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
	IL6014328	A. BUILDING: ______ B. WING ______	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PROSPECT HEIGHTS	**700 EAST EUCLID AVENUE** **PROSPECT HEIGHTS, IL 60070**

(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
S 000	Initial Comments Facility Reported Incident IL/00119195 of 01/08/2020 330.710 a) 3) A) cited 330.720 b) cited	S 000		
S9999	Final Observations Statement of Licensure Violations: Section 330.710 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part. 3) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following: A)Analysis of the risk of injury to residents and nurses and other health care workers, taking into account the resident handling needs of the resident populations served by the facility and the physical environment in which the resident handling and movement occurs.	S9999	**Attachment A** **Statement of Licensure Violations**	

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This STANDARD was NOT MET as evidenced by:

Based on interview and record review the facility failed to develop policies for escorting residents and the use of a rolling walker. This failure has the potential to affect one (R1) of three residents (R2, R3) reviewed for the use of a rolling walker in the sample of three.

FINDINGS:

On 1/28/2020 at 1:00 PM R1 said, I was walking to the other elevator, my legs were giving out. (V4-Resident Associate) said, I'll push you. She was pushing me on my walker. In the doorway there was a metal strip. The strip stopped us and I went over and landed on my neck. I was told that she landed too. I went to the hospital, I have a cracked vertebra. I asked (V1-Administrator) what is this for (indicated rolling walker with seat). V1 said, walking.

On 1/28/2020 at 1:45 PM V4 (Resident Associate) said, the elevator was broken. R1 asked me to walk with him. He asked to sit in one of the chairs in the hall, he was tired. He started walking again. He sat on the walker and said, just push me on the walker. We came to an uneven place on the floor. He put his feet down and that's when he fell. I tried to hold him, he did not hit his head or pass out. We helped him up and took him to the dining room. About 10-15 minutes later he started shaking. They called the paramedics to the dining room. They took him to the hospital. That was the first time that I pushed him on the walker.

The progress note for R1, dated 1/8/2020 10:15 AM reads, resident fell backward while sitting in

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the w/c (wheelchair) in the (dining room) location where carpet changed to laminate floor ....Slight redness noted to mid back, non-tender to touch, no complaints of neck pain ...Called from dining room few minutes later complained of being cold and arms shaking ...Resident requested to go to the hospital, 911 phoned. (Fire Department) transported to hospital.

The progress note for R1, dated 1/9/2020 11:41 PM reads, called (Hospital) and per ER (emergency room) nurse, resident is admitted with diagnosis of Thoracic Compression Fracture.

The Discharge Handoff from the hospital by R12 (Physician) dated 1/9/2020 reads, Ct (Computerized Axial Tomography) showed an acute T1 (Thoracic vertebrae 1) fracture.

On 1/29/2020 at 1:33 PM V2 (Director of Nursing, Shelter Care) said, they shouldn't use a walker as a wheelchair. (V4) was re-educated. She should have used a wheelchair. R1 has a wheelchair now. I do not have a policy for escorting residents and the use of a rolling walker.

(B)

Section 330.720 Admission and Discharge Policies

b) No resident determined by professional evaluation to be in need of nursing care shall be admitted to or kept in a sheltered care facility. Neither shall any such resident be kept in a distinct part designated and classified for sheltered care.

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This STANDARD was NOT MET as evidenced by:

Based on interview and record review the facility failed to transfer one resident with multiple falls with injuries (R3) to a higher level of nursing care. This failure affected one resident (R3) of three residents (R1, R2) reviewed for falls in the sample of three.

FINDINGS:

On 1/30/2020 at 10:20 AM V5 (Physical Therapist) said, (R3) has confusion and agitation. There may be some language barrier, he speaks several languages including English. I evaluated him for Physical Therapy. He needed stand by supervision with the walker anytime, even in his room. I recommended the patient needs safety cues and reminders because of confusion and inability to comply with safety measures. There were no recommendations for continued physical therapy sessions. I verbally notify the caregivers, nurses or RAs (Resident Associates) of the recommendations.

On 1/31/2020 at 11:05 AM V2 (Director of Nursing) said, we tried to keep (R3) out of his apartment as much as possible to monitor him. When he insisted on going back to his apartment we increased checks on him to every one to two hours. We tried to anticipate his needs, asking do you need to go to the bathroom, is there anything we can get for you? For residents that needed increased supervision they could be moved to memory care. The staffing ratios are different and the residents are kept out of their rooms more.

On 1/31/2020 at 2:35 PM V10 (Physician) said,

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(R3) developed worsening safety awareness due to advancing Alzheimer's disease. He was always resistive to medical care and exams. We recommended that he move to Memory Care or Skilled Care due to his declining condition to receive more supervision.

The Fall Risk Evaluation Form for R3, dated 4/20/2018 upon move in reads that his Fall Risk Level is Level 3 which is the highest risk for falls.

An incident report for R3, dated 7/30/2019, reads that R3 had a laceration to the left eyebrow and was transported to the hospital as a result of being found on the floor. The Progress Note for 7/30/2109 reads that R3 was found lying on the floor when his pendant was answered. An incident report for R3, dated 8/20/2019, reads that R3 had an unwitnessed fall. R3 said that he hit his head and had a big bump on the back of his head. R3 was sent to the hospital for evaluation and returned with a diagnosis of head contusion. An incident report for R3, dated 12/15/2019 reads that R3 was found lying on the bathroom floor with a laceration noted on the posterior head. R3 was sent to the hospital and returned with four staples. An incident report for R3, dated 1/20/2020 reads that R3 was found on the floor in his room. R3 complained of pain in his left hip and was sent to the hospital and was admitted with a left hip fracture.

R3 had the following falls which did not result in an injury: 7/1/2019, 7/26/2019, 8/5/2019, 8/9/2019, 8/11/2019 (three falls on that date), 8/13/2019, 8/21/2019, 8/27/2019, 10/7/2019, 10/27/2019, 11/20/2019, 12/1/2019, 12/19/2019 (three falls on that date), 12/25/2019 and 1/10/2020. All the falls occurred in R3's apartment. The falls on 2/25/2019 and 1/10/2019

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were witnessed by staff and occurred as a result of the resident becoming agitated and physically aggressive.

A Visit Note Report for R3 by V5 (Physical Therapist), dated 12/24/2019 reads that patient is a high fall risk due to impaired safety awareness and unsteady gait. Needs SBA (stand by assistance) and safety cues during functional activities with RW (rolling walker) for support. The Home Health/Hospice/Third Party Provider Collaboration Notes for R3 by V5, dated 12/27/2019, reads: patient needs to be supervised with walk to dine using the RW (rolling walker) to ensure safety; unsafe to be alone in apartment. It was signed by V2 (Director of Nursing) on 12/27/2019.

The Home Health/Hospice/Third Party Provider Collaboration Notes for R3 by V13 (Occupational Therapist), dated 12/27/2019 reads: needs 24 hour supervision for safety. A.L. (Assisted Living) staff notified (V14 and V15 Resident Associate) that patient needs verbal cues and stand by assistance for safe activities of daily living, self-care, transfers and mobility. It was signed by V2 (Director of Nursing) on 12/20/2019

(B)