

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6015648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/23/2017
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NAME OF PROVIDER OR SUPPLIER CITADEL ESTATES-HAZEL CREST	STREET ADDRESS, CITY, STATE, ZIP CODE 3701 WEST 183RD STREET HAZEL CREST, IL 60429
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S 000	Initial Comments Complaint Investigation 1695989 / IL89284	S 000		
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS 330.710 a) 330.710c) 330.710 3)A 330.710 B) 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. c) The written policies shall include, but are not limited to, the following provisions: 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	S9999	<p>Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>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.</p> <p>B) Education of nurses in the identification, assessment, and control of risks of injury to residents and nurses and other health care workers during resident handling.</p> <p>These regulations were not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility's admission criteria failed to include a guideline for assessing a risk of injury to residents when transferring and lifting while performing Activities of Daily Living (ADL). This failure resulted in the death of one resident in the sample of 3 residents (R1).</p> <p>This failure has the potential of affecting the 33 residents identified as at risk for falls.</p> <p>Findings include:</p> <p>Incident Report dated 9/30/2016, says R1 was lower to the floor after complaining of pain then losing her balance. An X-ray was done. R1 had a fracture of the right and left femur. According to R1's Death Certificate dated 10/28/2016, R1 died from complications of bilateral femur fractures caused by a fall.</p> <p>The facility's Staffing schedule for 9/30/2016 has E3 and E4 (Caregivers) working in the Garden Path where R1 resided. E3 and E4 were interviewed 1/19/2017 about the incident.</p> <p>E3 and E4 said R1 is a 2 person assist when transferring. R1 was incontinent of bowel and</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>bladder. R1 wore incontinent pads. R1 was up in her wheelchair and dressed when Z1 (Hospice Certified Nursing Assistant/CNA) arrived 9/30/2016. Z1 took R1 in her room to give incontinent care. Z1 did not ask for assistance in transferring R1 until she was taking R1 off the toilet. E3 said when Z1 asked for assistance, R1 was sitting on the toilet. Z1 admitted to R1 that she had had a problem putting R1 on the toilet. Z1 never told E3 what kind of problem. E3 said when they lifted R1 off the toilet to transfer R1 to her wheelchair, R1's knees buckled. Z1 and E3 lowered R1 to the ground. R1 complained of pain. E4 was assisting another resident at showering when the incident took place and did not see R1 until she was back in her wheelchair.</p> <p>1/19/2017 at 2pm, Z1 was interviewed by telephone. Z1 said R1 was a 2 person assist. Z1 did not remember if anyone was in the room when she was giving R1 incontinent care.</p> <p>R1's clinical record was reviewed. R1 was admitted to the facility 12/30/2015 with a history of falls. A care plan for falls was not written until 5/10/2016 when the goal was to reduce the amount of falls. The care plan does not address R1 needing 2 staff members to assist at transferring.</p> <p>1/19/2017 during the Daily Status meeting the issue of R1 being a 2 person assist was addressed with E1 (Exe. Director) and E2 (Director of Nursing/DON). They said that sometimes R1 could assist at transferring and sometimes she could not. Because sometimes R1 did not need a 2 person assist it was not care planned.</p> <p>1/19/2017 at 1pm, R3 was observed sitting in a wheelchair in the Garden Path Wing. R3 has a mechanical lift for transferring. During interview</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>1/19/2017 E1 and E2 said the mechanical lift was used by hospice.</p> <p>1/23/2017 at 11am, Z2 (Hospice Nurse) was interviewed by telephone. Z2 said R3 requires 2 to 3 people for transferring safely. The mechanical lift is for safety purposes. Z2 said a hospice CNA visits R3 twice a week to bath R3. R3 is incontinent of bowel and bladder. R3 was care planned for a 2 person assist with a mechanical lift.</p> <p>The facility's Criteria for Admission was reviewed. The Criteria has no guideline concerning how much assistance in transferring and lifting the facility is capable of doing safely during ADL care.</p> <p>330.720 b)</p> <p>Section 330.720 Admission and Discharge Policies</p> <p>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.</p> <p>These regulations were not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility's admission criteria failed to include a guideline for assessing a risk of injury to residents when transferring and lifting while performing Activities of Daily Living (ADL). This failure resulted in the death of one resident in the sample of 3 residents (R1).</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>This failure has the potential of affecting the 33 residents identified as at risk for falls.</p> <p>Findings Include:</p> <p>Incident Report dated 9/30/2016, says R1 was lower to the floor after complaining of pain then losing her balance. An X-ray was done. R1 had a fracture of the right and left femur. According to R1's Death Certificate dated 10/28/2016, R1 died from complications of bilateral femur fractures caused by a fall.</p> <p>The facility's Staffing schedule for 9/30/2016 has E3 and E4 (Caregivers) working in the Garden Path where R1 resided. E3 and E4 were interviewed 1/19/2017 about the incident. E3 and E4 said R1 is a 2 person assist when transferring. R1 was incontinent of bowel and bladder. R1 wore incontinent pads. R1 was up in her wheelchair and dressed when Z1 (Hospice Certified Nursing Assistant/CNA) arrived 9/30/2016. Z1 took R1 in her room to give incontinent care. Z1 did not ask for assistance in transferring R1 until she was taking R1 off the toilet. E3 said when Z1 asked for assistance, R1 was sitting on the toilet. Z1 admitted to R1 that she had had a problem putting R1 on the toilet. Z1 never told E3 what kind of problem. E3 said when they lifted R1 off the toilet to transfer R1 to her wheelchair, R1's knees buckled. Z1 and E3 lowered R1 to the ground. R1 complained of pain. E4 was assisting another resident at showering when the incident took place and did not see R1 until she was back in her wheelchair. 1/19/2017 at 2pm, Z1 was interviewed by telephone. Z1 said R1 was a 2 person assist. Z1 did not remember if anyone was in the room when she was giving R1 incontinent care.</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>R1's clinical record was reviewed. R1 was admitted to the facility 12/30/2015 with a history of falls. A care plan for falls was not written until 5/10/2016 when the goal was to reduce the amount of falls. The care plan does not address R1 needing to 2 staff members to assist at transferring.</p> <p>1/19/2017 during the Daily Status meeting the issue of R1 being a 2 person assist was addressed with E1 (Exe. Director) and E2 (Director of Nursing/DON). They said that sometimes R1 could not assist at transferring and sometimes she could not. Because sometimes R1 did not need a 2 person assist it was not care planned.</p> <p>1/19/2017 at 1pm, R3 was observed sitting in a wheelchair in the Garden Path Wing. R3 has a mechanical lift for transferring. During interview 1/19/2017 E1 and E2 said the mechanical lift was used by hospice.</p> <p>1/23/2017 at 11am, Z2 (Hospice Nurse) was interviewed by telephone. Z2 said R3 requires 2 to 3 people for transferring safely. The mechanical lift is for safety purposes. Z2 said a hospice CNA visits R3 twice a week to bath R3. R3 is Incontinent of bowel and bladder. R3 was care planned for a 2 person assist with a mechanical lift.</p> <p>The facility's Criteria for Admission was reviewed. The Criteria has no guideline concerning how much assistance in transferring and lifting the facility is capable of doing safely during ADL care.</p> <p>(A)</p>	S9999		