STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002026	A. BUILDING: _____ B. WING _____	C 05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY CARE CENTER	4314 SOUTH WABASH AVENUE CHICAGO, IL 60653

(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 Complaint Investigation 1880469/IL99720 1880922/IL100220 Statement of Licensure Violations	S 000		
S9999	Final Observations 300.1210b) 300.1210d)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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

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 record and interview the facility failed to immediately assess a resident for injury after a fall which delayed in the treatment for a major fracture. This applies to one of three residents (R3) reviewed for fall, in a sample 22. As a result R3 was left in severe pain over a long period of time before he was sent out for evaluation at the local hospital. R3 was diagnosed with a intertrochanteric fracture of the proximal right femur and hip, that required surgery to repair.

Findings include:

R3 is a 63 year old admitted to the facility 2/25/14. R3 has a diagnosis including Senile Dementia without behavioral disturbance and Schizophrenia disorder which affects his cognition, short term and long term memory. R3 is non verbal and not able to make his needs known.

Facility fall investigation report dated 11/21/17 7:46 AM read: in room 223-4. Resident was noted with rt (right) upper extremity(thigh) warm to the touch skin , swelling , shortness noted to rt lower extremity, upon assessment resident noted with facial grimacing when area touched. Facility's X Ray of right femur noted impacted intertrochanteric fracture of the proximal right femur with some varus deformity. R3 was sent to the hospital for evaluation and treatment. R3 required surgery to treat the fracture. R3 did not return to the facility. This was considered an

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S9999	Continued From page 2	S9999		

unwitnessed fall. The report implies R3 had crawled back into his bed after he fell.

Also according to facility report the CNA who discovered the injury , was informed by another CNA that R3 was a total care and needs to be fed as well going to assist him with feeding. R3 was in his bed and when the CNA pulled the sheets back is when she discovered the injury. This report further states that when the investigation was completed it was noted that the previous 11-7AM nurse(V12) and CNA(V11) failed to do a proper appropriate head to toe assessment of the resident on that particular day of 11/21/17. They did not notice the resident was injured. Both the nurse and CNA received disciplinary actions which included 3 day suspension with write-up final warning.

V2 (Director Of Nursing) 5/17/18 10AM per phone stated V11(CNA) and V12(Nurse) were reprimanded for failing to to properly assess R3 on their shift(11PM -7AM) to detect a fracture to R3's right hip. They were given a three day suspension .V12 resigned at this time.

Hospital record dated 11/21/17 states R3 was diagnosed with a right hip fracture-unwitnessed fall-confirmed on X-ray. R3 required surgery to place right hip nail.

On 5-16-18 2:30pm, V1, Administrator reported the investigation completed by the facility revealed R3 injury was due to a fall from his bed. The surveyor asked how did R3 get back to bed and V1 was unable to explain how the resident got back to bed.

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S9999	Continued From page 3 On 5-21-2018 at 12:38pm, V15 (attending physician) reported, the type of fracture R3 is caused by a fall 99% of the time. R3 could have fell due to a seizure or he forgot he couldn't walk and tried to get up. It is unlikely that the resident with a fracture could get himself back to bed. As far as pain, this fracture is very painful. It could have been nine on a scale of one to ten. V15 stated, R3 had dementia (frontal temporal lobe) and was non-verbal. R3 could not verbalize he was in pain. No one could have moved him without him having some reaction to the pain. (B)	S9999		