure two (R5, R10) of three residents were free from abuse. This failure resulted in R5 being hit on the face and R10 being bitten on the arm by R6.<br><br>Findings include:<br><br>R6 is a 64-year-old resident. R6's diagnoses include but are not limited to schizoaffective disorder, bipolar type, bipolar disorder, moderate intellectual disabilities, generalized anxiety disorder, schizophrenia, altered mental status.<br><br>According to R6's care plan, R6 has impaired cognitive functioning related to R6's diagnoses of | S9999 | | |

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schizophrenia, unspecified and altered mental status, unspecified and moderate intellectual disabilities. R6 has difficulties managing anger/frustration related to diagnoses of schizophrenia and bipolar disorder. R6 has physically aggressive behavioral symptoms. R6 was physically aggressive towards peer.

R6 Quarterly Behavioral Health Assessment, 2/2/2024, documents in part: Resident has a history of aggression or violence; resident remains aggressive due to mental status; mood is anxious, labile, angry, depressed; behavioral concerns include physical aggression, disruptive behavior, delusions, hallucinations.

R5 is a 69-year-old resident. R5's diagnoses include but are not limited to schizoaffective disorder, bipolar type, hypertensive heart disease, paranoid personality disorder, osteoarthritis, blindness left eye category 3.

R5 Resident Safety/Abuse Screening Assessment, 4/10/2023, documents in part: R5 has diagnoses of schizoaffective disorder, bipolar type and paranoid personality which makes R5 at risk for abuse.

According to R5's care plan, R5 is at risk for abuse related to diagnosis of severe mental illness of schizoaffective disorder, loud, disruptive outbursts, and vision impairment in left eye.

R10 is a 58-year-old resident. R10's diagnoses include but are not limited to schizophrenia, type 2 diabetes mellitus, psychosis not due to a substance or known physiological condition.

According to R10's care plan, R10 has history of verbal and physical aggression toward staff and

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peers. R10 was bitten by a peer. Risk for abuse related to diagnosis of severe mental illness schizophrenia.

On 3/20/24 at 10:25 AM, V21 (Certified Nursing Assistant) stated I was at the desk with V10. R6 came to get R6's medicine. R6 was saying R6 was tired. I was charting. R6 walked off and seconds later I heard a slap sound and then R5 yell out. R6 said R5 tried to trip R6. R5 was in the wheelchair sleep in the hallway. We separated R5 and R6. I took R6 to the social service office. R5's behavior includes shouting-out. R5's shouting is not directed at anyone. R6 behaviors include getting agitated and needing redirection.

On 3/20/24 at 12:31 PM, V10 (Registered Nurse) stated I was the nurse for both R5 and R6 that morning, 1/28/24. I was giving medication. I gave R6 medications. R5 was sitting in the hallway in the wheelchair close to the nursing station. R6 got a cup of water from me, drank it, and walked away. As R6 walked pass R5, R6 just slapped R5 with open hand on the left of R5's face. R5 screamed out and said, "Why did you hit me". V21 and I separated them. V21 walked R6 away. I assessed R5 and R6. No injuries on either. I notified the NP's (Nurse Practitioners), administrator, DON (Director of Nursing), supervisor, social service and both families. I sent R6 out to the hospital. R5 was not sent out because there were no injuries. The NP ordered to monitor and assess R5 for pain. R6 told me "I don't know why I hit R5". It was not fair to R5 to be hit. No one wants to get hit. Residents are not supposed to hit each other, its violence.

On 3/20/24 at 1:21 PM, R10 was observed in the dining room. R10 said R6 hit R10 in the face and bit R10 on the arm (R10 pulled up shirt leave on

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left arm to show bite mark). Observed healed circular red mark on R10 left arm. R10 said there was a little blood when R10 was bit. R10 said R10 was hurt and angry because R6 wanted to hurt R10. R10 said R10 did not know why R6 attacked R10. R10 remembers trying to get away from R6. R10 said it was a bad experience and R10 does not want to remember it.

On 3/20/2024 at 3:30 PM, V1 (Administrator) stated I am the abuse coordinator. If staff witness abuse, they are to immediately separate the residents and notify me immediately. The nurse would assess the residents involved in the incident. Call doctor, family, follow physician orders. For resident-to-resident abuse I would conduct an investigation. Report to the State Agency within two-hour time frame. The incident with R5 and R6 is considered resident to resident abuse. V10 reported to me. I spoke to both V10 and V21. They were at the nursing station. R5 was sitting in the hallway asleep. R6 walked up to get medications and water. When R6 walked to the room R6 hit R5. V10 and V21 separated R5 and R6. V10 did assessments. R6 was sent out to the hospital. R5 was not sent out. R5 did not have an injury. I interviewed R5 on the following day. R5 said R5 was hit and R5's face did not hurt. I started working here 1/15/24. The incident with R6 and R10 happened before I was Administrator and before I was working here. The incident between R10 and R6 was abuse.

On 3/21/24 at 1:20 PM, V24 (Psychiatrist) stated the facility has notified V24 many times for R6's behaviors. R6 has been struggling with behaviors. Behaviors are a part of R6's illness and we were trying to treat those. R6's behaviors included, long standing behaviors, verbal and physical aggression from schizophrenia, bipolar, moderate

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intellectual disability. R6 has a long psychiatric history, with multiple hospitalizations. R6's challenges are chronic in nature, nothing new. We first saw R6 in 12/2023. R6 admitted to auditory hallucinations, required PRN (as needed) medications, noted to be paranoid. Residents should not be biting each other. It's not a good experience to be bitten. I don't know what could have been done to prevent that. We recommended sending R6 to the hospital. R6 has episodic and sporadic behaviors, behaviors are random. I was notified about the incident on 1/28.

R6 Post Occurrence Documentation, 1/28/2024 13:55, reads in part: Description of occurrence: R6 come to the nursing station and ask for cold water. Writer gave R6 the water and R6 drinks it. While walking away the resident turn and slap another resident (R5) who is sitting quietly and falling asleep in wheelchair. R6 slap the other resident on left side face. Administrator, Assistant Administrator, Clinical Director, DON (Director of Nursing), and Clinical manager made aware. NP (Nurse Practitioner) made aware and order to send the resident to hospital. POA (power of attorney) for R6 made aware of the incident and the transfer out to hospital.

R6 Behavior/Interventions note, 1/1/2024 07:58, reads in part: Describe Behavior: The resident (R6) got into a verbal and physical altercation with another resident (R10) and bit the resident on the left arm. Staff have had previous conversations with the resident (R6) about outbursts towards other residents. The resident (R6) continues to exhibit uncontrollable behaviors even when being redirected. The resident (R6) continues to have difficulties evaluating consequences of own actions.

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Facility Reported Incidents, date of occurrence 1/28/2024, documents in part: Resident R6 approached resident R5 in the unit hall and struck R5 on the side of face. The psychiatrist for R6 contacted with orders to send R6 to hospital for inpatient psychiatric evaluation. R5 assessed and noted with redness to side of face.

Facility Final Report, 1/29/2024, concludes: Resident R6 was interviewed regarding the incident. R6 stated that R6 was hearing voices and doesn't know why R6 struck R5. Resident R5 was interviewed and stated that R5 was sleeping and felt that R5 was struck on the side of face. Staff were interviewed and according to the staff present, R6 received a cup of water from nurse and upon walking back to unit dayroom, R6 struck R5 on side of face.

Facility Incident Log - Reg 8, incident date 1/1/24, documents in part: Resident R6 approached resident R10 in the dining room and began arguing over a purse. R6 then bit R10 on left forearm. R10's arm was assessed and cleansed. Psychiatrist for R6 was contacted with orders to send R6 to hospital for inpatient psychiatric evaluation.

Facility policy Abuse Policy, 9/20, documents in part: This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. This facility is committed to protecting our residents from abuse by anyone including, but not limited to, facility staff, other resident, consultants, volunteers, and staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals. Abuse means any physical or mental injury or sexual assault

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| S9999 | Continued From page 7<br>inflicted upon a resident other than by accidental means in a facility. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Physical abuse includes hitting, slapping, pinching, kicking and controlling behavior through corporal punishment.<br><br>(B)<br>Statement of Licensure Violations 2 of 2:<br>300.610a)<br>300.1210b)<br>300.1210d)3)6)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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 | S9999 | | |

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| S9999 | Continued From page 8<br>resident to meet the total nursing and personal care needs of the resident.<br><br>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:<br><br>3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.<br><br>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.<br><br>These Regulations are not met as evidenced by:<br><br>Based on interviews and records review the facility failed to supervise and monitor one (R3) of three residents reviewed for falls. This failure resulted in R3 falling and sustaining a right hip fracture.<br><br>Findings include:<br><br>R3 is an 87-year-old resident with diagnoses included but are not limited to intracapsular fracture of right femur, alzheimer's disease, type 2 diabetes mellitus, atherosclerotic heart disease of native coronary artery, dementia, chronic kidney disease, stage 4, history of falling, and heart failure. | S9999 | | |

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R3's minimum data set/MDS dated 1/16/24, indicates a Brief Interview for Mental Status score of 3 which indicates severe cognitive impairment. R3 has impairment both sides of lower extremities. R3 uses a wheelchair for mobility. R3 requires substantial/maximal assistance with toileting hygiene, upper body dressing, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, walk 10 feet once standing. R3 is dependent with shower/bathe self, lower body dressing, putting on/taking off footwear, personal hygiene, chair/bed-to-chair transfer, toilet transfer, tub/shower transfer.

According to R3's care plan, R3 is at risk for falls related to weakness, poor balance and has an intracapsular fracture of right femur related to history of falls.

R3's Fall Risk Assessments dated 3/3/24 and 3/13/24, have scores of eight, indicating at risk for falls, implement general safety interventions.

On 3/19/24 at 12:05 PM, V10 (Registered Nurse) stated R3 is a high fall risk. V10 stated we keep high fall risk residents in the day room. V10 stated we always have someone monitoring. V10 stated we do rounds when they are in bed. We keep the bed in the lowest position. V10 stated we assist residents to the toilet. V10 stated we round every hour. V10 stated I noticed R3 in pain. I V10 checked R3's labs and noticed the x-ray fracture. I V10 called the NP (Nurse Practitioner) who ordered to send R3 out to the hospital.

On 3/19/24 at 12:20 PM, V11 (Registered Nurse) stated R3 is a high fall risk. R3 is a two person assist. R3 uses a wheelchair.

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On 3/20/24 at 8:52 AM, V19 (Licensed Practical Nurse) stated R3's fall occurred approximately 12 AM. I was R3's nurse that night. R3 was confused, trying to get out of bed. R3 was in bed at approximately 9 PM and R3 was trying to get up. R3 tried to get up multiple times and staff tried to redirect R3. I asked if R3 was in pain and where was R3 trying to go. R3 stated R3 was trying to go home. V19 stated we got R3 up to the chair approximately 10 PM in the dining room. There were approximately three or four residents in the dining room at that time. V19 stated I was in the dining, R3 stood up, tried to move, and tripped over the wheelchair. R3 fell on R3's buttock in a sitting position. I assessed R3 for pain. R3 said R3 was okay. I still gave R3 something for pain. R3 said R3 was trying to go home. We got R3 up to the chair. I took R3 to the nursing station with me and called R3's wife and NP (Nurse Practitioner). R3 was still trying to get up. R3 talked to R3's wife. R3 told R3's wife that R3's hip was hurting. I checked R3's range of motion again. R3 flinched with the right leg. The NP ordered an x-ray. R3 still kept trying to get up. At approximately 2 AM we took R3 to the room and to bed. The CNA (Certified Nursing Assistant) sat with R3. R3 can move/walk but R3's gait is very unsteady. R3 has floor mats.

On 3/20/24 at 9:09 AM, V20 (Certified Nursing Assistant) stated V20 was doing rounds when V19 told me R3 fell. I assisted V19 with putting R3 back in the chair. V19 assessed R3. R3 said R3 was not in pain. V20 stated we put R3 back in bed. R3 kept trying to get up. V20 stated I did a 1:1 with R3 for the rest of the shift until someone relieved me.

On 3/21/24 at 11:45 AM, V23 (Restorative Nurse) stated I do the MDS functional abilities and goals

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for R3. R3 required more help when R3 was first admitted. R3 was extensive to total assist when first admitted, except R3 was able to feed self. When first admitted, R3 used a manual wheelchair, was non-ambulatory. When first admitted R3 was incontinent of bowel and bladder. When first admitted, R3 was able to stand and pivot with one person staff assist with gait belt. We had to propel R3's wheelchair because R3 did not know how. R3 went through physical therapy. For on the unit mobility, R3 started improving with mobility, wheelchair mobility/propelling, standing, taking a few steps, transfers from chair to toilet and back. R3 is still incontinent. R3 currently requires one person assist with gait belt. After R3's fracture, I assessed and did a Geri chair for comfort measures. There is possibility to go back to the manual wheelchair. R3 has been picked back up for physical therapy.

On 3/21/24 at 12:45 PM, V2 (Director of Nursing) stated to keep residents from falling, we assess and put interventions in place and try to monitor them. V2 stated we follow the four 'P's, observe for pain, positioning, personal items, and personal needs. V2 stated to monitor, we put the resident in common areas for supervision. V2 stated we anticipate if they are in pain, reaching for items, do they need repositioning and personal needs. According to my investigation V19 stated R3 was trying to get up from the bed and stand. V19 took R3 from the bed, put R3 in the wheelchair and took R3 to the common area to monitor R3. V19 stated that R3 stood up quickly. V19 witnessed the fall but could not catch R3 in time. V19 said even after that, R3 was still trying to get up and that is when V19 had V20 monitor R3. The fall was 3/3/24, the x-ray was ordered on 3/4, the x-ray was done on 3/4, the results from the x-ray

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6009856 | A. BUILDING: _____ B. WING _____ | C 03/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WENTWORTH REHAB & HCC | 201 WEST 69TH STREET CHICAGO, IL 60621 |

| (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 |
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came 3/5. R3 was sent out to the hospital 3/5. There was no delay in sending R3 to the hospital. Upon learning of an injury, the fracture, R3 was immediately sent out to the hospital.

R3 Fall Progress Note, 3/3/2024 23:44, reads in part: The resident aaox1 (alert and oriented times one), confused and forgetful. R3 was in bed, continues to get up out of bed and walking to the hall stating that R3 does not know where R3 is going. The resident gait is unsteady. R3 has BLE (bilateral lower extremity) swelling/edema, and feet as well. The resident BLE are to be elevated, the foot of bed is elevated, but the resident continues to get out of the bed. The resident was sitting up in w/c (wheelchair) and got up and lost balance and fell down on buttocks. The resident did not hit head. The writer done a complete body check, no injury noted, but the resident c/o (complaint of) right hip pain after being lifted to feet and put back in w/c by the writer and staff. The resident verbalized was trying to go home. V/S (vital signs) B/P (blood pressure) 138/84, P (pulse) 72, R (respirations) 18, T (temperature) 97.6, 98% RA (room air).

R3 Radiology Results Report, examination, and report date 3/4/2024, indicates right hip: possible impacted subcapital fracture; right femur: possible impacted subcapital fracture of the right femoral neck.

R3 hospital record, 3/13/24, documents in part: clinical impression is closed fracture of head of right femur.

Facility Reported Incident, date of occurrence 3/3/24, documents in part: R3 had a change in plane resulting in a fall. x-ray results show possible subcapital fracture of the right femoral

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|---|---|---|---|---|
| S9999 | Continued From page 13<br>neck. Nurse Practitioner gave order to send resident to hospital for further evaluation.<br><br>Facility policy Fall Management Program, 8/2020, documents in part: The facility is committed to minimizing resident falls and/or injury so as to maximize each resident's physical, mental and psychosocial wellbeing.<br><br>(A) | S9999 | | |