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FAIRMONT CARE	5061 NORTH PULASKI ROAD CHICAGO, IL 60630

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S 000	Initial Comments Complaint Investigation: 2185205/IL136282 Facility Reported Incident of June 23, 2021/IL135509	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 300.610a) 300.1210b) 300.1210d)2) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. 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: 2) All treatments and procedures shall be administered as ordered by the physician. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These regulations are not met as evidenced by: Based on record review and interview, the facility failed to follow physician orders for stat ER (Emergency Room) comprehensive exam and head CT (Computed Tomography) post fall to rule out intracranial hemorrhage, failed to call 911 for stat transfer, failed to ensure that accurate information was provided to EMS (Emergency Medical Services) and Physician, failed to document accurate neurological assessments, failed to conduct neurological assessments as directed, and failed to provide timely care/services to one of seven residents (R1)	S9999		

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reviewed for falls. On 6/23/21, R1 fell, sustained a large subdural hematoma and hemorrhagic brain contusions. R1 expired on 6/24/21.

Findings include:

R1's (6/23/21) progress notes state around 10:30pm, CNA (Certified Nursing Assistant) noted resident's door opening and immediately went to assist resident. The resident lost her balance and attempted to grab onto the door handle however was unable to maintain her balance and fell to the floor. CNA was unable to reach the resident to assist her to the floor however witnessed resident falling to the floor and hitting her head. Neuro check initiated and noted WNL (Within Normal Limits). No change in LOC (Level of Consciousness). Vital signs assessed and noted as follows: BP (Blood Pressure) 124/75, HR (Heart Rate) 64, Respirations 18, SpO2 97%, Temp (Temperature) 97.7. Notified Telepage MD (Medical Doctor), order received to send the resident to (Hospital) for evaluation. Resident left facility around 11:15pm by ambulance.

R1's (6/23/21) Telemedicine Consultation Note includes; Subjective: Patient had a witnessed fall. Patient did hit their head. Patient is confused at baseline but concerned for increased confusion. Patient demented and increased confusion noted. Objective: (Nurse Assisted Exam) Vitals reviewed, stable. BP 149/75, Pulse 64, RR (Respiratory Rate) 19, SpO2 97% on room air [However aforementioned vital signs were documented at 8:36pm - prior to falling]. Fall Assessment/Plan: Witnessed fall, elderly patient with increased confusion. Patient requires stat ER (Emergency Room) comprehensive exam and head CT scan to rule out intracranial hemorrhage. Advised staff to prepare for ER

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S9999	Continued From page 3 transfer. On 8/5/21 at 11:02am, surveyor inquired about R1's (6/23/21) fall V7 (Licensed Practical Nurse) stated "She fell and hit her head." Surveyor inquired who was notified of R1's fall V7 responded "First I called the family they are not answering, then I called the doctor (within 5 minutes after assessing R1) and he said send her out." Surveyor inquired which transport service was requested BLS (Basic Life Support) or ALS (Advanced Life Support) V7 stated "I called the ambulance services (1-800 number). I asked them that I need a stretcher of course because she is not gonna be stable in the wheelchair. I called the direct number of the ambulance and told them I have to send out a patient to the hospital so I need an ambulance." Surveyor inquired why 911 was not called for emergency transport due to fall with potential head injury V7 responded "Because she was stable, the doctor just told me to call the ambulance ["Stat" ER exam and head CT were ordered by the physician, and the physician "advised staff to prepare for ER transfer"], I didn't see any changes in her so far." ["Increased confusion noted" was documented by the physician during "Nurse assisted exam"]. On 8/5/21 at 2:43pm, surveyor inquired about R1's (6/23/21) fall V8 (Certified Nursing Assistant) stated "I wanted to check and make sure that she's in bed but before I could get to her she was out of bed and she fell. I went to check to see if she was alright and then she wasn't responding so I went to get the Nurse. She was breathing but she just wasn't responding. She just kept like saying uh uh real lightly. I was with the Nurse and (V10/Activity Aide) we carried her to the bed. I was trying to tell this lady (R1) that she's going	S9999		

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to the hospital and she wasn't responding at all. She was breathing and her eyes were a little bit open but she just had no response."

On 8/9/21 at 10:39am, surveyor inquired about R1's (6/23/21) fall V10 (Activity Aide) stated "I saw a lady was lying down on the floor. When we moved her to the bed she was lying there saying aiya aiya not too loud" and affirmed she was unable to move without assistance.

The (undated) change in resident's condition or status policy states prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider.

R1's (6/23/21) Ambulance Run Report includes; Call Type: BLS (Basic Life Support) dispatch notify: 11:26pm (approximately 1 hours after fall). At patient: 11:43pm. In summary; was dispatched to (facility name) for an 80 y/o male [R1 was an 85 y/o female] that fell out of bed [R1 did not fall out of bed]. Being transported to hospital ER. Crew met with patient nurse to gather paperwork and information on what happen to patient. Patient nurse was little confused on what actually happen [R1's fall was witnessed by staff]. Patient is unresponsive. Patient is alert and oriented x0. Patient only withdraw from sensation. Blood Pressure 220/110, pulse 100 (weak), respiratory 20 normal, 96% on room air. Transport 11:55pm [not 11:15pm as stated in the progress notes]. At destination: 12:04am [1.5 hours after fall].

On 8/5/21 at 1:16pm, surveyor inquired if a resident falls and hits their head what's an appropriate plan of care V9 (Physician) stated "The expectation would be to evaluate the

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S9999	Continued From page 5 patient, have telemedicine evaluate the patient, and monitor any change in behavior." Surveyor inquired about potential harm to a resident that falls and hits their head V9 responded "It may be nothing or it could be bleed. That's the reason you do the neuro checks and assess the patient. The neuro checks have to be done." The neurological assessment policy (revised 10/2010) states neurological assessments are indicated: following a fall or other accident/injury involving head trauma; or when indicated by resident's condition. When assessing neurological status, always include frequent vital signs. Particular attention should be paid to widening pulse pressure (difference between systolic and diastolic pressures). This may be indicative of increasing intracranial pressure. Any change in vital signs should be reported to the physician immediately. Notify the physician of any change in a resident's neurological status. R1's (6/23/21) neurological assessments were conducted at 10:30pm, 10:45pm, 11:00pm and include the following documentation; level of consciousness "5" (indicating resident was oriented) however Physician documentation affirms she was "demented" with "increased confusion noted." Stimulus response "5" (indicating resident responds to commands) and motor ability "2" (indicating all extremities were strong) however V8 affirmed she "wasn't responding at all." Pupils size "3" (indicating pupils are equal) and pupils reaction "2" (indicating brisk response), however R1's ER pupil assessment (see below) is also incongruent with this assessment. The Neurological flow sheet includes the following instructions; vital signs every 15 minutes	S9999		

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S9999	Continued From page 6 (x 4), 30 minutes (x 4). On 8/9/21 at 12:34pm, surveyor inquired about the neurological assessment protocol V2 (Director of Nursing) replied "Were doing it every 15 minutes times 4. Then 30 minutes times 4." V2 reviewed R1's (6/23/21) neurological flow sheet and affirmed 10:30, 10:45, and 11:00pm assessments were documented [EMS arrived "at patient 11:43pm" therefore an additional assessment was required at 11:15pm]. Surveyor inquired what the number 5 indicates under level of consciousness V2 responded "The 5 means the patient is conscious and oriented." [The Physician documented "Patient demented and increased confusion noted" therefore incongruent with V7's assessment]. Surveyor inquired what the number 5 indicates under stimulus response V2 replied "Patient was responsive I would say" [V8 affirmed "She wasn't responding at all"]. R1's (6/24/21) history & physical states she unfortunately comes in after an unwitnessed fall at the nursing home and found in the ER to be non-responsive to verbal, tactile and deep pain stimuli. Eye Exam: doll's eyes in ER and on arrival. Non-reactive pupils bilateral. Family is unable to give any additional details to the fall, and Nursing Home did not witness. On head CT there was massive bleeding found on right side with mass effect and midline shift to the left. She required intubation in the ER. Clinical signs of non-reactive pupils, doll's eyes, spontaneous muscle spasm, inability to draw breath without a vent, and non-responsive to all stimuli all support likely brain death. Unclear what caused the fall, what she may have struck or where exactly the fall occurred. The (undated) emergency transfer policy states should it become necessary to make an	S9999		

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emergency transfer to a hospital or other related institution, our facility will implement the following procedures: notify the receiving facility that the transfer is being made. Assist in obtaining transportation. [There is no documentation that the hospital received report on R1's 6/23/21 status and they were unaware her fall was witnessed].

R1's (6/24/21) head CT affirms there is a large subdural hematoma overlying the entire right cerebral hemisphere, measuring 2.5cm in thickness. There is significant mass effect upon underlying brain with severe right to left midline shift. There is also a smaller subdural hematoma overlying the left frontal lobe measuring 7mm in thickness. There are hemorrhagic brain contusions in both frontal lobes and anteriorly in both temporal lobes with blood in the cortical sulci.

R1's (6/24/21) certificate of death states death includes; Cause of death: subdural hematoma, fall. Manner of death: accident.

The fall occurrence prevention policy (revised 5/31/17) states if there are signs of life threatening injury call 911 and let the paramedics transport resident to the emergency room. The director of nursing will investigate all unusual occurrences and necessary intervention will be implemented immediately.

On (8/5/21) at approximately 3:45pm, surveyor relayed concerns to V1 (Administrator) and V2 that V7's documentation and (8/5/21) interview concerning R1's (6/23/21) assessments were incongruent with hospital records and V8's interview. Also, 911 was not called due to head trauma and significant change in condition. V1

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S9999	Continued From page 8 and V2 affirmed an investigation was conducted however they were unaware of said findings. (AA) 2 of 2 300.610a) 300.1210a) 300.1210b) 300.1210d)3)5) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that	S9999		

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S9999	Continued From page 9 includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. 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. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who	S9999		

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S9999	Continued From page 10 enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These regulations are not met as evidenced by: Based on record review and interview, the facility failed to conduct skin assessments as ordered, failed to identify skin integrity impairments, and failed to obtain treatment orders (before necrosis occurred) for one of four residents (R2) reviewed for pressure ulcers. These failures resulted in R2 sustaining multiple DTPI (Deep Tissue Pressure Injuries) with necrotic/eschar tissue and gangrene of her right great toe identified at a doctor's appointment on 12/10/20. Findings include: R2 was re-admitted to the facility (11/16/20) with diagnoses which include but not limited to; type II diabetes mellitus, encephalopathy, peripheral vascular disease, and pressure induced deep tissue damage of unspecified site. R2's (11/16/20) Physician Order Sheets include; skin check daily and PRN (as needed).	S9999		

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S9999	Continued From page 11 R2's (11/18/20) ADL (Activities of Daily Living) care plan states; report signs/symptoms of skin breakdown to MD (Medical Doctor). Check resident every 2 hours and change as needed. R2's wound history includes the following (facility acquired) wounds (identified) on said dates; (11/30/20) right heel DTPI (Deep Tissue Pressure Injury) 3.0 x 6.0 x 0.0cm (centimeters) with 100% necrotic/eschar tissue. (12/10/20) Right heel extending right lateral foot DTPI, 9.5 x 4.5 x 0.0cm with necrotic/eschar tissue. (12/10/20) Right lateral foot DTPI, 3.0 x 2.2 x 0.0cm with necrotic/eschar tissue. (12/10/20) Right medial great toe arterial wound, 1.3 x 1.4 x 0.0cm with necrotic/eschar tissue. (12/10/20) Left heel DTPI, 5.5 x 10.0 x 0.0cm with necrotic/eschar tissue. (12/10/20) Left gluteal crease extended to left buttock pressure wound (stage 2) 5.0 x 5.5 x 0.2cm. R2's (12/10/20) progress notes state; spoke with daughter in regards to the acquired wounds of the resident (discovered by the daughter during the resident's appointment at the hospital, as she was with her mother at that time). Writer was notified that new skin alterations were discovered upon arrival at the physician's appointment. On 8/16/21 at 9:38am, surveyor inquired about R2's (12/10/20) wounds. V2 (Director of Nursing) stated "When they were at the doctor appointment, that's when they (Daughter/Physician) noticed the wounds. When they returned, the wound care assessed the patient." Surveyor inquired why the facility was unaware of R2's wounds (most of which were necrotic) V2 responded "I guess the morning she was going to the appointment, she had her heel protectors on and the CNA (Certified Nursing	S9999		

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S9999	Continued From page 12 Assistant) sent her out without noticing it before she left (R2 also had a wound on her gluteal crease/left buttock, and her 11/23/20 care plan affirms she was "totally incontinent" of bowel and bladder). Surveyor inquired how long it takes for necrosis/eschar to develop V2 replied "This can take days before it happens." R2's (12/10/20) vascular surgeon consult includes history of present illness: she is currently at nursing home and developed bilateral heel pressure sores. She also has right 1st toe open wound [Right great toe dry gangrene]. On 8/16/21 at 2:01pm, surveyor inquired about the protocol for skin integrity impairments V19 (Wound Care Coordinator) stated "If they notice something, they would notify the floor nurse or would notify wound care." Surveyor inquired how a wound develops gangrene V19 responded "Gangrene usually forms from necrotic tissue over time." On 8/16/21 at 3:40pm, surveyor inquired about potential harm to a patient if wounds are not identified and/or reported immediately to the physician V18 (Wound Physician) stated "It depends on the wound really. If they are infected then there is a problem but if they are stable there's not." Surveyor inquired how long it took for R2's tissue to become necrotic V18 responded "Probably was going on for at least 1 day or so because the necrosis does not develop so fast, for necrotic tissue it takes at least 24 hours." The (undated) pressure ulcer prevention policy states any new ulcer or significant changes must be reported to the skin care coordinator, physician and family. Comprehensive	S9999		

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FAIRMONT CARE	5061 NORTH PULASKI ROAD CHICAGO, IL 60630

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S9999	Continued From page 13 assessment is required. The skin care coordinator or designee will inform the physician of the assessment and treatment option. The physician may recommend treatment if needed. (B)	S9999		