Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED							
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IL6000137			B. WING		06/23/2021							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
FOSTER HEALTH & REHAB CENTER 2840 WEST FOSTER AVENUE CHICAGO, IL 60625												
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE							
S 000	Initial Comments		S 000									
į	Complaint Investiga	ition 2184180/IL134983										
	Facility Reported Inc	cident of May 15, 2021			=							
S9999	Final Observations		S9999									
	Statement of Licens	ure Violations:		-89								
	300.610 a) 300.1210 b) 300.1210 d)6)		. 3									
	a) The facility s procedures governir facility. The written be formulated by a F Committee consisting administrator, the admedical advisory confinering and other policies shall comply The written policies the facility and shall	dvisory physician or the mmittee, and representatives services in the facility. The with the Act and this Part. shall be followed in operating be reviewed at least annually ocumented by written, signed										
	Nursing and Persona b) The facility s care and services to practicable physical, well-being of the resi each resident's complan. Adequate and	deneral Requirements for al Care hall provide the necessary attain or maintain the highest mental, and psychological ident, in accordance with prehensive resident care properly supervised nursing are shall be provided to each										

STATE FORM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

6899

05T311

TITLE

(X6) DATE

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING IL6000137 06/23/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2840 WEST FOSTER AVENUE FOSTER HEALTH & REHAB CENTER** CHICAGO, IL 60625 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) S9999 Continued From page 1 S9999 resident to meet the total nursing and personal care needs of the resident. 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: 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. These regulations were not met as evidenced by: Based on interviews and record reviews, the facility failed to supervise a resident (R1) while on the toilet for 1 of 4 residents reviewed for falls. This failure resulted in R1 falling and sustaining a head injury requiring emergency room care and two staples to R1's posterior head. Findings include: R1's face sheet has diagnoses include, but are not limited to: difficulty in walking, abnormalities of gait and mobility, history of falling, dementia and muscle weakness. All listed diagnoses have an onset date of 2018, and were present on admission. R1's Quarterly MDS (Minimum Data Set) Assessment, dated 4/15/2021, reads R1's cognitive skills for daily decision making are severely impaired. It also reads R1 requires extensive assistance with one person physical

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assist for toilet use and personal hygiene.

R1's comprehensive care plan reads R1 is cognitively challenged, initiated 1/04/2021. R1

PRINTED: 07/14/2021 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING IL6000137 06/23/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2840 WEST FOSTER AVENUE **FOSTER HEALTH & REHAB CENTER** CHICAGO, IL 60625 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 2 S9999 exhibits forgetfulness and confusion. R1 requires guidance and cues. R1 has impaired decision making, short and long term memory deficits. Cognitive skills for daily decision making is impaired. R1's comprehensive care plan also reads R1 is at risk for falls due to cognitive impairment, unsteady standing balance, unsteady balance during transitions and generalized weakness. Problem was initiated on 7/23/2020. It also reads R1 has impaired ability to ambulate due to generalized weakness, unsteady standing balance and cognitive impairment. Date initiated 7/23/2020. Interventions include "Give hands on assist," "Give verbal cues" and "Provide appropriate level of assistance to promote safety of the resident." All interventions were initiated 7/23/2020. Surveyor reviewed facility's 'Fall During Staff' report, dated 5/15/2021 11:37 AM, prepared by V10 (Nurse). Report reads: "Called to shower room per CNA [Certified Nursing Assistant]. Resident observed with bleeding to back of head left side. Pressure applied bleeding stopped. Resident noted with small laceration to back of head. ..." Surveyor reviewed facility's Incident Report Notification addressed to the Illinois Department of Public Health, dated 5/20/2021. Surveyor also

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davs."

reviewed V13's (Nurse) progress note dated 05/15/2021 at 3:52 PM. "Resident returned from emergency room with two staples to R1's left middle posterior head. Staples in place for 7

On 6/16/2021 at 10:17 AM, surveyor interviewed V5 regarding the incident involving R1 on

5/15/2021. V5 stated V5 assisted R1 to the toilet in the shower room. V5 stated R1 was on a

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2840 WEST FOSTER AVENUE CHICAGO, IL. 00025	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
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PREFIX TAG REGULATORY OR LSC IDEMTFYING INFORMATION) S9999 Continued From page 3 tolleting program, and V5 wanted to tollet R1 prior to giving R1 a shower. At 10:16 AM, V5 asked surveyor to accompany V5 to the shower room to show surveyor the shower room setup, and demonstrate the events of the lincident. Shower room is across the hall from R1's room. Shower room has a half separation wall parallel to the doorway to the hall. Immediately behind the half separation wall is its tollet. In front of the toilet is the shower. V5 stated V5 put R1 on the tollet and left V5 sitting on the floiet in the shower room. V5 then went around the separation wall to grab linens from the linen cart. V5 stated when V5 returned to R1, R1 was sitting on the floiet in beliet and the shower. V5 stated if it wasn't for the half separation wall, V5 would be able to see R1 from the linen cart. V5 stated V5 could not see R1 because the wall was dividing the doorway and the toilet. V5 stated V5 and V11 (Certified Nursing Assistant) assisted R1 up to the shower chair. V5 stated they both noted bleeding to the back of R1's head. On 6/17/2021 at 10:43 AM, surveyor interviewed V12 (Restorative Nurse). V12 stated R1 is confused and needs frequent redirection. V12 stated R1 stated R1 can fall because R1 unsupervised. V12 stated R1 is unacceptable, V12 stated R1 has unsteady balance and is unaware of R1's safety needs. Reviewed V5's position contract and duties,	FOSTER HEALTH & REHAB CENTER 2840 WEST FOSTER AVENUE									
tolleting program, and V5 wanted to toilet R1 prior to giving R1 a shower. At 10:18 AM, V5 asked surveyor to accompany V5 to the shower room to show surveyor the shower room setup, and demonstrate the events of the incident. Shower room is across the hall from R1's room. Shower room has a half separation wall parallel to the doorway to the hall. Immediately behind the half separation wall is the toilet. In front of the toilet is the shower. V5 stated V5 put R1 on the toilet and left V5 sitting on the toilet in the shower room. V5 then went around the separation wall to grab linens from the linen cart. V5 stated the linen cart was in the hallway but right at the doorway of the shower room. V5 stated when V5 returned to R1, R1 was sitting on the floor in between the toilet and the shower. V5 stated if it wasn't for the half separation wall, V5 would be able to see R1 from the linen cart. V5 stated V5 could not see R1 because the wall was dividing the doorway and the toilet. V5 stated V5 and V11 (Certified Nursing Assistant) assisted R1 up to the shower chair. V5 stated they both noted bleeding to the back of R1's head. On 6/17/2021 at 10:43 AM, surveyor interviewed V12 (Restorative Nurse). V12 stated R1 is confused and needs frequent redirection. V12 stated R1 in the toilet was required to the back of R1's head. On 6/17/2021 at 10:43 AM, surveyor interviewed V12 (Restorative Nurse). V12 stated R1 is confused and needs frequent redirection. V12 stated R1 in the toilet and leave R1 unsupervised. V12 stated R1 is a high risk for falls. V12 stated R1 has unsteady belance and is unaware of R1's safety needs. Reviewed V5's position contract and duties,	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES	D BE	COMPLETE			
signed 10/01/2019. It reads: "The Certified Nursing Assistant (CNA) is responsible for		toileting program, at to giving R1 a show surveyor to accomp show surveyor the sow surveyor the sow surveyor the surveyor to the hall separation wall is the shower. V5 stated then went around the linens from the linen was in the hallway be shower room. V5 stated the shower. V5 separation wall, V5 stated the shower. V5 separation wall, V5 stated the linen cart. V5 stated the shower wall was the toilet. V5 stated the wall was the toilet. V5 stated they both note R1's head. On 6/17/2021 at 10:4 V12 (Restorative Nuconfused and needs stated R1 should be including during toile not put R1 on the toil unsupervised. V12 stated R1 can fa for falls. V12 stated R1 can fa for falls. V12 stated R1 is unaware of R1's si Reviewed V5's positi signed 10/01/2019. I	and V5 wanted to toilet R1 prior rer. At 10:18 AM, V5 asked any V5 to the shower room to shower room setup, and ents of the incident. Shower hall from R1's room. Shower rearation wall parallel to the Immediately behind the half e toilet. In front of the toilet is ed V5 put R1 on the toilet and toilet in the shower room. V5 is separation wall to grab in cart. V5 stated the linen cart but right at the doorway of the lated when V5 returned to R1, is floor in between the toilet stated if it wasn't for the half would be able to see R1 from lated V5 could not see R1 is dividing the doorway and V5 and V11 (Certified Nursing R1 up to the shower chair. V5 is debleeding to the back of let and leave R1 is frequent redirection. V12 supervised at all times, sting. V12 stated staff should let and leave R1 tated that is unacceptable. The call because R1 is a high risk R1 has unsteady balance and afety needs.	\$9999						

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FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: ___ COMPLETED IL6000137 B. WING 06/23/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2840 WEST FOSTER AVENUE **FOSTER HEALTH & REHAB CENTER** CHICAGO, IL 60625 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) S9999 Continued From page 4 S9999 of daily living and ensures the health, welfare and safety of all residents." Facility policy titled 'Assessing Falls and Their Causes' reads: "Preparation 1. Review the resident's care plan to assess for any special needs of the resident. 3. Assemble the equipment and supplies as needed." It continues to read: "5. Residents must be assessed in a timely manner for potential causes of falls. 6. Relevant environmental issues should be addressed promptly." (B)

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