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
	IL6007793	A. BUILDING: ______ B. WING ______	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS AT REGENCY	**6631 MILWAUKEE AVENUE NILES, IL 60714**

(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 INVESTIGATION FRI of 6/26/2019/IL00113475- F689	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b)5) 300.1210d)6) 300.3240a) 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. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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resident to meet the total nursing and personal care needs of the resident.

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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 were not met as evidenced by:

Based on interview and record review the facility failed to develop plan of care with intervention utilizing 2-person physical assist for a resident totally dependent on staff for activities of daily living to reduce or prevent a fall incident while staff is providing a shower for 1 of 3 residents (R1) reviewed for supervision during showers. This failure resulted in R1 falling out of the shower chair while in the shower room. R1 was observed grimacing of pain, an x-ray was

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obtained that documented R1 had sustained a right inter trochanter fracture, R1 was sent to the local hospital for evaluation and treatment of a right femoral neck fracture.

Findings include:

On 7/9/19 at 1:35PM Observed (R1) on bed, slide down to the foot part of the bed. Bolster bed attached to the left side on the bed, while the other bolster on the right side of the bed was on the floor, (R1) has left heel protector, while the other is on the recliner chair. (V3 CNA (Certified Nurse Assistant) Supervisor) stated that she is waiting for another CNA to pull up (R1). (V4 CNA) came to help (V3). (V3) and (V4) pulled up (R1), provided incontinence care, repositioned and applied bilateral heel protector. Observed right hips dressing with purplish bruise on right upper hip extending to right buttocks. (V3) stated that (R1) has bilateral bolsters for his fidgeting. (R1) was just transferred back to bed from high back recliner chair. (R1) is on low bed with floor mat on the left side of the bed. (R1)'s right side of the bed was pushed against the wall. (V4) stated that she heard from the report that (R1) fell but did not know the details. (R1) is actively constantly moving and on fall precaution. (R1) needs total care with ADLs (Activity of daily living) and transfers. (R1) uses Hoyer lift for transfers.

On 7/9/19 at 2:33PM (V6 Restorative Director/Fall coordinator) stated that fall assessment is done upon admission, quarterly, annual and after each fall. Fall interventions depends on individual needs. Record review of (R1)'s comprehensive care plan last revised 7/5/19 with (V6) indicated "(R1) requires bolsters to bed due to poor posture. He is cognitively impaired and is physically and mentally unable to get out of bed

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on his own. Bolsters are provided for positioning due to poor trunk control. He is a mechanical lift transfer due to generalize muscle weakness. He has behavioral problem manifested by sign and symptoms of agitation and anxiety- calling out, restlessness movement in chair, dangling his legs off the arm rest of his specialized chair, removing the bolsters from the bed. He is at risk for fall due to decreased bed mobility, dementia, anxiety disorder and other medical conditions. He is on psychotropic medication. He has history of right femur fracture due to fall s/p (status post) right hip ORIF (Open reduction internal fixation) on 6/29/19". (V6) admitted that for safety issue, (R1) needed to have 2 persons assist during shower. Shower supervision instruction was not addressed in care plan of (R1). (V6) admitted that she did not address precautions of 2 persons assist in giving shower in care plan but verbally informed the staff. Review of fall precaution care plan was updated but not individualized to the need of (R1) based on the root cause analysis of fall incident. (V6) stated that after the fall incident there should be 2 persons assist giving shower to (R1) to prevent fall.

Record review of (R1)'s most recent fall assessment prior to fall incident dated 4/4/19 documented by (V6 Restorative Director/Fall Coordinator) indicated "High fall risk".

Record review of (R1) 's fall incident dated 6/26/19 with (V6 Restorative Director/Fall Coordinator) indicated "(V9 RN (Registered Nurse)) observed shower room alarm and heard (V8 Agency CNA) called for help. (V9 RN) immediately went to shower room, observed (R1) on the shower floor lying on his back. (V9 RN) asked (V8CNA) what happened and (V8 CNA) informed (V9 RN) that (R1) was anxious and

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began to slide from the shower chair. (V8 CNA) lowered (R1) to the shower floor, to prevent injury. (V9 RN) performed head to toe assessment. (R1) with ROM (Range of motion) at baseline. No shortening of extremity observed, no swelling or discoloration noted. (R1) observed grimacing, due to mental cognition unable to give accurate indication of exact location of pain. (V9 RN) with 3 other CNAs assisted (R1) back to bed. Physician notified with order for 650mg Tylenol for pain and stat X-ray of bilateral hips and lower back. Vital signs 164/78, 60, 18, 97.6F, 98% O2 saturation. Supervisor and DON made aware. X-ray results indicated right inter trochanter fracture. (R1) was sent to hospital for evaluation on 6/27/19 and was admitted with diagnosis of right femoral neck fracture". Recent incident occurrences (last 60 days) indicated in report included: on 6/12/19 (R1) obtained skin tear on right elbow measures 0.1cm x 0.1cm x 0.1cm while CNA was giving shower.

Record review of Facility's reportable fall incident initial report dated 6/27/19 and final report dated 7/3/19 sent to IDPH. Observed discrepancies in report that were discussed with (V1 Administrator) and (V2 DON). V1 and V2 stated the fall incident was happened in 4th floor shower room not 2nd floor. (V8 Agency CNA) was not (R1)'s usual CNA who gives him showers. Interviewed with (V8) on 7/10/19 at 3:29pm stated that it was the first-time giving shower to (R1) on 6/26/19, the day of fall incident. (V8 CNA) stated that (V9 RN) assisted V8 to transfer (R1) to shower chair in his room using Hoyer lift. (V8 CNA) wheeled (R1) to shower room. (V8 CNA) turned V8's back away from (R1) to grab the towel, (R1) become restless and slid from the shower chair. (V8 CNA) tried to ease (R1) down to the floor and called for help. (V8 CNA) stated

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that if there was another CNA to assist V8, the fall could be have been preventable. All CNAs were busy at that time and (V9 RN) was busy passing medications to residents.

(R1) care plan was updated by (V6 Restorative Director/ Fall Coordinator) on 7/9/19 indicated "(R1) requires assistance of 2+ staff members while receiving shower in shower room".

On 7/10/19 at 4:22PM (V21 CNA), (V13 Agency CNA) and (V3 CNA supervisor) prepared (R1) for transfer from bed to shower chair. (V22 CNA) also came to help. There were total of 4 CNAs preparing (R1) for shower. (R1) was transferred to specialized shower chair using Mechanical lift. Observed (R1) lethargic dosing on and off. Calm and quiet. Asked (V21 CNA) if it was safe for (R1) to provide shower when he was sleepy. (V21 CNA) stated "He is okay. He is awake". They wheeled (R1) to shower room. 3 CNAs (V21), (V13) and (V22) stayed in the shower room. (V21 CNA) provided shower to (R1) while the 2 CNAs handled bath supplies to (V21). (V22 CNA) in and out of the shower room to get bath supplies. Shower was completed at 4:45PM.

During complaint investigation dated 7/9/10 to 7/11/19 at different times, interviewed with the following employees who were familiar with (R1)'s physical and mental conditions: (V3 CNA Supervisor), (V6 Restorative Director/ Fall coordinator), (V7 CNA), (V8 Agency CNA), (V9 RN), (V12 Restorative nurse/fall coordinator), (V13 Agency CNA), (V17 Nurse Practitioner), (V19 Psychiatrist), (V21 CNA) and (V22 Agency CNA). All of them stated that the (R1)'s fall incident was preventable if there was adequate supervision of 2 persons assist during shower. All of them stated that there should be a 2 person

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assist during shower for safety purposes. All CNAs (except for (V8)) interviewed stated that they use 2 persons assist to (R1) during shower.

On 7/10/19 at 11:17AM (V17 Nurse Practitioner) stated that (R1) is on strict fall precaution due to history of dementia, stays on recliner chair due to poor trunk control, agitation, anxiety and restlessness. (V17) agreed with problems identified in (R1)'s care plan. (V17) stated that R1 should have 2 persons assist for shower for safety issues. (R1)'s fall incident is preventable with adequate supervision. (V17) added that shower room is uncontrolled environment. Water temperature and slippery floor will increase restlessness especially when a resident has dementia, their response during shower that will require increase supervision.

On 7/10/19 at 11:56AM (V19 Psychiatrist) stated that (R1)'s fall was preventable. Based on (R1)'s physical and mental clinical condition, (R1) should have adequate supervision of 2 persons assist when giving shower.

Record review of Facility's fall prevention in-services (before and after the fall incident) dated 3/28/19, 4/19/19, 4/30/19, 5/4/19, 5/31/19, 6/11/19 and 6/28/19. (V8 Agency CNA) who was involved with (R1) fall incident did not attend any of the in-services given by the facility.

Record review of Facility's Fall Reduction Program revised date 4/2019 given by (V2 DON) indicated:
Objective: Fall Reduction program promotes the safety of residents in the facility. The program intent is to assist clinical staff in determining the needs of each resident through the use of standard assessments, the identification of each

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S9999	Continued From page 7 resident's individual risks, and the implementation of appropriate interventions, supervision, and or assistive devices deemed appropriate. Program contents: 6. Communication with direct care staff members 7. Care Plan incorporates: preventive measures; modification and implementation of care plan approaches based on newly identified risk or recent fall occurrences. Standards: 8. Attempts shall be made to implement new or modified interventions as needed to enhance safety and consistent with root cause analysis; new interventions to be communicated to the facility staff through revision of resident care plan and profile to maintain continuity of care. Examples of Standards Fall/Safety Precautions that may be applicable: 10. Supervision of residents who require staff assistance with bathing, showering or toileting. (A)	S9999		