

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000277	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/24/2023
NAME OF PROVIDER OR SUPPLIER CRESCENT CARE OF ELGIN		STREET ADDRESS, CITY, STATE, ZIP CODE 180 SOUTH STATE STREET ELGIN, IL 60123		
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S 000	Initial Comments Investigation of Complaints: 2375801/IL162021 2375640/IL161820	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 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 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.	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	<p>Continued From page 1</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care 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.</p> <p>Based on observation, interview, and record review, the facility failed to provide the necessary supervision to a resident to prevent a fall that resulted in a serious injury. This failure resulted in R1 sustaining a leg fracture because of the fall, that required urgent surgery upon admission to the hospital on July 11, 2023. This applies to 1 of 3 residents (R1) reviewed for falls in the sample of 9.</p> <p>The findings include:</p> <p>R1's EMR (Electronic Health Record) showed R1 was re-admitted to the facility on February 28, 2023, and discharged to the local hospital on July 11, 2023. R1 had multiple diagnoses that including Dementia with psychotic disturbance, glaucoma, hypertension, atherosclerotic heart disease, repeated falls, and cognitive communication deficit. R1's most recent fall risk assessment dated May 23, 2023, showed R1 was at high risk for falls.</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>R1's MDS (Minimum Data Set) dated April 18, 2023, showed R1 had severe cognitive impairment, required extensive assistance with bed mobility and transfer, did not walk, was dependent on staff for locomotion. Also required extensive assistance for dressing, personal hygiene and eating.</p> <p>R1's care plan had a fall intervention dated May 1, 2022, that stated "Remain in a room near the nurse's station for visual checks."</p> <p>R1 sustained an unwitnessed fall on July 9, 2023, at 6:30 PM, as documented in R1's EMR (Electronic Medical Record).</p> <p>On July 17, 2023, at 4:23 PM, V10 (CNA-Certified Nursing Assistant) stated R1 was noted on the floor, face on the floor, on her knees, in front of her wheelchair on July 9, 2023, at approximately 6:30 PM.</p> <p>On July 20, 2023, at 1:14 PM, V10 (CNA) stated she was passing dinner trays and there was no staff at the nurse's station, when she saw R1 had a fall on July 9, 2023. V10 stated she called for V12 (LPN-Licensed Practical Nurse) who was passing medications in the hall, to assist with R1 after the fall. V10 stated V12 came, and they assisted R1 to a sitting position with R1's legs in front of her and then assisted R1 back into her wheelchair by lifting R1 up. V10 stated that process took about one to two minutes. V10 also stated after R1 was seated in the wheelchair, V10 left the nurses station to return to passing dinner trays and V12 texted V7 (LPN) to let her know that her assigned resident, R1 had a fall because V7 was not in the facility at the time.</p> <p>V7 (LPN) stated on July 17, 2023, at 2:15 PM,</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>that she was R1's assigned nurse on July 9, 2023, on the evening shift and was not in the facility at the time of R1's fall. V7 stated R1 is usually sitting in her wheelchair behind the nurse's station so staff can "keep an eye on her." V7 stated around 6:00 PM on July 9, 2023, V7 left the facility to go on break and as she exited the building her coworker V12 (LPN) was already outside the building on break.</p> <p>V8 (CNA) stated on July 17, 2023, at 3:21 PM, that V8 worked the evening shift on July 9, 2023, and saw R1 sitting in her wheelchair, at the nurse's station and noticed bruising on R1's face around 6:30 PM. V8 stated V12 (LPN) told her that R1 just had a fall. V8 also stated she was unaware of the time when V7 went on break and was not asked to supervise R1 during that shift.</p> <p>V11 (CNA) stated on July 17, 2023, at 4:09 PM, that she was assigned to care for R1 on July 9, 2023, during the evening shift. V11 stated around 7:30 PM she was putting R1 to bed and noticed a bruise on R1's face. V11 stated she put R1 back into the wheelchair and took her to the nurse's station to show V7 (LPN) the bruise on R1's face. V11 (CNA) stated V10 (CNA) saw V11 taking R1 to the nurse's station and told V11 that R1 had fallen earlier. V11 further stated she was unaware when V7 (LPN) left the building to go on break and was not asked to watch R1 during that shift.</p> <p>V11 (CNA) had stated to V2, (DON), who provided a written statement on July 19, 2023, that on July 9, 2023, evening shift, V11 had fed R1 dinner between 5:15-5:30 PM at the nurse's station and then went to assist other residents with the dinner meal, leaving R1 in the nurse's station.</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>On July 20, 2023, at 9:15 AM, V35 (CNA) stated she works in the facility full time and knows R1 well. V35 stated staff bring R1 to the nurse's station so all staff can "keep an eye on her." V35 demonstrated the usual position of R1 when sitting at the nurse's station. R1 sits in her wheelchair and likes to rock back and forth. V35 stated R1 sits behind the nurse's station, at the counter, and puts both knees flexed, up against the counter, and moves back and forth in a rocking motion. V35 further stated R1 sits next to staff at the counter while staff chart on the computer.</p> <p>V10 (CNA) stated on July 20, 2023, at 1:14 PM that at the time of the fall on July 9, 2023, R1 was sitting away from the counter on the left side of the nurse's station, with no counter in front of her. The wheelchair was upright, and R1 was face down on the floor in a kneeling position on the floor.</p> <p>On July 20, 2023, at 9:30 AM, V34 (LPN) stated she has worked at the facility for eight years and has worked with R1 since her admission to the facility and knows R1 well. V34 stated R1 requires a lot of attention and "somebody must keep an eye on her at all times." V34 further stated that R1's routine includes if she is awake, staff keep her at the nurse's station and R1 sits behind the counter with staff while in her wheelchair. V34 also stated that nursing staff know staff are not to take their breaks during resident mealtimes. Staff break times are assigned to occur either before or after resident mealtimes. V34 also stated that nurses cover for each other during staff breaks and don't leave the unit at the same time for breaks.</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>On July 19, 2023, at 4:51 PM, V21 (R1's Physician) stated he relies on the facility nurses to inform him regarding a resident's injury as the nurses are his "eyes and ears." V21 stated he did not receive any information regarding injury to R1 until July 11, 2023, at 3:30 AM, via text and he ordered an X-ray of the left knee due to report of the knee swelling. V21 also stated had he been told that R1 had an unwitnessed fall from her wheelchair onto her face that resulted in facial bruising on July 9, 2023, V21 would have ordered to send R1 to the hospital immediately. V21 also stated the cause of the fracture was "most definitely" the fall on July 9, 2023.</p> <p>R1's hospital record progress note dated July 11, 2023, by V36 (Orthopedic Surgeon) showed R1 had an "open left distal femur fracture that likely occurred July 9, 2023," two days prior. V36 recommended "urgent I&D (Incision and Drainage) of open fracture site in OR (Operating Room) with application of knee spanning external fixator."</p> <p>During multiple interviews, between July 17 and July 20, 2023, at various times, staff who worked the evening shift on July 9, 2023, V7(LPN), V10 (CNA), V11(CNA) and V8 (CNA) each stated R1 was at risk for falls and was kept at the nurse's station for visual monitoring.</p> <p>During additional staff interviews, between July 17 and July 20, 2023, at various times, V2 (DON), V35 (CNA), V34 (LPN), V33 (LPN), V9(LPN) and V6 (RN) each stated R1 was at risk for falls and R1 was often positioned behind the nurse's station to provide visual monitoring.</p> <p>The Facility policy "Fall and Fall Risk, managing", dated March 2018, showed under the section,</p>	S9999			

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S9999	Continued From page 6 "Resident-Centered Approaches to Managing Falls and Fall Risk," 1. The staff will implement a resident centered fall prevention plan to reduce the specific risk factor for each resident at risk." -A-	S9999		