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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | IL6010367 | A. BUILDING: ______ B. WING ______ | 07/27/2017 |

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| S9999 | Final Observations | S9999 | | |

Statement of Licensure Violation:

300.610a)
300.1010h)
300.1210b)
300.1210d)3)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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the

Attachment A
Statement of Licensure Violations

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health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. (B)

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 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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be

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made by nursing staff and recorded in the resident's medical record.

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. (A, B) (Section 2-107 of the Act)

These Requirements are not met as evidenced by:

Based on observation, interview and record review the facility failed to follow their Fall Management Policy and failed to supervise and monitor one resident (R7) displaying unsafe behaviors of eight residents reviewed for falls of 24 sampled residents. Facility failed to notify a residents physician in a timely manner of continued severe pain after a fall incident. This applies to (R12) 1 of 9 residents reviewed for pain in the sample of 24.

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This failure resulted in R7 sustaining neck fractures from a fall in the bathroom while unsupervised.
This failure resulted in R12 sustaining a fractured humerus.

This applies to 3 of 9 residents (R3, R7, R12) reviewed for fall risk in the sample of 24.

1) Physicians Order Sheet (POS) dated 7/1/17 to 7/31/17 indicates R7 is 71 years old and was admitted to the facility 11/25/16 and has current diagnoses that include Unspecified Dementia with Behavioral Disturbance (Primary), Obesity, Unspecified Cervical Vertebra fracture, Pseudobulbar Affect, Conduct Disorder - Aggression, History of Falls.

Significant Change MDS (Minimum Data Set) dated 6/13/17 indicates R7 scores 7/15 on BIMS (Brief Interview for Mental Status) and is severely cognitively impaired.

On 7/11/17 at 2:20pm R7 was in bed and was noted to be scooting along the length of the bed in an effort to get out of bed.

On 7/12/17 at 9:45am R7 was observed in bed sleeping. No floor mats were in place next to R7's bed.
On 7/12/17 at 1:55pm R7 was observed in bed sleeping with no floor mats on the floor the next to R7's bed. A grey floor mat was noted to be leaning against the wall to the right of R7's bed and a rolled up black mat was near the window by R7's bed.

On 7/12/17 at 2:10pm E30, CNA (Certified Nursing Assistant) stated that she was R7's

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assigned CNA for the day and is aware of R7's "Care Cards" that indicate what type of basic care should be given to R7. E30 stated that she did not notice that R7 should have floor mats when R7 is in bed. At that time E15, LPN (Licensed Practical Nurse) stated that Hospice staff were with R7 and left R7's room without placing the floor mats on the floor. E15 acknowledged that R7's assigned staff (nurse and CNA) are responsible to ensure the mats are on the floor when R7 is in bed.

Care Card found inside R7's closet on 7/12/17 indicate R7 requires "Floor mat - both sides." Falls Care Plan dated 11/25/16 indicates R7 at risk for falling due to history of multiple falls, impaired cognition and balance. Approach dated 3/23/17 indicates bilateral mats to bedside.

Nurses Notes and Fall Root Cause Analysis Forms indicate R7 had seven documented falls prior to 2/20/17.
On 12/12/16 fell in bathroom while attempting self grooming.
On 12/25/16 fell while reaching for something in her drawer.
On 12/28/16 fell due to wheelchair unlocked.
On 12/28/16 fell while trying to get something out of bathroom drawer.
On 1/3/17 stood up to close to drapes and slipped to floor.
On 1/8/17 at 2:20am fell while transferring from bed to wheelchair while trying to go to the bathroom.
On 1/8/17 at 2:02pm stood up to pour water, lost balance with only socks on feet and fell.
\
Nurse Note dated 2/10/17 1:41am indicates R7 busy wandering hallways, several attempts to get out of her wheelchair, using foul language, refused care "sitting in wheelchair at this time."

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Nurse Note dated 2/10/17 at 2:15am indicates R7 was found on the bathroom floor under the sink. Note indicates R7 sustained a laceration to back of her head. Note indicates R7 was transferred to the hospital for evaluation at 2:40am .
Nurses Note dated 2/20/17 at 1:30pm indicates R7 returned from the hospital with a cervical collar, posterior cervical spine fusion due to C6, C7 and T1 vetebral body fractures.

Safety Events - Fall Event dated 2/22/17 at 9:30pm indicates R7 was found on her back on the floor of her room.
Progress Notes dated 2/22/17 at 10:00pm indicate R7 fell in her room out of her wheelchair onto the floor and was found lying on her back.
Root Cause Analysis Form dated 2/22/17 indicates R7 was agitated from not sleeping.
Recommendation/Interventions: Medication review to address insomnia.

Safety Event - Fall Event dated 2/23/17 at 4:50pm indicates R7 was observed sitting on her buttocks in the hallway.
Progress Note dated 2/23/17 at 4:50pm indicates R7 was observed sitting on her buttocks on the floor in front of her wheelchair in the hallway near the nurses station.
Root Cause Analysis Form dated 2/23/17 indicates R7 was agitated due to pain.
Recommendations/Interventions: Physician to schedule pain medications.

Safety Event - Fall Event dated 3/22/17 at 8:28pm indicates R7 fell from bed onto floor and was found sitting with her back against bed.
Progress Note dated 3/22/17 at 8:25pm indicates R7 stated that she slid off the bed onto the floor.
Root Cause Analysis Form dated 3/22/17 indicates R7 stated slid off bed.

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Recommendations/Interventions: Floor mats to bedside.

Safety Event - Fall Event dated 3/27/17 at 3:45am indicates R7 slid from wheelchair in hallway.
Progress Notes dated 3/27/17 at 6:17am indicates R7 was sitting in her wheelchair in front of the nurses station. Staff noticed resident was sitting on the edge of the chair. Note indicates R7 refused redirection to sit back in chair and the "a few seconds later" staff was at end of hallway and noted R7 had slid from wheelchair and was sitting on floor in front of her wheelchair.

Safety Events - Fall Event dated 6/8/17 at 11:45pm indicates R7 fell forward from the wheelchair in the hallway at that time and was witnessed.
Event indicates care plan was reviewed on 6/9/17.
Progress Note dated 6/8/17 at 11:45pm indicates R7 was behind the nursing station, staff was in front of the nursing station when R7 suddenly landed on the floor with the high back wheelchair tipped over. Note indicates R7 sustained a bump on right forehead.
Fall Root Cause Analysis Form dated 6/8/17 at 11:45pm indicates R7 was attempting to stand up.
Recommendations/Interventions: (R7) will use a regular wheelchair without leg rests and not with a high back.

Safety Event - Fall Event dated 6/15/17 at 8:05pm indicates R7 fell forward from her wheelchair to the floor while out in the hallway. Event indicates R7 was witnessed trying to move her wheelchair, leaning forward and then falling forward onto the floor.
Progress Note dated 6/15/17 at 8:05pm indicates

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R7 fell to the right side on her hand. Note indicates R7 sustained small dry abrasion on left knee.
Fall Root Cause Analysis Form dated 6/15/17 at 8:05pm indicates "(R7) wanted to go to the room with roomate."
Recommendations/Interventions: Drop rear axle of wheelchair seat.

Safety Event - Fall Event dated 6/18/17 at 8:00pm indicates R7 fell from wheelchair near nursing station. Event indicates R7 was leaning forward from wheelchair and that the fall was witnessed.
Progress notes dated 6/18/17 at 8am indicates "At 8pm (R7) sitting at nurses station in wheelchair, leaned forward in wheelchair and fell forward on left lateral side."
Fall Root Cause Analysis Form dated 6/18/17 at 8pm indicates R7 "fell asleep in chair."
Recommendations/Interventions: Place R7 on sleeping schedule and place into bed at 7:30pm.

Safety Event - Fall Event Form dated 6/20/17 at 10:35am indicates R7 fell from wheelchair in hallway. Event indicates fall was unwitnessed and that just prior to fall R7 was observed leaning forward to pick things off the floor.
Progress Note dated 6/20/17 at 10:45am indicates R7 was found laying on the hallway floor by another nurse. Note indicates that a few minutes prior to the fall, staff witnessed R7 reaching for something on the floor, was repositioned and asked to sit back in her chair. Note indicates R7 injured right side of forehead.
Fall Root Cause Analysis Form dated 6/20/17 at 10:23am indicates R7 was reaching for something on the ground.
Recommendation/Interventions: Care plan with family who agreed to have resident placed into reclining chair during restless and lethargic

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periods and a rummage box provided to assist with activity needs.

Safety Event - Fall Event Form dated 6/23/17 at 8:00pm indicates R7 fell while trying to get up from her wheelchair and attempting to walk. Event indicates R7 received a reddened bump to right side of forehead.
Progress Note dated 6/23/17 at 9:30pm indicates that staff found R7 on the floor by the nurses station.
Fall Root Cause Analysis Form dated 6/23/17 at 8pm indicates R7 had "agitation due to pain." Recommendations/Interventions: Hospice to evaluate medication regimen, attempt to place R7 in bed every 2 hours.

All Root Cause Analysis Forms identifying pain as the cause of R7's falls was not indicated on the corresponding Safety Event Form Assessment of Resident Pain. All assessments indicated "No pain."

On 7/21/17 at 9:45am Z8, NP (Nurse Practitioner) stated that she is not an "official" part of the fall management team however does make suggestions related to residents falls. Z8 stated that R7 is very non-compliant with care and redirection. Z8 stated that R7 will at times attempt to go to the bathroom by herself and refuses to let staff help.
Z8 stated that she has witnessed R7 attempting to go to the bathroom by herself and at those times she (Z8) has stayed with R7 until another staff could stay with R7 as she would be unsafe to be alone in the bathroom (due to impulsive behavior and poor safety awareness). Z8 stated that the only way to keep R7 safe at those times is to stay with her, definitely requiring close supervision or 1:1. Z8 stated that only having staff

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stay with (R7) "1:1" would have prevented R7 from falling when she fractured her neck. Z8 stated that R7 could be really mean to staff but they still needed to stay with (R7) for safety.

On 7/21/17 at 10:20am E2, DON (Director of Nursing) stated that a Restorative Nurse (who no longer is employed at the facility) was gathering information on falls and bringing it to the team for analysis. E2 stated that a "new" Restorative Nurse started three months ago. E2 stated that it was identified that the previous Restorative nurse was not accurately identifying the root cause of falls, updating care plans or obtaining accurate information gathered for falls and "It was not long after that she (Restorative Nurse) resigned." E2 stated that there is a "mismatch" of the root cause of the falls and the actual documentation and interviews of staff. E2 stated that the Restorative Nurse was also responsible for the falls care plans. E2 stated that if any resident is exhibiting unsafe behaviors, staff should stay with the resident. E2 agreed that R7 was at risk for falling when sitting on the edge of her wheelchair , bending forward in her wheelchair and when agitated and restless. E2 stated "I don't know why staff didn't stay with (R7)."

Notes indicate neck fractures on 2/20/17 as a result of a fall were preceeded by restless and agitated behaviors with "multiple attempts" by R7 to get out of her wheelchair. Staff did not monitor or supervise R7 while displaying unsafe and high risk behaviors which resulted in R7 sustaining cervical neck fractures.

Care plans presented by the facility do not address the need for staff to stay with R7 when exhibiting unsafe behaviors and did not update R7's frequent behaviors of bending forward from

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her wheelchair as R7 continued to fall forward after the rear axle of the wheelchair was modified. No other interventions were found to address R7's falling forward out of her wheelchair.

Facility Policy/Falls Clinical Protocol dated/revised 2008 indicates:
Based on preceeding assessment, staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling.
The staff will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling.
If individual continues to fall, the staff and physician will re-evaluate the situation and consider other reasons for the residents falling (besides those that have already been identified) and will re-evaluate the continued relevance of current interventions.

2) R12 admitted to facility February 17, 2017 with diagnosis to include metabolic encephalopathy, dementia and obesity.

On July 11, 2017 at 2:30PM, R12 observed in a bariatric bed with a low air loss mattress. R12 was unable to move lower extremities upon request. R12 had oxygen at three litters per nasal cannula infusing, rarely spoke when questioned. R12 did say her pain is not being managed with medications provided. R12's right arm was in a sling and daughter at bedside.

July 11, 2017 at 2:30PM, R12's daughter (Z5), stated R12 has had a couple fall incidents since admission to facility. The facility told me she fell in June trying to get out of bed by herself. R12

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is reporting that the resident has increasing pain in right upper extremity. R12 cries out when touched or range of motion applied. Z8 called and notified.
June 21, 2017 at 11:46AM, resident shouting and yelling with pain of right upper extremity. Resident reports the pain is terrible. Z8 called and notified. Z8 ordered an X-ray of right upper extremity.
June 22, 2017 at 8:00AM, Resident complaint of pain to right shoulder and right arm, scheduled Tylenol administered as ordered. Resident scheduled for an X-Ray waiting for technician to come to facility. Seen by Z7 (attending physician) and Z8 with orders to start resident on Tramadol 50mg twice a day and Medrol dose pack.
June 22, 2017 at 10:45AM, X-Ray completed, pending results.
June 22, 2017 at 3:50PM, X-Ray results relayed to Z8 and orders received to send R12 to the emergency room for further evaluation.
June 22, 2017 at 5:00PM R12 transferred to hospital for evaluation of right shoulder pain.
There is no documentation that the physician or nurse practioner were called and notified of R12's severe right shoulder pain between June 15, 2017 fall and June 20, 2017.

R12's June 22, 2017 hospital emergency report documents presence of a post traumatic, acute right humeral neck fracture without displacement.

R12's February 24 and April 14, 2017 minimum data set assessment (MDS), include R12 requires extensive assist from 2 staff with bed mobility, transfers and bathing. The MDS also documents requires extensive assist with ambulation, dressing, eating, hygiene and toileting. R12 scored always incontinent of both bowel and bladder. R12's MDS scored the resident with cognitive impairments with a BIMS

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|---|---|---|---|
| | IL6010367 | A. BUILDING: ______ B. WING ______ | 07/27/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHATEAU NRSG & REHAB CENTER | 7050 MADISON STREET WILLOWBROOK, IL 60521 |

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score (brief interview of mental status) at a 5 out of possible 15.

July 21, 2017 at 9:55AM, during a telephone interview, Z8 (nurse practioner), stated I have cared for R12 since she was admitted to facility. R12 is alert and oriented to person and sometimes time. R12 is totally dependent on staff for all areas of activities of daily living and requires a mechanical sling lift for transfers. When I was told R12 slid out of bed on June 15, 2017 while trying to answer a phone, I was pretty sure it was due to positioning to close to the edge of the bed. R12 would not ever attempt to get out of bed independently.
Z8 stated I was not notified that R12 was complaining of severe pain in the right shoulder after her June 15, 2017 fall until June 20, 2017. If I was aware I would have ordered stronger pain medication and another X-Ray. I am usually off on weekends but I still take calls for my patients, so there is no reason not to notify me of the severe pain until June 20, 2017 when the residents daughter requested further evaluation of the pain.

R12's April 20, 2017 restorative referral include requires mechanical sling lift for transfers and requires maximum assist to roll from side to side in bed with use of small circular hand grip device at head of bed "Halos."

During July 14, 2017 , 2:05PM interview E27 (R12's occupational therapist), stated R12 would never attempt to get out of bed or initiate independent bed mobility without staff assistance and requires mechanical sling lift transfers with two person assist.
During this interview E27 took surveyor into the therapy room to show the sit to stand lift used on

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R12 when the resident sustained skin tears. The sit to stand lift was observed to still be without a cap covering the metal edge of the right arm handle.

During July 14, 2017, 10:30AM interview, E26 (R12's nurse aide), stated R12 requires two assist with bed mobility and transfers using a mechanical sling lift. R12 would not attempt to get out of bed without staff assistance. R12 is unable to independently move around in bed and frequently refuses to get out of bed.

July 14, 2017 at 10:35AM, E25 (nurse), stated R12 is sometimes observed with her legs dangling off the edge of her bed.

During July 14, 2017, 10:49AM interview, E9 (restorative nurse), stated R12 requires extensive assistance of two staff with bed mobility and transfers. E9 stated "(R12) would absolutely not attempt to get out of bed on her own." E9 said staff need to carefully place R12 in the center of the bed during mechanical lift transfers, not near the edge of bed. R12's June 15, 2017 fall from bed was directly caused from being positioned to close to the edge of the mattress, poorly positioned, not in the center of mattress by staff. E9 stated she re-educated staff on proper positioning R12 in bed for safety. Staff also told to use pillows for positioning on R12. E9's description of the root cause of this fall is not documented on the incident report or fall analysis report.

July 14, 2017 at 10:55AM, R12 observed being provided care by E26 and E4 (restorative aide). E26 and E4 were attempting to pull R12 up toward head of bed without locking bed wheels. During this repositioning R12's bed continued to

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move around and back and forth. After E4 and E26 repositioned R12 further up in bed they left R12 alone in room. R12 was positioned toward the right side of mattress within two - three inches from the edge of mattress and no pillows were being utilized to aide in positioning R12.

During July 14, 2017 telephone interview, around lunch time, E28 (nurse aide), stated R12's left posterior hand skin tear occurred while E28 was turning the resident in bed, R12 attempted to grab hold of the bedside Halos but the bed control device was wrapped around the Halos and cut open her hand.

R12's current care plan does not include any individual interventions to prevent incidents and accidents with or without injury.

Facilities fall protocol dated revised August 2008, include the need to thoroughly evaluate possible causes of falls and accidents and develop individual interventions and then evaluate if interventions are working. This was not done with any of R12's 4 fall and/or injury reports.

3) On July 11, 2017 at 1:48pm, E18 and E20 (Nursing Assistants) transferred R3 via a mechanical lift. E18 operated the controls on the lift and E20 stood behind a wheelchair that was pushed up to and on the same side of the bed as E18 as R3 was lifted into the air. Neither E18 nor E20 were near R3 to guide and supervise R3 while being lifted nor close enough to intervene if R3 required assistance during the transfer.

On July 12, 2017 at 10:23am R3 was in bed with the bed in the high position. R3 stated E18 left the room to get assistance to transfer R3 to the

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wheelchair. At 10:34am E18 entered R3's room with E19 (Nursing Assistant). E18 and E19 transferred R3 via a mechanical lift. E18 operated the controls on the lift and E19 stood behind a wheelchair that was pushed up to and on the same side of the bed as E18 as R3 was lifted into the air. Neither E18 nor E19 were near R3 to guide and supervise R3 while being lifted nor close enough to intervene if R3 required assistance during the transfer.

On July 12, 2017 at 10:44am, E19 stated one person is supposed to be located next to the resident to spot the resident during the mechanical lift transfer. E20 stated the bed is supposed to be in low position when a resident is in bed unsupervised.

R3's Fall Risk Assessment dated June 2, 2017 documents R3 at a high risk of falls.

(B)