STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007876	A. BUILDING: _____ B. WING _____	C 05/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOWNERS GROVE REHAB & NURSING	3450 SARATOGA AVENUE DOWNERS GROVE, IL 60515

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S 000	Initial Comments Complaint Investigation Survey 2473328 / IL172481 Facility Reported Incident of April 22, 2024 / IL172302 Facility Reported Incident of April 18, 2024 / IL172595	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 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 and services to attain or maintain the highest	S9999		

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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.

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:

Based on interview and record review, the facility failed to provide safe transfer assistance. This failure resulted in R1 sustaining left and right femoral fractures. This applies to 1 of 3 residents (R1) reviewed for safe transfers.

Findings include:

R1's Medical diagnosis from the electronic record documents R1 as a 90 year old with diagnoses to include a right and left periprosthetic fracture around both artificial knee joints, dementia and physical disability.

On 05/02/2024 at 11:18 AM, V13 Hospital staff stated "Before these fractures, (R1) could not bear weight, she was contracted and unable to stand up on her own. She was bedbound."

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On 04/30/2024 at 02:17 PM, V9 Certified Nursing Assistant (CNA) stated "That morning I got (R1) up out of bed like I always do. I put my arms under her armpits and did the pivot transfer. I felt her become dead weight then. Her knee seemed like it was swelling. I told the nurse (V6 Licensed Practical Nurse [LPN]). Then I took her down to the shower room and gave her a shower. The other knee was starting to swell up then, so I made sure the nurse knew what was going on."

On 04/30/2024 at 11:00 AM V6 LPN stated "(R1) is a one person assist for transfer. She's a pivot transfer. We don't always use a gait belt; it seems to cause (R1) pain when we do. We just put our hands under her arm pits and transfer."

The Final Report to Illinois Department of Public Health dated 04/22/2024 documents under Summary "CNA stated 'When I got to the room to get the resident up to the shower room, the resident was transferred by placing both arms under the patient's armpits to pivot and transfer.'" The CNA stated she felt patient dead weight and sat the resident down in wheelchair. The CNA noticed when putting the gown on the resident, there was swelling observed to the left knee and the resident stated that there was pain to the left knee also. Under Summary of the Investigation, it documents "All the staff from the day before (04/21/2024) stated they did not notice any swelling to the left or right knee. Xray's bilateral legs were ordered. The results stated there were fractures to both legs."

The Radiology Results Report for R1 dated 04/22/2024 at 01:00 and 01:13 PM document under Findings: "Right knee- There is an acute versus subacute comminuted fracture of the

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distal femur, immediately proximal to the distal femoral prosthesis with angulation. Left knee- There is an acute distal femoral shaft fracture, located immediately adjacent to the prosthetic femoral component of total knee replacement, which remains in anatomic alignment."

The care plan for R1 dated 09/02/2023 and reviewed 03/05/2024 documents "Transfer : The resident requires (SPECIFY what assistance) by (X) staff to move between surfaces (SPECIFY FREQ) and as necessary. Date Initiated: 09/02/2023 Revision on: 10/07/2023;" which was incomplete and did not specify R1's individualized transfer needs.

On 05/02/2024 at 10:45 AM, V2 Director of Nursing stated "Transfer status is determined by the physical therapist. We monitor the residents everyday. The staff will notify nursing if a resident has a change in ability so the resident's transfer status can be reassessed. That information is then used in the care plans. The care plan for (R1) isn't updated. That is why there is no direction for transfers."

On 05/01/2024 at 02:30 PM, V5 Physical Therapist stated "The gait belt should always be used for every transfer. Anything else is not a safe transfer."

On 05/01/2024 at 11:25 AM, V4 Medical Director stated "(R1) has a lot of medical issues and has declined recently. She is very contracted on both legs. The injury may be the result of a forceful transfer."

The undated Activities of Daily Living policy documents under Mobility "(transfer and ambulation, including walking) i. Residents will be

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S9999	Continued From page 4 assisted with transfer and mobility as ordered by the physician/practitioner and/or as instructed in the resident's care plan...." (A)	S9999		

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S9999	Final Observations Statement of Licensure Violations 330.4240a) 330.4240b) Section 330.4240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act) These REQUIREMENTs are not met as evidenced by: Based on interview and record review, the facility failed to prevent employee to resident mental abuse or report the abuse immediately. This applies to 1 of 6 residents (R6) reviewed for abuse in a sample of 6.	S9999		

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S9999	Continued From page 1 Findings include: The facility final Abuse Investigation dated 04/29/2024 documents on 04/18/2024 that (V13 Certified Nursing Assistant [CNA]) reported to (V14 Wellness Director) that (V12 CNA) moved (R6's) walker out of reach, then made an inappropriate hand gesture (open hand to slap). (V13 CNA) told (V14 Wellness Director) she witnessed (V12 CNA) take hold of (R6's) walker and reposition it in another direction. (R6) then yelled leave me alone I want to go to my room! (R6) then swung her arm towards (V12 CNA). (V12 CNA) then returned the gesture. On 05/03/2024 at 03:21 PM, V13 (CNA) stated (R6) just wanted to go to her room and V12 was not in a good mood. V13 stated V12 moved the walker around so (R6) wasn't able to grab the handle and go. The resident started yelling "leave me alone I want to go to my room" then raised her hand and tried to slap V12. V12 jumped up and took a swing (open hand slap) back at (R6). Neither slap made contact. I was scared of the situation and what I had witnessed. That's why I didn't report it immediately. It never sat well with me. I went to (V14 Wellness Director) a week later and reported what happened." On 05/02/2024 at 08:55 AM V1 Administrator confirmed the allegation was substantiated and the V12 CNA was terminated. On 05/03/2024 at 03:31 PM, V1 Administrator stated "We reported it immediately after it was reported to us. Unfortunately, the staff that witnessed did not report immediately." On 05/02/2024 at 11:09 AM, R6 was interviewed. R6 is oriented to name only and had no	S9999		

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S9999	Continued From page 2 recollection of any stated events. R6's Brief Interview of Mental Status dated 04/03/2024 documents R6 with severe cognitive deficits. An Employee Termination form dated 05/03/2024 documents V12 CNA as being terminated as of 04/25/2024. (C)	S9999		