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
	IL6000988	A. BUILDING: ______ B. WING ______	C 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD PLAZA	1426 WEST BIRCHWOOD CHICAGO, IL 60626

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S 000	Initial Comments Facility Reported Incident of 9-7-23/IL164278	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)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 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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. Restorative measures shall include, at a minimum, the following procedures:

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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:

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.

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These requirements were not met as evidenced by:

Based on interview and record review the facility failed to properly transfer a resident (R2) who is totally dependent on staff for transfers; and failed to ensure that R2 was free from injuries of unknown origin for one of four residents (R2) reviewed for Injury of Unknown Origin on the sample list of four. These failures resulted in R2 sustaining a left tibia comminuted fracture involving the tibia with multiple fracture clefts, pain and swelling to the left leg.

Finding include:

R2's face sheet shows that R2 has a diagnosis which includes but not limited to: Nondisplaced comminuted fracture of shaft of the left tibia subsequent encounter for closed fracture with routine healing.

R2's Minimum Data Set dated 08/07/23 shows that R2 requires Total dependence two-person assistance for transfers. R2's Brief Interview for Mental Status (BIMS) shows that R2 has memory problems.

On 09/25/23 at 12:23 PM, R2 was observed in bed awake and alert not able to communicate needs. V4 (Certified Nursing Assistant) was observed feeding/assisting R2 with R2's lunch meal. R2's feet was observed in a heel protector with swelling observed to R2's left foot, and no discoloration noted. V4 stated, R2 was not getting out of bed on 09/25/23 due to the unit with COVID 19 positive residents. When V4 was asked regarding R2's transfer status from the bed to the wheelchair V4 stated, V4 transfers R2 and does

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not need help with transferring R2 and R2 was not getting out of bed on 09/25/23.

On 09/25/23 at 12:30 PM, V9 (Licensed Practical Nurse, LPN) R2's nurse was asked regarding R2's transfer status. V9 stated, "I'm (V9) not sure about that. It (referring to the residents on the second-floor unit transfer status) on the daily assignment sheet but they (referring to the CNA's) know their job."

On 09/26/23 at 10:31 AM, V8 (Certified Nursing Assistant, CNA) stated, V8 works with R2 as the facility frequently and was R2's CNA on 09/06/23 and 09/07/23. V8 stated, on 09/07/23 V8 was about to clean R2's lower perineal area and lower extremities when V8 observed R2 with swelling to the left leg from the knee to the ankle are while V8 was providing care to R2 in bed after breakfast. V8 stated, V8 got R2's upper body area dressed in a blouse but did not get R2's lower area dressed. V8 stated, when V8 touched R2's left leg, R2 screamed. V8 stated, V8 then went to get V11 (Licensed Practical Nurse, LPN) and V11 assessed R2's left leg and dialed 911 to send R2 to the local hospital. V8 stated, R2 did not return to the facility when V8 left on 09/07/23. V8 was asked regarding how does V8 transfer R2's from the bed to the wheelchair. V8 stated, on 09/26/23 V8 transferred R2 from the bed to the wheelchair by picking R2 up from R2's bed and carrying R2 to R2's wheelchair. V8 stated, "I (V8) carry her (R2) because she is not big. I (V8) sit R2 on the side of the bed and place R2's wheelchair next to R2's bed and carry R2 to from R2's bed to R2's wheelchair." V8 stated that R2 does not assist with R2's transfer and that V8 carry's R2 when transferring R2 from bed to wheelchair and from the wheelchair to the bed. V8 also stated, on 09/06/23 V8 carried R2 from

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R2's wheelchair back to R2's bed after breakfast to provide incontinence care to R2 and carried R2 from R2's bed back to R2's wheelchair so R2 could go back to the dining room for activities after V8 provided incontinence care to R2 after lunch. V8 stated, R2 remained in the dining room after V8 shift was over on 09/06/23 for the 3:00 pm - 11:00 pm to place R2 back to bed. V8 also explained, if a resident is new to V8, V8 will ask the charge nurse or another CNA how to transfer the resident.

On 09/26/23 at 11:20 AM, V10 (Restorative Nurse, Registered Nurse, RN,) stated that all residents are assessed by therapy department upon admission and that therapy department at the facility recommends the residents transfer status. V10 stated, residents transfer status is verbally told to the nurses and the nurses share the information regarding the residents transfer status with the CNA's verbally. V10 stated, the residents transfer status is also placed in the residents electronic medical record in the special instructions task bar section on the residents profile. V10 stated, R2 required moderate assistance of one person for transfer prior to R2's injury in 09/07/23. V10 explained, staff should never carry a resident to transfer a resident from bed to the wheelchair or from the wheelchair to the bed. V10 also explained, carrying a resident when transferring a resident is not safe for the patient or staff and can cause injury to the staff and the resident.

On 09/26/23 at 2:20 PM, V11 (Licensed Practical Nurse, LPN) stated, V11 was R2's nurse on 09/07/23 . V11 stated, on 09/07/23 in the morning after breakfast, V11 was passing medication to the residents and V8 (CNA) notified V11 that R2's left leg was different from R2's right leg. V11

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explained, R2 was still in bed when V11 assessed R2's left leg swollen from the knee to the toe area with a purplish discoloration. V11 stated, R2 complained of pain to R2's left leg and V11 called V2 (Director of Nursing DON). V11 stated, V2 stated that R2's left leg appeared fractured and V2 dialed 911 to send R2 to the local hospital. V11 stated, R2 did not return to the facility on 09/07/23 during V11's shift. V11 stated, V11 was not R2's nurse on 09/06/23 and V11 did not receive in report any changes with R2's condition or that R2 had an injury to R2's leg on 09/07/23.

On 09/26/23 at 2:56 PM, V12 (R2's Nurse Practitioner) stated, V12 is R2's nurse practitioner. V12 stated, V12 recall the facility calling V12 regarding R2's left leg having discoloration and swelling. V12 stated, V12 gave orders to send R2 to the local hospital emergency room (ER) for an evaluation. V12 stated, R2 sustained a comminuted fracture to R2's left leg. V12 also explained, R2 had an orthopedic evaluation and was not a candidate for surgery for R2's leg due to R2's co-morbidities. When V12 was asked regarding how R2's injury occurred, V12 stated, the facility denied that R2 sustained a fall and that it was difficult for V12 to state how R2's left leg fracture occurred. V12 stated, R2 is a resident with dead weight, fragile bones and R2's injury was probably from an improper transfer from staff. V12 was asked regarding staff transferring a resident by carrying a resident from the bed to the wheelchair. V12 stated, staff should have a mechanical lift device especially for the elderly like R2 otherwise the staff is subjecting the resident to trauma or a fall and placing everyone at a risk for an injury if the staff is carrying a resident during transfer.

On 09/27/23 at 11:10 AM, V2 (Director of

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S9999	Continued From page 6 Nursing, DON) stated, on 09/07/23 V2 was called to R2's room to assess R2's left leg and observed R2's left leg with swelling from the knee to the toes with discoloration to R2's left foot toes. V2 stated, V2 called V12 (R2's Nurse Practitioner) and was given orders to send R2 to the local hospital for an evaluation. V2 stated, R2 was diagnosis with a left leg fracture and sent back to the facility in a post mold cast to R2's left foot area. V2 stated, R2 was given orders for R2 to follow up with orthopedic surgeon and that R2 was seen by the orthopedic physician who said R2 was not a candidate for surgery and removed R2's post mold cast due to concems for R2 acquiring skin breakdown to R2's foot/leg area from the post mold cast. V2 was asked regarding how R2 obtained the injury to R2's left leg. V2 stated, V2 did not know. V2 explained, V2 interviewed all the staff and staff denied R2 falling. V2 was asked regarding resident transfers at the facility. V2 stated, the therapist and the restorative nurse work together to determine a residents transfer status. V2 stated that the CNA's are made aware of a residents transfer status in the residents electronic medical record Plan of Care (POC) section under the task label. V2 stated that the facility uses two types of transfers for residents. V2 stated, the CNA's transfer the residents with a gait belt assist transfer. V2 explained, the resident must be able to stand and ambulate when the CNA's are doing a gait belt transfer. V2 then stated, with a gait belt with assistance transfer when the staff places the gait belt around the resident in case the resident loses balance the staff can ease the resident to the chair or floor. V2 then explained, staff also use a mechanical lift device transfer with two staff members to transfer the resident. V2 stated, staff should not carry a resident from the bed to wheelchair for a transfer because the staff can	S9999		

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hurt themselves and staff can cause injury to the resident.

The facility's daily staffing from August 06, 2023, and August 07, 2023, shows that V8 was working in facility.

The facility's document dated 09/10/23 and titled "Incident Investigation Interview Statement Employer Profile" authored by V8 (CNA) documents, in part: "I (V8) usually pick her (R2) up to get her (R2) out of bed because she (R2) is so light."

The facility's undated policy titled "General patient transfer techniques" documents, in part: General Rules of Patient Transfer: 2. Get equipment you need ... 5. Get the people help you need."

R2's Transfer Self Performance reviewed with concerns for facility following R2's as a total dependence transfer status.

R2's medical record profile shows that R2 transfer status is two person "(Mechanical Lift)" 2 person assist.

R2's Fall Risk Evaluation dated 07/31/23 and 09/08/23 reviewed.

R2's Care Plan dated 02/13/23 shows that R2's Focus: Self-Care deficit require assist with ADL (Activities of Daily Living) ... Intervention: Transfer: R2 requires extensive to total 2 staff assist to move between surfaces.

R2's Minimum Data Set dated 08/07/23 shows that R2 requires Total dependence two-person assistance for transfers. R2's Brief Interview for Mental Status shows that R2 has memory

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problems.

R2's progress note dated 09/07/23 authored by V11 (LPN) shows that CNA notified V11 that R2's left knee all the way to the left foot was swollen and also noted R2's left eye was swollen. 911 was called and R2 was sent to the local hospital for evaluation.

R2's incident report dated 09/07/23 authored by V2 (DON) shows that V2 noted R2 with swelling from the left knee down to the foot and R2's foot purplish in color upon touching the left knee the resident is grimacing.

The facility's Initial Reportable incident to the local state agency dated 09/07/23 at 9:21 pm, shows that R2 sustained a left Tibia comminuted fracture involving tibia with multiple fracture clefts.

The facility's Final Reportable incident to the local state agency dated 09/11/23 at 4:11 pm, shows that R2 sustained a left tibia comminuted fracture involving tibia with multiple fracture clefts and returned to the facility on 09/07/23 with a post mold cast of left leg and is to follow up with orthopedic physician.

R2's local hospital record dated 09/07/23 shows diagnosis of closed fracture of proximal end of left tibia, unspecified fracture morphology initial encounter. R2's Radiology report dated 9/7/23 documents: Findings:: Left tibia and fibula: Comminuted fracture involving the tibia is identified with multiple fracture clefts. There is predominantly transverse fracture cleft involving the proximal tibial metaphysis however there is another vertically oriented fracture cleft along the lateral tibial diaphyseal cortex.

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