

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6009377</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/14/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THE TERRACE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1615 SUNSET AVENUE WAUKEGAN, IL 60087</b>
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S 000	Initial Comments  2212801/IL145615	S 000		
S9999	<p>Final Observations</p> <p>Statement of Licensure Violation:</p> <p>300.610a) 300.1010h) 300.1010i) 300.1030a)3) 300.1210b) 300.1210d)3)6)</p> <p>Section 300.610 Resident Care Policies</p> <p>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.</p> <p>Section 300.1010 Medical Care Policies</p> <p>h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the 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.</p>	S9999	<p><b>Attachment A</b> <b>Statement of Licensure Violations</b></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>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.</p> <p>i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid procedures.</p> <p>Section 300.1030 Medical Emergencies</p> <p>a) The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur from time to time in long-term care facilities. These medical emergencies include, but are not limited to, such things as:</p> <p>3) Traumatic injuries (for example, fractures, burns, and lacerations).</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p> <p>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:</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>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 made by nursing staff and recorded in the resident's medical record.</p> <p>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.</p> <p>These Regulations are not met as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to provide a safe environment for a resident and ensure a resident was assessed after a change in condition was reported to staff. These failures resulted in R1 sustaining unwitnessed injuries in the facility and being found approximately 24 hours later, grimacing in pain, with swelling to her bilateral knees and ankles, with subsequent X-rays/radiology reports showing fractures to her right fibula (lower leg) and left femur (upper leg). This applies to 1 of 3 residents (R1) reviewed for quality of care. This applies to 1 of 5 residents (R1) reviewed for safety and supervision in the sample of 5.</p> <p>The findings include:</p> <p>R1's current care plan showed R1 was severely cognitively impaired related to her diagnoses of Dementia and Alzheimer's Disease.</p> <p>R1's Incident Note dated April 4, 2022, at 6:02</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>PM, showed V16 Registered Nurse (RN) was notified by V19 (Daughter of R1) that R1's bilateral knees and ankles were swollen. The note showed that upon assessment, V16 RN found R1's bilateral knees and ankles to be swollen with R1 "grimacing in pain" with movement of her lower extremities. R1's physician was notified of V16's assessment and X-rays were ordered. R1's Lab/Rad (Radiology) note dated April 4, 2022, at 10:30 PM showed. "Received X-ray result: Impression...Distal right fibular fracture...Subtle fracture to the (left) medial femoral epicondyle..." The note showed R1 was then sent to a local hospital for an evaluation of the fractures.</p> <p>On April 11, 2022, at 10:30 AM, V19 (Daughter of R1) stated, "I am upset. When I visited (R1) in the afternoon of April 3 (2022), I noticed she was limping. Her knees and ankles were swollen. No one knows what happened to (R1). No one knows what caused these (fractures). (V1 Administrator) told me he was looking into what happened." V19 stated when she visited with R1 on April 2, 2022, R1 was not limping or complaining of any leg swelling. V19 stated she notified V11 Licensed Practical Nurse (LPN) of R1's limping and lower leg swelling on April 3, 2022. I asked (V11 Licensed Practical Nurse/LPN) that day to take a look at (R1) to see what was going on because she was limping. When I came back for a visit the next day (April 4, 2022), I find out (V11 LPN) never looked at her so I asked the other nurse to look at her...No one knows what happened to (R1). No one knows what caused these (fractures)."</p> <p>On April 12, 2022, at 10:50 AM, V11 LPN stated she was notified of R1's leg swelling and limping on April 3, 2022, by V19 (Daughter of R1). V11</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>LPN stated, "Yes, that afternoon (April 3, 2022), (V19 Daughter of R1) did stop me and ask me to take a look at (R1) because she was limping. When I went down to look at (R1), she was asleep in bed. I didn't want to bother her, so I didn't assess her or look at her legs. We got busy. I didn't report the limping to the doctor or the next nurse...I feel bad. I should have assessed her that day. Normally, I would have done an assessment and reported anything abnormal to the doctor..." V11 LPN stated she had no knowledge of what caused R1's injuries. V11 LPN denied any knowledge of recent falls for R1.</p> <p>On April 13, 2022, at 8:00 AM, V16 RN stated, "That afternoon (April 4, 2022), (V19 Daughter of R1) came up to me and said (R1's) knees and ankles were swollen. (R1) was seated in a wheelchair in the dining room. I went and assessed her. Both of her knees and ankles were swollen...She would grimace with any movement of her legs, so I called the doctor right away and got orders... No staff had reported any limping or swelling to me. I was not told of any recent falls or injuries for her..."(V19 Daughter of R1) stated she had told the nurse the day before about (R1's) limping and no one did anything about it...No staff had reported any limping or swelling to me."</p> <p>On April 12, 2022, at 12:05 PM, V4 Physician stated, "Any change in condition, including any limping or new swelling, should be reported to me immediately so I can initiate treatment as needed. I was first notified of (R1's) leg swelling on April 4 (2022)..."</p> <p>On April 12, 2022, at 2:10 PM, V18 Chief Clinical Officer stated staff are to promptly notify the physician of any change in resident condition so care and treatment can be provided immediately</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>if needed. V18 stated, "If a family member and/or resident complains of new swelling to an area or any injury, I would expect the nurse to go and assess the resident immediately and then call the physician with any findings."</p> <p>The facility's Nursing Schedule dated April 2 and April 3, 2022 (afternoon/second shift) showed V9 Registered Nurse (RN) was assigned to provide cares to R1. On April 12, 2022, at 2:30 PM, V9 RN stated, "I am not sure I was even assigned to her those days. I don't recall seeing her walking at all...I have no idea what happened to (R1)."</p> <p>The facility's Nursing Schedule dated April 3, 2022 (day shift) showed V14 LPN was assigned to provide cares to R1. On April 12, 2022, at 1:30 PM, V14 LPN stated, "I didn't see (R1) walking around at all that day. I only saw her in her wheelchair or lying-in bed. No one reported any falls or injuries to me. I didn't do an assessment on her that day because I didn't see any reason too..." V14 stated she had no knowledge of what caused R1's injuries.</p> <p>On April 12, 2022, at 11:00 AM, V12 Certified Nursing Assistant (CNA) stated she provided cares to R1 on April 1-3, 2022. V12 stated, "I have no idea what happened to (R1). She didn't fall for me. I don't remember her limping..."</p> <p>On April 12, 2022, at 12:05 PM, V4 Physician stated, "I assumed (R1's) injuries were the result of a fall but no one reported any falls...If she had fallen, she would have never been able to get herself back up off the floor, by herself, with those fractures, especially the one to her right leg. She wouldn't be able to walk with those fractures...We really don't know for sure what happened. Something traumatic happened to cause her</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>injuries, we just don't know what..."</p> <p>The facility's Change in Condition policy dated March 2021 showed, "GUIDELINE: To keep the physician or extender, who is in charge of medical care, responsible party, responsible for health care decisions, informed of the resident's medical condition so they may direct the plan of care as needed. STANDARD: Notification of physician or extender, legal representative, or responsible party, should occur when there is a change in the resident's condition. Change in condition is defined as...An incident or accident, that involves the resident which results in injury and requires physician or extender intervention. A change in the resident's physical, mental or psychosocial status. A need to alter treatment. A decision to transfer or discharge the resident from the facility. PROCEDURE: 1. Determining When To Call - Evaluate the condition and determine when it is an emergency, medical situation or a non-emergency situation..."</p> <p>(A)</p>	S9999		