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
	IL6002315	A. BUILDING: ______ B. WING ______	C 12/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW REHAB CENTER	5888 NORTH RIDGE CHICAGO, IL 60660

(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 1/13/2020/IL119121 Complaint Investigation: 2080976/IL119915	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.1210b) 300.1210d)6) 300.1220b)2)3) 300.3240a) 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. Restorative measures shall include, at a minimum, the following procedures: 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.	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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S9999	Continued From page 1 Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to supervise and prevent an impaired resident from obtaining a severe injury that required surgery. This failure resulted in one of	S9999		

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three residents (R6) obtaining a femur fracture that required extensive surgery to repair the fracture, in a total sample of eight residents.

Findings include:

R6 is an expired resident. R6 was a 76 year old male resident of the facility. R6's diagnoses include: adult failure to thrive, cardiac issues, lung disorders, sepsis, unsteadiness on feet, weakness, altered mental status, heart disease, repeated falls, auditory and visual hallucinations, dementia with behaviors, paranoid schizophrenia, depression, and cognitive communication deficit.

R6's BIMS (Brief Interview of Mental Status) notes that he is alerted and oriented, but has impairments with focusing and understanding questions and thoughts. R6 has disorganized thinking. The behavior is continuously present. R6 is also an extensive one person assist when transferring or ambulating. Fall risk review dated 1/13/2020, 1/14/2020, and 1/24/2020, notes that R6 is high risk for falls. X-ray dated 1/14/2020, notes R6 has acute complete intertrochanteric fracture present with displacement resulting in varus angulation.

Review of R6's progress notes document the following:

On 01/06/2020, it was reported to staff that R6 was observed getting on his knees and laying on the floor intentionally. R6 was assessed from head to toe. No visible injury noted. Resident educated that if he feels sleepy he should lay in his bed.

On 01/07/2020, it was reported to social services by the 2nd floor charge nurse that R6 continues

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to place himself on the floor. Staff spoke to him in regards to his behavior. He stated that he gets tired and he wants to lay down. Staff suggested to R6 to lay in his bed or sit in a chair, not on the floor when he is feeling tired.

On 1/11/2020, it was reported to staff that the resident was observed getting on his knees and laying on the floor intentionally. R6 was assessed from head to toe. No skin breakdown or visual injury noted. Resident was educated that if he feels sleepy, he can lay down on his bed.

On 1/13/2020, staff reported that R6 stated that he fell on the floor while trying to reach his bed. On assessment, no visual injury noted. R6 complained of right knee pain on a 6/10 pain scale. Physician and nurse practitioner notified. X-ordered. At 9:47PM, a CNA (Certified Nursing Assistant) reported to a nurse that R6 was reported to be on his knees when rounds were made. Nurse went to the room immediately and observed the resident on the floor on his knees. Resident was then placed to bed with a two person assist.

On 1/14/2020, R6 x-ray reveals an acute complete intertrochanteric fracture of the right femur. The right leg was immobilized and R6 was transferred to a local hospital.

On 1/24/2020, R6 returned to the facility from a local hospital. Surgical wound noted to right hip with a total of 25 staples which is intact and covered with an abdominal pad.

On 1/25/2020, R6 was seen by V14 (Medical Doctor). Progress note documents that R6 fell on his knees which resulted in a stress fracture of the femoral neck (head of femur bone).

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Nursing management report dated 1/13/2020, notes that R6 does not always ask for assistance and he gets confused. He has poor impulse control.

Care plan dated 07/20/2020, notes if the resident becomes preoccupied by his hallucinations and/or thoughts, simply remind him that he is in a safe and secure environment and staff will protect him. R6 is noted with poor communication and comprehension and has impulsive behavior. In-service staff for frequent monitoring; every two hours and as needed.

On 12/26/2020, at 4:00PM, V9 (Restorative Nurse) stated, R6 was a high fall risk.

On 12/27/2020, at 10:15PM, V10 (Nurse) stated " R6 normally falls. He was a fall risk. I was right at the nurses' station when they called me and told me that he was on the floor. R6 stated that he slipped and fell. He used to be in the wheelchair. During my shift, he was walking to the bathroom. All residents are required to use the call light. Anytime they need assistance, we encourage them to pull the call light. R6 was very delusional. He has a lot of behavioral issues and he had to be continuously redirected."

On 12/28/2020, at 8:38AM, V12 (CNA) stated, R6 is confused. R6 is limited assistance to total care. R6 had a lot of behaviors. R6 had to be watched closely. He needed to be watched closely because he liked to get up and move a lot.

On 12/28/2020, at 8:52AM, V13 (CNA) stated," Sometimes his care was different. He was limited care and he became extensive assistance. R6 required close monitoring. He had times were he

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S9999	Continued From page 5 was paranoid because his eyes would shift and he would question everything we did. At times, he could be redirected, but he had a lot of anger. When he had the anger, he was not redirect able. He was defiant. He needed supervision." On 12/28/2020, at 9:42AM, V14 stated "R6 had dementia. He did not call for assistance and he had a fall. I require my staff to monitor my residents every two to three hours, especially if they have dementia. His fall required surgery to fix the fracture." (B)	S9999		