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| S 000 | Initial Comments<br><br>Facility Reported Incident of January 31, 2024<br>IL170097 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.1210 b)<br>300.1210 c)<br>300.1210 d)6)<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<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 care needs of the resident.<br>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.<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>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 requirements are not met as evidenced by: | S9999 | | |

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| S9999 | Continued From page 1<br><br>Based on interview and record review, the facility failed to have effective interventions in place for the monitoring and supervision of residents assessed to be at risk for falls and requiring staff assistance with dressing and ambulation; and failed to follow the resident plan of care by not providing needed assistance with dressing and ambulation. This failure applied to two of two (R3, R4) residents reviewed for falls, and resulted in R3 sustaining a fall resulting in a left hip fracture requiring surgical intervention, and R4 sustaining a left wrist fracture after a fall while not being assisted during ambulation.<br><br>Findings include:<br><br>1. R3 is an 82-year-old female admitted to the facility on 6/7/23, with medical diagnoses that include displaced fracture of base of neck of left femur, unspecified lack of coordination, Dementia, need for assistance with personal care, weakness, other lack of coordination, unsteadiness on feet, history of falling, and Schizoaffective disorder.<br><br>Review of R3's MDS (Minimum Data Set) Assessment, dated 11/29/23 (Quarterly), documents R3 has a BIMS (Brief Interview for Mental Status) of 15 (cognitively intact), and (Section GG) requires supervision or touching assistance for upper and lower body dressing; requires partial/moderate assistance for sit to stand; requires supervision or touching assistance for walking 10 ft, 50 ft, and 150 ft.<br><br>R3's current care plans include the following focus areas:<br>"Wandering/elopement risk with demonstrated signs and symptoms of cognitive loss/decline, | S9999 | | |

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poor judgement, and mood distress (Date Initiated: 6/8/23); abuse/neglect/trauma factors includes psychiatric illness (Date Initiated: 6/28/23);
Mental health challenges including diagnoses with Schizophrenia, Schizoaffective d/o (disorder), Psychotic d/o, delusional d/o, major depressive d/o recurrent (Date Initiated: 6/30/23);
PAS/MH Level II Notice of Determination: (R3) is in need of long-term care placement/services, has a diagnosis of severe persistent mental illness (Date Initiated: 7/20/23);
Care Rejection - At times I present with anger, I may make decisions that are not in my best interests. This includes being resistive to care including refusing to take my medications. At times, I will be verbally aggressive towards my nurse when my nurse attempts to give me my medications or provide care. At times, resident is impatient and does not wait for staff's assistance despite education and encouragement (Date Initiated: 7/01/23);
(R3) has an ADL Self Care Performance Deficit related to impaired ability with Dressing and Grooming such as: Put on or take off clothing, Unable to obtain or replace article of clothing, Unable to fasten clothing, Unable to groom self satisfactorily, Unable to complete task with personal hygiene, Unable to bathe and groom self independently (Date Initiated: 6/9/23);
(R3) has an ADL Self Care Performance Deficit and Impaired Mobility r/t generalized weakness, limited ability to follow/retain direction, dx. of osteoarthritis disorder, major depression, HTN, anemia, general anxiety (Date Initiated: 6/9/23) - Interventions include: Dressing: I require staff participation to dress (Date Initiated: 6/9/23);
(R3) at high risk for falls related to generalized weakness, limited balance in stance/endurance. On medications which may affect balance and

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judgement. Dx. of major depression, osteoarthritis, HTN (hypertension), bradycardia, general anxiety. Limited safety awareness. Does not use the call light for assistance/needs on consistent basis. History of fall. With diagnosis of dementia, schizoaffective disorder, osteoarthritis. Increased weakness, increased confusion, decline in urinary B&B (bowel and bladder) status (frequently incontinent of B&B), decline in gait, decrease endurance, require assistance of one/two with asl's task (Date Initiated: 6/9/23). New intervention added 2/2/24, Resident requires assistance of one staff with self-care task for completion and safety.
(R3) is on Psychoactive medications (Date Initiated: 6/8/23).
(R3) requires psychotropic medication [Olanzapine, Mirtazipine, Conazepam] to help manage and alleviate Agitation and aggressive behavior, Anxiety, neurosis, anxiety d/o, Depression, behavior with depressive features, Mood swings, mood lability, mood instability, Psychosis (i.e., delusions, hallucinations, altered thought process, loss of contact with reality) r/t other Schizoaffective Disorders (Date Initiated: 6/8/23)."

Per facility incident reportable, on 1/26/24, at around 7:15AM, R3 was found by the night nurse, sitting on the floor holding part of her pants in her hands and the other part was dangling on her left foot. Resident stated she was putting her pants on, lost her balance and fell over; resident said she hit her head. Nursing assessment done. MD (Medical Doctor) on call notified; new order to send resident to the hospital for further eval and treat. Resident is able to move all her extremities within her normal limitations, no external rotation noted. Resident was assisted back to bed by 2 CNA's (Certified Nursing Assistants), RN

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(Registered Nurse) and (mechanical) lift. Resident complaints of the groin pain on left side. Pain medication given. Noted left elbow scraped and left knee scrape no blood.Resident has a metal clamp in her head history of aneurysm.

Report additionally includes on 1/26/24 at 2:15PM, facility received call from hospital with x-ray result of R3, revealing a left sub capital femoral neck fracture. R3 returned back to the facility on 1/30/24 status post L hip hemiarthroplasty, with follow up appointment with Bone Health and MD in two weeks, staples to be removed in two weeks.

Review of R3's hospital record documents R3's admission date of 1/26/24 and discharge date of 1/30/24, primary diagnosis of left femoral neck fracture, and summary of hospitalization and incident findings includes: "Pt (patient) presents to (hospital) s/p (status post) fall where pt sustained a left hip fx (fracture). On 1/2,7 pt underwent a left hip hemi (hemiarthroplasty). Perioperative abx (antibiotic). Postoperative pain management, PT/OT (Physical Therapy/Occupational Therapy), and discharge planning." It is noted R3 is on anti-psychotic medication, Olanzapine 15mg (milligrams) daily at bedtime, and Rivastigmine 4.5mg daily at breakfast.

Employee/Resident Statement form completed by V14 (CNA) documents R3 is able to transfer independently and R3 ambulates independently, but that a mechanical lift was used to transfer the resident after the fall. V14 also documents they were the assigned CNA for R3. Documentation also includes the last time V14 saw R3 prior to the fall was at 6:25AM, while in the room to check on R3's roommate. V14 documented R3 was

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getting dressed for the morning, but did not verbalize for any need for assistance. Statement continues to read R3 was trying to put on her pants, and while standing, she felt she was losing her balance and she grabbed the overbed table for support, but the overbed table moved causing her to fall.

On 3/01/24 at 2:07PM, V14 (CNA) said, "I have been working here since December. Prior to the fall, she was very independent. She could set up and do things independently. I always offered (to help). She walked slow but would get dressed on her own. She is alert, not forgetful, and communicates well. She's sleeping more now since the fall. The fall was a pure accident. There were no special interventions for her."

Employee/Resident Statement form completed by V12 (Licensed Practical Nurse/LPN) documents R3 is able to transfer independently and R3 has Safety Risk Behavior of "wants to exit." V12 also documented on the form R3 is independent for toileting. V12 also documented being the assigned nurse for R3 at this time, and had last seen R3 five minutes prior to fall, sitting on the bed.

On 3/01/24 at 1:54PM, V12 (LPN) stated on 1/26/24, when R3 fell, she was doing rounds when she heard a sound. R3 had fallen and broken her hip. She was standing up, getting dressed. R3 was about 95% independent prior to falling. When asked what happened, R3 said that she was standing up and lost her balance, she grabbed on to the bedside table and it rolled. It was her normal routine to get dressed in the morning by herself.

On 3/1/24 at 1:39PM, V11 (CNA) stated she has

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been working at the facility for over 10 years, and is familiar with R3. V11 said that prior to falling, R3 was able to do most things independently, but staff would help set her up, but she didn't want anyone to see her (when she was unclothed). She would get her clothes independently. R3 had no bed alarm before because she wasn't a fall risk but now, she has one.

On 3/01/24 at 12:34PM, V8 (Restorative Nurse) stated, "I do the restorative MDS (Minimum Data Set), section GG and H, monitoring resident functional abilities, if they need PT, falls, decline. I am in charge of falls and supplies like wheelchair and chair alarms. When the resident has a fall, the nurse on duty starts the process of 72-hour neurochecks, assessment, change of condition. That all gets documented in electronic medical record under Assessments - Post Incident 72 Hours Follow-up. The DON (Director of Nursing) and I will conduct the investigation, and if there is someone involved, they will also help with the investigation. Regarding (R3), prior to her fall, she could walk, with slow, steady gait. She is alert and quiet, but able to communicate her needs. She is able to do for herself, but she goes to the bathroom. She is incontinent. She is confused at times. There is no such thing as independent, she needs supervision and assistance - cueing, supervision, She is insistent on doing things independent, but she required assistance like helping put on pants and blouse over her head. We encourage residents to ask for help and provide reminders to staff to remind (R3) that she needs help. She is very slow in gait and walk and it's easy for her to lose her balance. She really needs assistance with ADL's. She would not normally ask for help."

2. R4 is a 66-year-old male admitted to the facility

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on 4/4/23, with medical diagnoses that include unspecified lack of oordination, cognitive communication deficit, need for assistance with personal care, unsteadiness on feet, other lack of coordination, extrapyramidal and movement disorder, unspecified, and adult failure to thrive.

R4's MDS (Minimum Data Set) Assessment, dated 12/19/23 (Quarterly), documents R4 has a BIMS of 11 (moderate cognitive impairment) and (Section GG) uses walker; requires supervision or touching assistance for upper and lower body dressing, sit to stand, walking 10 ft, 50 ft, and 150 ft.

R4's fall risk assessment, dated 1/2/24, documents R4's fall risk score is a 12 = high risk. Contributing factors include use of NSAIDS and anti-depressants, memory problem, inadequate vision, and history of falls.

R3's current care plans include the following focus areas:
"Cognitive loss/disorientation (Date Initiated: 4/5/23).
PASRR Level 2 screening indicates diagnosed with anxiety, schizoaffective disorder, bipolar type; I make decisions without thinking about the result; when I am sad or upset, I choose to come out of my room; I am often confused and have trouble with my memory (Date Initiated: 4/18/23).
Care Rejection - At times I present with impatience. I may make decisions that are not in my best interests. This includes being resistive to care including refusing to allow staff to assist me walking to the dining room. I also do not put call light on or ask for assistance if I need it. (Date Initiated: 1/02/24); Intervention includes behavior = communication
(R4) has an ADL Self Care Performance Deficit

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related to impaired ability with Dressing and Grooming such as: Put on or take off clothing, Unable to obtain or replace article of clothing, Unable to fasten clothing, Unable to groom self satisfactorily, Unable to complete task with personal hygiene, Unable to bathe and groom self independently (Date Initiated: 4/5/23);
(R4) has Impaired Mobility r/t generalized weakness. Limited balance in stance. R4 is on a transferring program. (Date Initiated: 4/5/23);
(R4) has an ADL Self Care Performance Deficit and Impaired Mobility r/t limited balance in stance, decrease endurance. Poor safety awareness. (Date Initiated: 4/5/23); Interventions include - requires staff participation with transfers (Date Initiated: 4/5/23).
(R4) at high risk for falls related to generalized weakness, limited balance in stance, decrease endurance. On medications which may affect balance and judgement. Poor safety awareness. Slow respond in gait and directions. Easily gets tired during activity. Does not use call light for assistance/ needs on consistent basis. Requires assistance with adl's. Dx. of schizoaffective disorder, adult failure to thrive, anemia, major depression. 2/25/24 diagnoses of pneumonia. Decrease endurance, easily get tired upon exertion during activity. Increased weakness. (Date Initiated: 4/5/23)
(R4) requires psychotropic medication [Olanzapine, Zoloft] to help manage and alleviate mood swings, mood lability, mood instability, Psychosis (i.e., delusions, hallucinations, altered thought process, loss of contact with reality) r/t other Schizoaffective Disorder, Bipolar type, Major Depressive Disorder, Recurrent, Mild. (Date Initiated: 4/5/23)."
Per facility incident reportable, on 2/28/24 at approximately 12:25PM, R4 was noted to be on the floor in the dining room. Resident stated he

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was trying to transfer himself from walker to chair to sit for lunch and lost his balance and fell, landing on his left hand first. R4 was able to move both upper and lower extremities, however, verbalized he was experiencing 7/10 pain on his wrist. Tylenol was administered and area kept immobilized. STAT Xray was ordered. Results showed acute Colles Fracture with Comminuted Intra-articular Fracture of the Distal Radius with slight dorsal impaction deformity, and nondisplaced fracture of the tip of the ulnar styloid process. Report also documents predisposing psychological factors for R4: lack of safety awareness, lower extremity weakness, and ambulating without assistance."

During the course of this survey, R4 was noted in his room, sleeping, with a cast on the lower left arm.

Medical Professional Progress Noted, dated 2/29/2024 at 12:09, reads:
"#. Left wrist fracture:
- Xray of Left Wrist: 1. Acute/recent Colles fracture of the left wrist with comminuted intra-articular fracture of the distal radius with slight dorsal impaction deformity, and nondisplaced fracture of the tip of the ulnar styloid process.
- s/p ER visit - cast in place
- PRN Acetaminophen for pain
- follow up with ortho
- Monitor"

On 3/1/24 at 1:39PM, V11 (CNA) stated she has been working at the facility for over 10 years, and is familiar with R4. V11 said that prior to falling, R4 would do things independently, but now he uses a wheelchair. He required staff assistance with showers and changing, but he was not

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compliant with using the call light. "At the time of the fall, I was in the dining room, but I didn't even notice when he came in. The dining room was full of staff, but everyone was passing trays. He was about to walk into the dining room for lunch, he usually sits at the first table when you come in."

On 3/1/24 at 2:01PM, V13 (CNA) confirmed he has worked at the facility for almost six years, and is familiar with R4. V13 confirmed at the time of the fall, V13 was the assigned CNA for R4. "Nurses, CNA's, and other staff monitor the dining room during mealtimes and activities. There's always someone supervising residents in the dining room. I did not witness the fall. He normally follows instructions. I don't know how he got to the dining room from his room. We got him up with the mechanical lift (after the fall). Prior to falling, I had seen him moving around. I've never seen him without assistance. I had gotten him dressed just minutes prior and told him to call me when he was ready to go to the dining room."

On 3/01/24 at 3:35PM, V15 (LPN) said, "I have worked here almost 10 years. I have been taking care of (R4) since he came here, I believe. He needs reminders, like when it's time for lunch and dinner. He needs a lot of encouragement. His sister is very involved in his care, and she is the POA (Power of Attorney) for him. I recently sent him to the hospital because his saturation is low. He walks by himself. He did therapy for many weeks with restorative. He is capable of doing things by himself. He walks independently with the walker. I would not say that he needs supervision when using the walker, he is steady. Even though he will sometimes say that he would like someone to be with him. But that's not possible, that's why he had therapy. He definitely doesn't need supervision. He is steady. He will

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constantly want someone to be with him 24/7 (24 hours a day, 7 days a week) to talk with him and be there with him but we can't do that level of attention. I had seen him about 15-20 minutes prior and he was fine in the room, laying down in his bed. I reminded him that lunch would be soon, so please get ready. I would disagree with the MDS/Care Plan when it comes to walking. They are always being supervised. I was called by the CNA to go in the dining room. I know there were a couple patients who are alert and oriented that witnessed it. There were a couple CNA's in there. V13 (CNA) came and helped me, and we used the mechanical lift. The Director of Nursing was there too. I don't think that anyone would think to help him because everyone knows that he has been doing this on his own. Even though I know him so well if I saw him walking, I wouldn't try to help him because I would think that he is just walking, he is fine."

On 3/01/24 at 12:34PM, V8 (Restorative Nurse) stated, "I do the restorative MDS, section GG and H, monitoring resident functional abilities, if they need PT, falls, decline. I am in charge of falls and supplies like wheelchair and chair alarms. When the resident has a fall, the nurse on duty starts the process of 72-hour neurochecks, assessment, change of condition. That all gets documented in electronic medical record under Assessments - Post Incident 72 Hours Follow-up. The DON and I will conduct the investigation, and if there is someone involved, they will also help with the investigation. Regarding (R4), prior to the incident (fall on 2/28/24) he was weak because of a recent diagnosis of pneumonia. He was in bed mostly because he was getting IV (intravenous) fluids and he needs help with getting up. The only thing with him is that he is not compliant with asking for help. Other than being in bed because

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | IL6003412 | A. BUILDING: _____ B. WING _____ | C 03/02/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GROVE OF NORTHBROOK,THE | 263 SKOKIE BOULEVARD NORTHBROOK, IL 60062 |

| (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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of the pneumonia he was walking with a walker. From time to time he would need cueing when walking with the walker, but he wouldn't walk that far before going back to bed. Prior to the incident, I wouldn't say he was independent because of the recent increased weakness, and he gets tired easily, but he doesn't call anyone to help him. The nurses remind him and encourage him to make sure he asks for assistance. He is alert and able to communicate needs. (R4) is forgetful and very quiet. He doesn't remember right away and alert x2. I would say that he doesn't call for help as a combination of forgetting and also just not wanting to ask for help."

On 3/1/24 at 2:47PM, V8 (Restorative Nurse) was again interviewed and asked about the discrepancy between R3's medical record documentation/MDS and staff interviews of R3 being independent. V8 responded, "No, she is not independent. I disagree with the staff. I believe one of her diagnoses is Dementia, so at least because of her cognition she would be at least supervision with one limited assistance, but not independently. I will make sure to in-service the staff to make sure that they know this resident is not independent. Now since the fall, she is definitely not, but I will make sure that they know to follow the plan of care for the resident. They are expected to follow the plan of care for all residents. I will be sure to in-service the staff on making sure they follow the plan of care."

On 03/01/24 at 3:48PM, V2 (Director of Nursing) was asked about the fall for R4, V2 said, "I was in the room, but he wasn't in my view. When I turned over, he had just fallen, and I looked over and I saw him on the floor. I am not too familiar with him. I would expect staff to follow the care plan. The care plan is the one that's guiding the

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| S9999 | Continued From page 13<br>care. If the staff disagree with the MDS/Care Plan, then we would re-evaluate. If the nurse disagrees, then it's teamwork, they should get with restorative and the clinical team, Social Services to see how we can comply with the plan of care. No matter the interventions, if they don't follow then it's a different thing. It takes teamwork from the group. We involve all the departments. It would be an issue if the care plan isn't being followed because it's about safety."<br><br>(A) | S9999 | | |