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
	IL6010367	A. BUILDING: ______ B. WING ______	C 10/26/2017

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CHATEAU NRSG & REHAB CENTER	7050 MADISON STREET WILLOWBROOK, IL 60521

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S9999	Final Observations	S9999		

Statement of Licensure Violation:
1 of 1 violation

300.610a)
300.1210b)
300.1210c)
300.1210d)6)
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

Attachment A
Statement of Licensure Violations

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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.

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.

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 Requirements are not met as evidenced by:

Based on observation, interview, and record

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review the facility failed to ensure fall precaution interventions were implemented for two residents and failed to ensure resident safety while providing care resulting in a resident falling out of bed sustaining a hip fracture.

This failure resulted in a hip fracture requiring hip surgery and hospitalization with blood transfusions.

This applies to 3 of 5 residents (R1, R2, and R3) reviewed for falls in the sample.

The findings include:

1. According to the Admission Face Sheet R1 had diagnoses including dementia, hemiplegia, and cerebral infarction with left side hemiparesis. The Minimum Data Set (MDS) dated July 10, 2017 shows R1's cognition was severely impaired with a Brief Interview for Mental Status (BIMS) scoring four out of ten points and weighed 251 pounds. The MDS shows R1 needed extensive assistance of two staff members for bed mobility and toilet use. The MDS shows R1 was totally dependent on two staff members for transfers. A Fall Risk Assessment dated July 10, 2017 shows R1 was a high fall risk. The care plan showed R1 was at a risk for falls due to a history of cerebral vascular accident causing impaired weakness and muscle strength on the left side. The fall care plan had interventions "encourage resident to use environmental devices such as hand grips, hand rails, etc. Bilateral halos to bed to aide in reposition and promoting bed mobility. Keep bed in lowest position with brakes locked. The care plan also showed R1 had limited ability to move independently in the bed due to left hemiplegia and other comorbidities. An intervention included to provide adaptive equipment as needed to

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assist with bed mobility. The care plans did not address whether R1 needed extensive assistance or the amount of staff members required during care.

According to the Ambulance Run Report dated October 17, 2017 at 5:41AM, the arrival crew found R1 "lying on the ground wailing in agony." R1 was complaining of left hip pain rating it 10 out of 10. R1 had laceration to the back of the head, swelling and tenderness to the left hip and the left leg was shorter than the right leg.

The hospital emergency room report dated October 17, 2017 showed R1 had a hematoma to the right eyebrow, a three centimeter laceration to the right posterior auricle with mild to moderate swelling and ecchymosis to the anterior auricle, and left leg shortened, rotated internally with left hip and thigh tenderness.

A Computerized Tomography report dated October 17, 2017 showed R1 had soft tissue swelling around the right frontal bone and right orbit.

An X-ray dated October 17, 2017 showed R1 had an acute displaced fracture of the proximal left femur, probably an intertrochanteric type.

An orthopedic consultation report from Z6, Medical Doctor (MD) Orthopedic Surgeon, dated October 18, 2017 showed R1 "suffered a fall at the facility "when they dropped me" injuring her left hip. Additionally, she had a scalp laceration as a complication of the fall...(R1) is in an extremely bad mood. She complains of pain and is frustrated in her situation." The impression shows a left hip intertrochanteric fracture with a recommendation for surgical intervention for pain

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control and to facilitate care. Risks and benefits of surgery including but not limited to infection and bleeding.

On October 25, 2017 at 10:10AM, Z7, Registered Nurse (RN) hospital, said R1 was confused and uncooperative most of the time. Z7 said R1 had received two units of blood for the second time since surgery due to R1's hemoglobin level dropping. R1 was lying in bed in the hospital with bruising noted around the entire right periorbital area. R1 said she wasn't doing so well since they dropped her at the nursing home.

On October 23, 2017 at 3:55PM E5, LPN, stated R1 was alert, verbal, and oriented to person and sometimes to place. R1 was able to express and localize pain. E5 said R1 preferred to stay in bed and did not want to get out of bed very often. E5 said R1 had an active pressure wound which required the use of the alternating pressure air mattress, plus R1 was larger requiring a bariatric bed. R1's bariatric bed had a trapeze positioning device above the head of the bed. On both the left and right side near the head of the bed were small round side handrails approximately 12 inches wide. E5 said a resident care card was placed inside the door of the resident's wardrobe closet for the nursing assistants to reference what type of care the resident needed.

R1's resident care card was starred showing R1 needed "cares in pairs". R1 was a total assist of two staff members for transfers with a total body mechanical lift and with bed mobility. The care card also showed R1 needed total assistance for toileting and transfers with a flaccid left side.

On October 25, 2017 at 4:15PM E9, Certified Nursing Assistant (CNA), stated she had taken

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care of R1 on October 17, 2017 when R1 slid out of bed. E9 said she had worked at the facility for 14 months but usually worked another unit. At the beginning of the shift, E9 received a "walk through" with the nurse who gives instructions about the residents. E9 said the nurse had mentioned to watch R1's roommate because she would get out of bed, but there was no mention of the care R1 had required. E9 said she had taken care of R1 without assistance of any other staff, without any problems, several months earlier when R1 was on another unit. E9 said she had done R1's incontinence care by herself a couple of times during the shift. Between 5:00 and 5:30AM E9 was standing on the right side of R1's bed with R1 positioned on her left side and was almost done providing R1's incontinence care by herself when R1 started wiggling in bed. E9 said she held onto R1's gown as R1 fell out of left side of the bed onto the floor. E9 said the air mattresses are slippery so R1 fell out of bed and the bed sheet went with. E9 ran out of the room to get a nurse. When asked how the CNAs received information about resident care, E9 said the residents had a care card on the inside of the door of their wardrobe closet. E9 said R1 did not have side rails on the bed because the facility had been side rail free.

On October 24, 2017 at 11:30AM E8, Licensed Practical Nurse (LPN), said it was the first time she had worked with E9 (CNA) on October 17, 2017 night shift. E8 said she told E9 to check the resident care cards to see what type of care they needed. E8 said sometime before 6:00AM E9 came running to the nurse's station saying R1 had fallen out of bed. E8 said R1 was a two person assist for incontinence care but E9 told (E8) she had been doing incontinence care by herself. Upon arriving in the room, E8 saw R1

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lying next to the left side of the bed on the floor trying to hold onto the dresser. R1 was on the floor with her bedsheets. E8 said R1 had blood coming from the right side of head but couldn't tell where it was coming from. R1 was screaming in pain "Pain! Left side. Left leg." E8 said she assessed R1 but R1 refused to do range of motion with her legs. E8 called 911 to take R1 to the hospital emergency room. E8 said R1 was not difficult to change when two people are assisting her and R1 can try to help with the over the bed trapeze bar.

On October 24, 2017 at 4:08PM E10, CNA, said on October 17, 2017 R1 was lying on the floor next to the left side of the bed and crying that her leg was hurting. E10 thought it took 4 people including the paramedics to get her off the floor. E10 said he had never seen R1 try to get out of bed by herself and had not seen her use the over the bed trapeze bar to assist with mobility. E10 said R1 needed two staff members to assist her with care.

The bariatric alternating pressure mattress user's instruction manual shows the mattress is 78.7 inches in length and includes "It is recommended to use this mattress system with a bedframe with adequate side rails to prevent falling." The user's manual shows the mattress is 78.7 inches in length. A quarter side rail would be 19.6 inches in length. This is significantly more than the approximately 12 inch round side handrails in place on R1's bed.

On October 26, 2017 at 8:20AM when asked what adequate side rails were, Z5, Drive Devilbiss Healthcare Technical Support, said quarter, half, full, and mid side rails could all be used but a minimum of a quarter side rail was recommended

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for use with the mattress to help prevent a resident from falling out of bed. Z5 said the side rail should also be high enough to clear the mattress plus the resident when lying in the bed.

2. According to the Admission Face Sheet, R3 had diagnoses including gastrointestinal hemorrhage, anxiety and hypertension. The MDS dated August 4, 2017 showed R3 was cognitively intact with a BIMS of 14 out of 15 points. The MDS shows R3 needed extensive assistance of one staff member for bed mobility, transfers and toilet use. Fall Risk Assessments dated October 23, 2017 and October 3, 2017 show R3 was a high fall risk. The Fall Risk Assessment dated October 23, 2017 showed R3 had three or more falls in the last three months including falls on October 21 and October 22, 2017. The care plan shows R3 was at risk for falls due to impaired mobility and lack of endurance. Interventions included to place R3 in high back wheelchair in a supervised area when having signs of increased agitation, keep bed in lowest position, to allow legs to touch the floor, provide proper, well maintained footwear, non-skid socks or slippers, left side floor mat, and bed up against the wall per family request. The care plan shows R3 had limited ability to move independently in bed due to decreased mobility and weakness related to abdominal cancer. The care plan did not address R3's mobility or transfer.

The Electronic Health Record (EHR) showed R3 had the following falls:
September 18, 2017 a fall between the bed and the wall;
September 18, 2017 a fall next to the bed;
September 27, 2017 a fall, R3 slid off the left side of the bed;
September 30, 2017 a fall near the foot of the

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bed;
October 2, 2017 a fall at the bedside;
October 21, 2017 a fall next to the bed; and
October 22, 2017 R3 slid out of the highback wheelchair.

On October 23, 2017 at 11:42AM R3 was awake, reclined in the highback wheelchair near the nurse's station. E6, LPN Restorative Nurse, stated R3 was alert and oriented to person with confusion. R3 said she needs to be watched for fall precautions.

On October 23, 2017 at 1:12PM R3 was sitting in the highback wheelchair and kept leaning forward. Z4, R3's family member, placed her hand on R3's left shoulder to hold (R3) back and said "Hey, don't do that, you'll fall." Z4 said R3 has had multiple falls while in the facility and would like to know what the facility was going to do about it. Z4 said R3's bed was not always in the lowest position and they gave R3 a scoop mattress but didn't feel it would keep R3 from falling out of bed. Z4 said she has often come into the room and the floor mat was not on the floor in the room. Z4 said when R3 was admitted in July 2017 R3 was able to get up to use the bedside commode but was no longer able to stand up.

On October 23, 2017 at 1:32PM E14, RN-Wound Care Nurse, and E6 (LPN Restorative Nurse), transferred R3 from the highback wheelchair to the bed using a total body mechanical lift for incontinence care. After incontinence care, E14 and E6 positioned R3 supine in bed with the head of the bed elevated 30 degrees. Both E14 and E6 left the room without lowering the bed to the low position or placing the fall mat on the floor. The fall mat was leaning against the wall near the

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window.

On October 23, 2017 at 3:15PM R3 was awake, lying in bed in a mid to high position with top of mattress approximately 30 inches from the floor. No floor mat was on the floor. E15, RN, stated R3's bed should be in the low position and a floor mat should be on the floor. The care card shows R3 should use a non-skid mat on the wheelchair seat which E6 (LPN) had written in earlier after care.

R3's resident care card provided by the facility includes "cares in pairs", left side floor mat, total body mechanical lift with two staff members, non-skid mat to wheelchair seat, bed bolsters, and bedside commode.

On October 24, 2017 at 10:30AM R3 was reclined in a highback wheelchair with regular white crew socks on.

On October 24, 2017 at 3:15PM R3 was awake in bed kicking her socks off her feet. R3's bed was not in the lowest position.

3. According to the Admission Face Sheet R2 had diagnoses including dementia with behavior, osteoarthritis and muscle weakness. The MDS dated July 27, 2017 shows R2's cognition was severely impaired with a three out of fifteen points on the BIMS. The MDS shows R3 needed extensive assistance for bed mobility, toilet use, and transfers with two staff members. Fall Risk Assessments dated July 26, 2017 and October 19, 2017 show R2 was a high fall risk. The EHR showed R2 had a fall on October 17, 2017. A care plan shows R2 was at risk for falling related to a diagnosis of dementia with poor safety awareness. Interventions included non-skid

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socks or shoes on while up in wheelchair or in bed, fall mat to the right side of the bed, low bed keep in lowest position.

On October 23, 2017 at 11:15AM R2 was asleep lying in bed with her upper body leaning to the left side near the edge of the bed.

On October 23, 2017 at 2:52PM R2 was awake in low bed with the head of the bed slightly elevated and was lying diagonal across the bed with her head to the left side of the bed and her feet at the right corner. R2 was lifting her legs onto the wheelchair which was positioned next to her bed. The waistband of R2's pants were pulled around her mid thighs and R2 had regular white crew socks on. E13, CNA, said when she came on shift at 2:30PM she noticed R2's pants were around her thighs but did not adjust them. E13 said the previous shift must have left them that way after providing incontinence care after lunch. E13 said R2's behavior frequently will be lifting her legs together in unison almost coming to a sitting position and will continue rocking like that causing her to scoot down in bed. E13 did not think R2 had any falls but said we keep an eye on her because of the rocking motion and scooting down in bed. After providing incontinence care E13 left R2's bed in a mid high position with the top of the mattress approximately 30 inches from the floor and placed the wheelchair on the floor mat against the bed. E13 stated R2 was a fall risk and thought the bed should be in the lowest position, but was told by management the bed should not be in the lowest position but left higher so the resident could get out of bed.

On October 24, 2017 at 10:50AM R2 was awake lying in bed lifting her legs up and down in unison. R2's pants waistband was around her mid thighs

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S9999	Continued From page 11 and she had regular white crew socks on. At 11:05AM E16, RN MDS Coordinator, did not know why R2's pant waistband was left around her thighs. E16 pulled R2's pants up and repositioned R2 in bed. E16 left the room but did not return the bed to the lowest position after providing care. On October 23, 2017 at 4:00PM E2, Director of Nursing (DON), said any fall precaution interventions are resident specific and would be reflected in the resident care plan and on the resident care cards. (A)	S9999		