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
	IL6012645	A. BUILDING: ______ B. WING ______	C 12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRINCETON REHAB & HCC	255 WEST 69TH STREET CHICAGO, IL 60621

(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 of October 4, 2022 IL152035 Facility Reported Incident of October 13, 2022 IL152630	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.690 a) 300.690 b) 300.690 c) 300.1210 b) 300.1210 d)6 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 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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S9999	Continued From page 1 affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. 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:	S9999		

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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.

These requirements are not met as evidenced by:

Based upon observation, interview, and record review, the facility failed to follow the fall management program/policy, and failed to implement fall prevention interventions (R1, R12), failed to conduct a thorough investigation to determine root cause (R1), failed to document a descriptive and/or accurate incident summary in the progress notes (R12), failed report serious injury to IDPH (Illinois Department of Public Health) within regulatory requirements (R12), and failed to conduct a timely investigation (R12) for 2 of 3 residents reviewed for falls. These failures resulted in R1's (10/4/22) fall with right foot soft tissue swelling.

Findings include:

1. R1's diagnoses include bilateral paralytic syndrome following cerebral infarction, paraplegia, right/left foot drop.

R1's (9/21/22) BIMS determined a score of 15 (cognitively intact).

R1's (9/21/22) functional assessment affirms 2 person physical assist is required for transfers and 1 person physical assist is required for locomotion.

R1's (9/27/22) fall risk assessment determined a score of 4 (at risk).

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S9999	Continued From page 3 R1's care plan includes (2/12/22) resident is at risk for falls secondary to paraplegia, wheelchair bound, functional deficits, and muscle weakness. Intervention: encourage appropriate use of wheelchair. (4/20/22) Resident is noted to have limitation in range of motion secondary to foot drop. Intervention: assist as needed. R1's (10/4/22) initial report states resident left facility with an escort for scheduled appointment at the hospital, resident was noted slightly slid off her wheelchair while taking her off the vehicle lift at the destination. According to her assigned escort, resident legs touched the floor, and she was immediately readjusted back on the wheelchair. R1's final report excludes a root cause analysis. R1's (10/4/22) history & physical includes chief complaint: fall. Stated complaint: foot pain status post fall. Patient accidentally slipped partially out of the wheelchair prior to arrival when she hit a bump and complains of some right foot discomfort. Patient states that after she had a stroke 6 months ago, she's been lying contracted in a crooked position on her right hip. R1's (10/4/22) x-rays include posterior dislocation of the right hip and soft tissue swelling along the dorsum of the (right) foot. On 11/28/22 at 11:02am, V3 (RN/Registered Nurse) was observed exiting R1's room. Surveyor inquired about R1 functional status V3 stated, "She's not able to walk." On 11/28/22 at 11:05am, R1 was lying in bed on her left side. R1's right leg was severely contracted and right foot drop was noted. Surveyor inquired about R1's contractures, R1	S9999		

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replied, "I had a stroke my whole body is contracted. I have a contracted hip." R1's bed was in high position and side rails and/or floor mats were not in use. Surveyor inquired about the (10/4/22) incident. R1 stated, "I fell out the wheelchair. I had to go to another facility to see the pain doctor. The gentleman was pushing me into the facility as we got to the doors, he hit a little crinch in the sidewalk and I slid out the wheelchair onto my bad leg because I was in a regular wheelchair not with a seatbelt." R1 affirmed her specialty wheelchair (which has a seatbelt) is too small, therefore, a regular wheelchair was in use at the time of the incident. Surveyor inquired about R1's (10/4/22) injuries. R1 responded, "My butt hit the ground and the back of my knee was bruised. My hip was already dislocated."

On 11/28/22 at 11:12am, V3 (RN) entered R1's room. Surveyor inquired about the height of R1's bed, V3 stated, "Right now, it's a bit high. It's supposed to be low." Surveyor inquired why side rails were not in use, V3 responded, "We need the rails."

On 11/28/22 at 3:37pm, surveyor inquired about R1's (10/4/22) incident, V15 (Bus Driver) stated, "I was unloading the passenger (R1) and she kinda slipped down. She ended up, I think, barely touching the floor." Surveyor inquired if V15 was pushing R1's wheelchair when the incident occurred. V15 responded, "I was assisting to bring it out to the ramp to go inside the hospital. If you don't push her out, she just stays there, so you gotta assist her to come out", and affirmed he (V15) was pushing R1's wheelchair towards the ramp. Surveyor inquired what R1's facility escort was doing. V15 replied, "Waiting for me (V15) to take her (R1) on the ramp so she (Escort) could

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take her (R1) inside." Surveyor inquired if V15 received training for transferring residents to and from the bus. V15 stated, "Yes, to work the lifter up and down." Surveyor inquired if V15 is a CNA (Certified Nursing Assistant), V15 responded "No."

On 11/29/22 at 9:23am, surveyor inquired about the root cause of R1's (10/4/22) incident. V2 (Director of Nursing) stated, "She (R1) was out on an appointment at the hospital, as they were letting the lift down, the wheel went on some uneven pavement and she slid out of the chair. To prevent it from happening again, we reassessed her (R1) for wheelchair, and spoke with her (R1) in regards to safety and sitting up in the chair, and spoke to staff regarding safety during transport." Surveyor inquired about the facility failures which likely caused R1's (10/4/22) incident. V2 responded, "I believe we didn't fail at all." Surveyor inquired why R1 was transported in a regular wheelchair (without a seat belt). V2 replied, "Because at that time she was using a regular wheelchair and was sitting comfortably in the wheelchair." Surveyor inquired if V15 received any training for transporting and/or assisting residents prior 10/4/22. V2 stated, "That's information that I would have to find out", however, no additional information and/or documentation was provided.

On 11/30/22 at 10:44am, surveyor inquired about R1's functional status, V31 (Restorative Nurse) responded, "Her functioning is bad she's pretty much total care. She can't do anything really, the way her body is crooked. I did a geri assessment on her when she's in the bed she can come up just a little bit, not a whole lot. She couldn't really lift up." Surveyor inquired if a regular wheelchair is appropriate for R1, V31 responded, "No,

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S9999	Continued From page 6 never." Surveyor inquired about an appropriate mode of transportation for R1's appointments, V31 stated, "If she has to go somewhere she has to go via stretcher." 2. R12's diagnoses include dementia and acquired absence of right leg (above knee). R12's (10/14/22) BIMS (Brief Interview Mental Status) determined a score of 1 (severely impaired). R12's (10/14/22) functional assessment affirms (1 person) physical assist is required for transfers. R12's (10/14/22) fall risk assessment determined a score of 7 (at risk). R12's (7/15/22) care plan states resident is at risk for falls secondary to history of falls, right AKA (Above Knee Amputation), dementia, and seizure disorder. Intervention: promote placement of call light within reach. R12's (11/15/22) incident report states the nurse went to resident's room and observed resident on the floor with linen wrapped around his body having a seizure. No visible bruises or injuries noted. Resident taken to hospital: no. R12's progress notes include (11/15/22) "Writer went to resident's room and observed resident on the floor with linen wrapped around his body having a seizure. Monitored resident's seizure lasted about 3 minutes and once subsided able to do head to toe body assessment. Resident denies having pain when asked. No visible bruises or injuries noted, vital signs taken, and neuro-checks initiated. ROM (Range of Motion) to all extremities rendered with resident able to	S9999		

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S9999	Continued From page 7 move them within his limit. Resident assisted off the floor to his bed by staff and made comfortable also call light placed at reach. (11/16/22) Patient returned with Normal CT scan results." R12's (11/16/22) head CT (Computed Tomography) includes deformity of the nasal bones with associated soft tissue swelling and could reflect fractures of indeterminate age. On 11/28/22 at 10:50am, R12 was sitting in a wheelchair (adjacent the bed) however a call light was not within reach. Surveyor inquired about the (11/15/22) incident, R12 stated, "I just fell out standing up or something." On 11/28/22 at 10:56am, V3 (Registered Nurse) entered R12's room surveyor inquired if R12 requires transfer assistance, V3 stated, "He needs help. We always tell him to wait for the CNA (Certified Nursing Assistant) to help him." Surveyor inquired about R12's fall prevention interventions. V3 responded, "We have a CNA to meet up with his needs if he goes back to the bed. He uses the call light to get the attention of the CNA or the Nurses. The call light is functioning." Surveyor inquired about the location of R12's call light. V3 moved R12's bed, lifted R12's mattress and stated "Where is the call light? It fell on the floor. It's supposed to be on the bed all the time." On 11/29/22 surveyor requested R12's (11/15/22) fall investigation, however, the investigation was not received. On 11/29/22 at 2:42pm, surveyor inquired about R12's (11/15/22) incident/injury, V2 (Director of Nursing) responded, "He was sent out to the ER (Emergency Room) to be evaluated. I know there	S9999		

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S9999	Continued From page 8 was no injuries." Surveyor inquired if an investigation was conducted for R12's (11/15/22) incident. V2 responded "Yes." Surveyor inquired why the investigation was not received. V2 affirmed she provided surveyor staff statements. On 11/29/22 at 2:42pm, surveyor inquired about the regulatory requirements for reportable incidents, V2 (Director of Nursing) stated, "We normally report incidents/accidents within 24 hours (the initial) and initiate an investigation and its ongoing depending on the nature of the incident 5-7 days. We do the final which includes the root cause analysis. The final would be sent over (to IDPH) within the 5-7 days." Surveyor inquired about R12's (11/15/22) incident/injury V2 responded, "He was sent out to the ER (Emergency Room) to be evaluated. I know there was no injuries." Surveyor inquired if an investigation was conducted for R12's (11/15/22) incident. V2 responded, "Yes." Surveyor advised that R12 sustained a serious nasal injury (per 11/16/22 CT) and inquired if R12's injury was reported to IDPH. V2 replied, "I'll go back and check my records." On 11/30/22 at 9:36am, surveyor requested R12's (11/15/22) alleged investigation. V2 stated, "I did report that deformity yesterday (14 days after the incident)." V2 subsequently presented R12's preliminary incident investigation report which includes date of alleged incident: 11/16/22 (the incident occurred on 11/15/22). Any obvious injuries: no (R12 sustained nasal injuries). The facility will continue to conduct a complete and thorough investigation until a conclusion is reached. R12's 11/15/22 final investigation was not received during this survey. On 11/30/22 at 1:36pm, surveyor inquired about	S9999		

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S9999	Continued From page 9 potential harm to a resident that sustains a fall. V29 (Medical Director) stated, "Usually with a fall that's unwitnessed let's say that the patient hits the head, there could be injury to the scalp or bleed to the brain that could lead to death. Another one would be fractures." The (8/2020) fall management program states it is the facility's policy to act in a proactive manner to identify and assess those residents at risk for falls, plan for preventive strategies and facilitate a safe environment. Educate staff members to check during room rounds the 4 P's (pain, positioning placement of personal items, personal needs). The nurse call device will be placed within the resident's reach. The bed will be maintained in a position appropriate for resident transfers. Use standard fall/safety precautions for all residents. The (8/2020) management of falls policy states provide assistive devices for mobility, hearing and vision as appropriate for the resident. Assess and monitor resident's immediate environment to ensure appropriate management of potential hazards. The (9/2020) incident/accident reports policy states the facility shall maintain a file of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or Nurse's notes of that resident. The Director of Nursing, Assistant Director of Nursing, or Nursing supervisor must notify the Illinois Department of Public Health of any serious incident or accident. The facility shall send a narrative summary of each reportable accident or	S9999		

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S9999	Continued From page 10 incident to the Department within seven days after the occurrence. (B)	S9999		