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
	IL6014377	A. BUILDING: _____ B. WING _____	C 06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN BARR LINCOLNSHIRE	150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069

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S9999	Final Observations Statement of LICENSURE VIOLATION 300.610a) 300.1210b) 300.3240a) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care needs of the resident. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) THESE REGULATIONS WERE NOT MET AS EVIDENCED BY: Based on observation, interview, and record review the facility failed to identify a resident with a history of falls as high risk for falls and failed to implement safety interventions. The facility failed to supervise a resident with a history of falls during toileting. The facility failed to safely transfer a resident who is at risk for falls with a gait belt. The facility failed to ensure a personal safety alarm was in working order. This failure resulted in R1 sustaining C1 and C2 neck fractures and experiencing a decline in activities of daily living. This applies to 3 of 4 residents (R1, R3, R4) reviewed for falls in the sample of 8. The findings include: R1's most recent face sheet shows that R1 was admitted to the facility on December 9, 2015 with a diagnosis of history of falls and left hip and wrist fracture status post fall. R1's undated Interim Care Plan shows R1 is at risk for falls and has interventions to observe for changes in ability to ambulate or loco mote, side rails as ordered, observe residents gait for	S9999		

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steadiness and balance, muscle coordination, and ability to turn and reposition self, keep call lights within reach when in bathroom or restroom, and use of wheelchair for assistive device.

R1's Minimum Data Set (MDS) dated November 28, 2016 shows R1 is cognitively intact, requires extensive assistance of 1 for bed mobility, transfers, walking, locomotion, and toileting, and R1 is not steady when moving from seated to standing position or moving on and off the toilet.

R1's Incident Report for R1's first fall dated June 16, 2016 shows R1 was found by a Certified Nursing Assistant (CNA) on the bathroom floor. R1 told the nurse writing the report "I was on the toilet and got up to wash my hands and my legs gave out." R1's Nurses Note from June 17, 2016 states the call light was not going off when the resident was found.

R1's Fall Risk Assessment dated June 17, 2016 (the day after the first fall) shows R1 is a low risk for falls and the section for recent falls is marked "no."

R1's Care Plan dated June 17, 2016 shows interventions added to risk for falls section of: frequently reorient the resident to surroundings, ensure resident is able to use the call light, and ask the resident every 2 hours if he needs to use the bathroom.

R1's Incident Report for R1's second fall dated November 16, 2016 showed the CNA observed R1 leaning off of his motorized wheelchair. R1 reported he had fallen off his chair while reaching for his heater.

R1's Fall Risk Assessment dated November 16,

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2016 (the day after the second fall) shows R1 is a low risk for falls and the section for recent falls is marked "unknown."

R1's Care Plan dated November 17, 2016 shows interventions of "be sure the residents call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance."

The facility's incident report for R1's third fall dated February 19, 2017 shows on February 19, 2017 R1 was found by the activity aide on his bathroom floor yelling for help. R1 was transferred back to bed and complained of neck pain. The doctor was informed of the fall and an order was obtained to send R1 to the hospital.

R1's Hospital Cervical/Spine Imaging Report dated February 20, 2017 shows an acute fractures of C1 and C2 (neck). R1 was admitted for further evaluation and management.

R1's Final Incident Investigation report for the third fall dated February 24, 2017 shows "based on various staff interviews and clinical record review that were conducted, the resident's fall was related to his leaning forward while he was removing feces out causing him to lose balance and fall. Resident is at risk for falls due to impaired balance, unsteady gait, impulsive behavior, and poor safety awareness.

R1's Nurses Note dated February 22, 2017 shows R1 was readmitted to the facility from the hospital with a cervical collar in place.

R1's MDS dated March 7, 2017 (after the fall with neck fractures) shows R1 requires extensive assistance of 2 staff for bed mobility and

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S9999	Continued From page 4 transfers, walking, and locomotion did not occur. R1's Care Plan dated March 3, 2017 shows R1 "is totally dependent on staff for repositioning and turning in bed, for dressing, requires total assistance to eat, and requires assist of 2 staff for activities of daily living." Prior to this fall, R1 was oriented, required assist of one staff to go to the bathroom and transfer to bed. R1 could stand and pivot with assistance and could propel his wheelchair around the unit. On May 30, 2017 at 2:00 PM, E5 Restorative Nurse stated the section for recent falls on the fall risk assessments done after R1's falls on June 16, 2016 and November 16, 2016 should have been marked "yes" which would have indicated R1 is at high risk for falls and interventions would have been put into place. After the second fall on November 16, 2016, the intervention of a personal alarm should have been added for R1. On May 30, 2017 at 1:40 PM, E2 Director of Nursing stated for residents who have had falls in the bathroom and who do not follow instructions to use call light, staff should remain with the residents while in the bathroom. If privacy is requested the bathroom curtain is pulled and the staff should remain in the resident room. For residents with poor safety awareness staff should have a visual of resident at all times. On May 31, 2017 at 10:00 AM, E8 CNA stated he assisted R1 to the bathroom and R1 asked him to step out for privacy. E8 stated he left the room and answered other residents' call lights. Another staff member, who was walking down the hall, heard R1 yelling out and found R1 on the bathroom floor. E8 stated the call light was not going off. If R1 was going to be fast in the	S9999		

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bathroom I would pull the bathroom curtain and wait in the room with him, if R1 was going to be longer, R1 would tell me to step out. "I'm not sure if he was a fall risk or if there were interventions in place."

On May 30, 2017 at 2:50 PM, E2 Director of Nursing (DON) stated when R1 requested privacy the CNA should have pulled the curtain and stayed in the room. R1 fell after the CNA had left the room.

On May 31, 2017 at 10:17 AM, E7 Licensed Practical Nurse stated before R1's fall on February 19, 2017, R1 was alert and oriented to person, place, and time, was able to take himself in his motorized wheelchair from his room to the dining and activity rooms. R1 needed help of one staff member with bathing, dressing, transferring, using the bathroom, and set up for meals. R1 was a fall risk and should be closely monitored by staff. After R1's fall in February R1 was in a neck brace for his broken neck, was only alert to self and could recognize familiar faces. R1 was bedbound and not able to get up into his wheelchair.

On May 31, 2017 at 12:50 PM, E1 Administrator stated the facility doesn't have a fall prevention policy. Interventions are based on the resident's fall risk assessment and interdisciplinary team meeting.

The facility's Fall Occurrence Policy dated February 20, 2017 shows "It is the policy of the facility to ensure that residents are assessed for risk for falls and interventions are put in place to prevent them from falling. If a resident had fallen, the resident is automatically considered at high risk for falls ...the nurse may immediately start

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S9999	Continued From page 6 interventions to address falls in the unit." 2. R3's Minimum Data Set (MDS) assessment dated May 24, 2017 shows that his cognition is impaired, requires extensive assistance to use the toilet and is not steady with moving on and off of the toilet. Nursing Notes dated June, 15, 2106 show that R3 was found on the floor in the bathroom. R3 stated, "I was trying to wipe myself." A new chair alarm was ordered. On May30, 2017 at 9:30 AM, R3 was in his wheelchair self-propelling himself down the hallway towards his room. The cord to R3's chair clip alarm was wrapped around his wheelchair handle instead of attached to the back of his shirt. R3 stated, "I am headed to the bathroom." When asked if he needed help, R3 stated, "No, I can do it myself." R3 got to his room and E3, Certified Nursing Assistant (CNA) was in the room with R3's roommate. E3 assisted R3 from his wheel chair to the toilet and back without using a gait belt. After R3 was assisted back to his wheelchair, E3 did not attach the resident's clip alarm to his shirt. At 10:30 AM, R3 was in the dining room in his wheelchair and the clip alarm was still wrapped around the handle of the wheel chair. At 12:19 PM, R3 was eating lunch and the clip alarm was still around R3's wheelchair handle. On May 30, 2017 at 12:19 PM, E4 (CNA) said that R3 is at risk for falls. R3 sometimes likes to try and take himself to the bathroom on his own. R3 has a chair clip alarm that should be on at all times. E4 also said that R3 requires extensive assistance of one person for transferring and a gait belt should be used for all transfers for a safe transfer. At 1:48 PM, E2 (Director of Nursing) stated, "gait belts should be used for all resident	S9999		

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transfers for the safety of the resident." E2 also said that wheelchair clip alarms should be on at all times when the resident is up in the wheel chair.

R3's activities of daily living care plan initiated June 16, 2016 shows, "TOILET USE: the resident requires extensive physical assist x 1 from staff." R3's fall care plan dated June 16, 2016 (one day after a fall in the bathroom) shows that he is at low risk for falls and the interventions put in place were, "Floor mats/Floor pads at bedside, PT/OT (Physical Therapy/Occupational Therapy) consult for strength and mobility and anticipate and meet the resident's needs"

3. R4's MDS dated April 7, 2017 shows an admission date of March 31, 2017. R4 is cognitively impaired, requires extensive assistance for transfers and has had one fall since admission.

On May 30, 2017 at 9:30 AM, R4 was in his wheel chair in the dining room. R4's wheel chair sensor alarm cord was not attached to the sensor pad that he was sitting on. At 9:55 AM, E4 put R4 into bed. At 12:40 PM, R4 was sitting in his wheel chair in the dining room again with the sensor cord still unattached.

At 12:45 PM, E4 said that R4 is at high risk for falls and should have a wheel chair sensor alarm on and attached at all times when he is up. At 1:48 PM, E2 said that wheel chair sensor alarms have a box that hangs on the handle of the wheel chair with a cord that comes out the bottom of the box and attaches to the wheel chair sensor pad. That needs to be plugged in for the alarm to work.

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S9999	Continued From page 8 The facility's Gait Belt Policy revised February 20, 2017 shows, "Staff will use a gait belt/transfer belt on residents who need limited to total assistance with transfer or walking." The facility's Fall Occurrence Policy revised February 20, 2017 shows, "If a resident had fallen, the resident is automatically considered as high risk for falls ... .the fall coordinator will add the intervention in the resident's care plan." (A)	S9999		