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
	IL6007074	A. BUILDING: ______ B. WING ______	C 04/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBRIDGE NURSING PAVILION	2242 NORTH KEDZIE CHICAGO, IL 60647

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S 000	Initial Comments Complaint Investigation: #1982708/IL111317	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d) 6) 300.3240 a) 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 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	**Attachment A** **Statement of Licensure Violations**	

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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.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These regulations are not met as evidenced by:

Based on observations, record review, and interviews, the facility failed to ensure resident safety, by failing to adequately supervise a resident who was left unattended by facility staff during a resident transfer; failed to ensure that a resident transfer was conducted safely by trained facility staff; and failed to implement fall interventions to ensure resident safety. These facility failures, resulted in a fall related incident for 1 of 3 residents (R1), who sustained a thighbone fracture at the right knee, as a result of an improper transfer.

Findings include:

On 4/25/19, V1 (Administrator) presented documentation of a facility investigation of an incident involving R1. V1 stated, "The psychologist tried to transfer (R1) and apparently couldn't hold her up, and one of my nurses came and helped to put her on the wheelchair. My DON

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did the investigation, but she's not here today. She'll be back tomorrow."

Review of the incident reports included a facility investigation dated 4/12/19, and written by V2 (Director of Nursing) who documented, "On 3/29/19 at about 10:30 AM, CNA (Certified Nurse's Aide) assisted resident to sit at side of bed. CNA went to get mechanical lift to transfer resident. Psychologist entered the room and attempted to transfer resident by himself to the wheelchair. The resident started to slip and called out. Nurse on the floor was in hallway, came in to room and assisted doctor to place resident in the wheelchair. Resident did not fall or touch the floor."

On review of the diagnostic services results report dated 3/29/19, it was documented that R1 was found to have a "Cortical fracture of the lateral supracondylar region of the distal femur" of the right knee.

On 4/8/19, R1 was transferred from the nursing home to the hospital. According to the hospital patient information and transfer form, "Patient admitted on 4/8/19 from nursing home. Admitted for increased heart rate and altered mental status. Diagnosed with sepsis. Presented with right knee fracture."

On 4/25/19 at 11:35 AM, R1 was observed laying in her bed watching television. The call light was above the bed, but not within her reach. There were no fall mats on either side of the bed; and no signage or instructions to identify R1 as a fall risk resident, as required per facility policy. During an interview on 4/25/19, R1 was asked if she recalled the incident on 3/29/19. R1 stated, "I fell down a couple of weeks ago. My nurse

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(V13-Certified Nurse's Aide) left me alone at the edge of the bed and then my doctor (V11) tried to put me on my wheelchair but he couldn't hold me up, so I must've twisted my knee or something. I screamed and screamed for help and some other guy came in (V12-Licensed Practical Nurse), and they both put me on my wheelchair. I was in pain later and I remember going to the doctor and they said I got a fracture on my leg right here (pointing to her knee area)."

On 4/25/19 at 11:48 AM, V7 (RN) was interviewed regarding the incident involving R1. During the interview, V7 stated, "I can't tell you much about (R1) because this is my second day on the job." Asked whether there were special instructions pertaining to the care of R1, V7 stated, "Not that I'm aware of." Asked if the previous nurse gave any sort of endorsement pertaining to R1, V7 stated, "No." Asked if there were special instruction for R1 was to remain in bed, V1 responded, "I don't know." Asked specifically if R1 was a fall risk, V7 stated, "I'm not sure, like I said, I don't know her because it's my second day."

On 4/25/19 at 12:05 PM, Surveyor then asked V6 (Certified Nurse's Aide) if she was the aide taking care of R1. V6 stated, "Yes, I have her (R1) today." Surveyor asked if she knew anything about R1, V6 stated, "Yes, I was told she fell last month I think." Surveyor asked if there was anything posted in the room or anywhere that showed R1 was a fall risk, V6 stated, "No, not that I know." Asked how R1 gets moved from her bed, V6 stated, "She don't like to get up."

During an interview on 4/29/19 at 11:45 am, V2 (DON) stated, "I did the fall investigation and based on that, I determined she did not fall. The psychologist shouldn't have transferred her. She's

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been here for several years and I think she's fallen maybe once a couple of years ago, but she has always been high risk for falls. She requires a mechanical lift because I know she has always had right sided weakness that puts her at risk for falls."

V13 (CNA-Certified Nurse's Aide), stated during an interview on 4/29/19 at 12:08 PM, "I put her at the edge of the bed and I went to get someone to help me, and next thing you know she was on her wheelchair with (V11) pushing her down the hallway." Asked why R1 was placed at the edge of the bed, V13 stated, "I always do that because I have to move her to the chair." Asked if there were any special instructions on how to move or transfer R1, V13 stated, " No, we always put her at the edge and then I put her on the chair with someone helping me." Asked if there were any special instructions on how to transfer R1, V13 stated, "No, not that I was told."

During an interview on 4/29/19 at 12:15 PM, V12 (LPN) stated, "I was the nurse involved in the incident with R1. I was close to her room around 9:30 or 10:00, and I heard a loud scream saying "help, help, help." So I came to the room right away, and I saw the psych doctor (V11) grabbing her around her waist trying to help her up. I quickly helped him and placed her on the wheelchair, but I never saw her fall or anything." I did get a call later from (V3-ADON) asking me if R1 ever hit the floor and I told her no, but she said the resident said she did hit the floor."

On 4/29/19 at 1:09 PM, an interview was conducted with V11 (Clinical Psychologist). During the interview, V11 stated, "I've been seeing (R1) for about a year now and I conduct my visits with her usually every Friday or so.

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When I came to see her this time, I came in to the room and she was by herself sitting at the edge of the bed, and I was concerned she was going to fall, and I was shocked she was left alone by herself. There was no one around and this concerned me, of course. R1 was unsteady and she asked me to help her to her chair, so I did, which I shouldn't have. When I tried to lift her, I immediately knew I couldn't manage her weight and she started shouting for help. The nurse came in immediately and helped, and we both helped her get on her wheelchair. She didn't fall or anything I don't recall, but it's possible I suppose, during the tense moment I struggled to keep her up, she could have twisted her knee or something." Surveyor asked V11 if there were any instructions pertaining to R1 indicating she was a fall risk, V11 stated, "No. I wasn't told she was a fall risk, nor were there any type of instructions anywhere present to alert me or anyone."

The facility Policy and Procedures dated 2/18 and titled "Falling Star Program Policy" states, "Policy: To ensure that all residents determined to be at risk for falls or who have fallen are properly monitored by initiating the falling star protocol. Procedure: Residents will be identified according to initial fall screening; A yellow strip will be placed on resident's chart; A yellow strip will be placed on room number plaque of the resident's door; A yellow strip will be placed on the resident's wheelchair or walker; A yellow strip will be placed at the end of the residents bed; A yellow strip will be placed on the residents chart; Individualized care plan will be initiated and immediate intervention will be put into place; Staff will be notified of any new resident at risk for falls or who has fallen via shift report and a message posted on point of care; Recommendations and updating of individualized

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S9999	Continued From page 6 interventions will be implemented and documented on the resident's care plan; Program will be monitored by restorative nurse and DON." (B)	S9999		