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
	IL6007918	A. BUILDING: ______ B. WING ______	C 02/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF RICHTON PARK REHAB & NS(	22660 SOUTH CICERO AVENUE RICHTON PARK, IL 60471

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S 000	Initial Comments Complaint investigations: 2190105/IL129988 20910098/IL129865 2190224/IL130116 20910053/IL129818 2190758/IL130707	S 000		
S9999	Final Observations Statement of Licensure Violations: 1of 2 300.610a) 300.1210b) 300.1210d)3) 300.1210d)6) 300.1220b)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.	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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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.
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.
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 300.1220 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

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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.

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 requirements were not met evidenced by:

Based on interviews, and record reviews, this facility failed to ensure that wheel locks on a residents bed were engaged in the locked position, and working properly to prevent an avoidable fall for one of three residents (R2) reviewed for safety and falls.
The failure resulted in R2 attempting to transfer from a wheelchair to the bed, the bed began to roll R2 fell to the floor and sustained a right femur fracture that required surgical intervention. The facility neglected to assess a resident found on the floor, next to the bed after an avoidable fall incident. The facility also neglected the resident by walking around the resident leaving the morning medication at the bedside, and documented in the nursing notes that the resident was sleeping on the floor. This affected one of four (R2) residents reviewed for neglect. These neglectful actions resulted in R2 being left on the floor for over 2 hours until morning staff found R2

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on the floor. R2 told staff that R2 had fallen the night before attempting transfer to the bed from the wheelchair. R2 was assessed at the hospital and diagnosed with a displaced comminuted fracture of the right femur from the fall that required surgical intervention. Also, facility failed to ensure the safety and well-being of a resident, and prevent the physical assault of a resident to resident attack for one of four (R4) residents reviewed for physical abuse. This failure resulted in R4 being hit in the left eye by another resident's closed fist without provocation. R4 sustained bruising and swelling to left eye.

Findings include:

Review of the medical record notes R2 with diagnoses including: paraplegia, displaced comminuted fracture of right femur, high blood pressure, diabetes, major depressive disorder, high cholesterol, insomnia, chronic pain syndrome, anxiety disorder, and neuromuscular dysfunction of bladder.

On 10/7/2020 at 8:54am, V5 RN (registered nurse) noted R2 is alert, and oriented times four. R2 was observed on the floor in R2's room, R2 was alert and responsive. R2 was assessed for signs of fractures, altered level of consciousness and neurological alterations, no changes/impairments observed. Head to toe assessment completed. R2 within R2's baseline function. No signs/symptoms of distress. R2 denies any pain at this time. No grimace noted. R2 was transferred to bed with staff assistance. R2 reports that R2 fell trying to get in bed, upon skin assessment bruising noted to upper back, upper arm, and upper body (front). Vital signs: blood pressure 90/60, pulse 114 beats/minute, respirations 16, temperature 97.2 degrees

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S9999	Continued From page 4 Fahrenheit, oxygen saturation level 98% on room air. R2's physician notified, orders received for X-ray of left arm and lumbar-sacral spine, orders noted, family member contacted but unsuccessful. Staff will continue to monitor. R2's incident report, dated 10/7/2020, was reviewed. V31's LPN (licensed practical nurse) statement notes V31 went into R2's room at 6:00am to give R2 medications and R2 was laying on the floor with pillow behind head. V31 noted R2 gets in and out of wheelchair by himself. V31 thought R2 got down on floor by himself. V31 left R2's medication and left R2's room. V31 noted V31 did not do a fall assessment. V32's TNA (temporary nurse aide) statement notes V32 did not know V32 had to round on residents every two hours. V32 did not check on R2 until 5:00am when V32 observed R2 on the floor. V32 did not assist R2 back to bed. V33's TNA statement notes V33 rounded on residents at 5:00am when V33 was assisting residents. V33 did not round on R2. V34's CNA (certified nurse aide) statement notes when V33 came in at 6:30am, V31 LPN informed V34 that R2 was on the ground sleeping. R2's statement notes R2 slipped out of wheelchair to the floor. R2 did not see any staff until 6:00am. V31 LPN left medications. V31 asked if R2 was okay and left R2's room. R2 notes R2 slipped onto buttocks and sustained scratch due to hitting wheelchair. R2 leaned up and grabbed pillow and sheets off bed and stayed on the floor. On 1/8/2021 at 2:45pm, R2 stated that on 10/7/2020 at 11:00pm, R2 fell while attempting to self-transfer from R2's wheelchair to bed. R2 stated that the CNA (Certified Nurse Aide) unlocked R2's bed brakes while changing bed linen and forgot to activate the bed brakes when	S9999		

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done causing R2 to fall later that day. R2 stated that staff did not round on R2 during the night. R2 stated that R2 laid on the floor until the day shift staff found R2 between 8:30am and 9:00am the following morning.

On 1/12/2021 at 4:30pm, V5 RN (registered nurse) stated that V5 received report on 10/7/2020 from the off-going nurse, but was not informed of R2's fall during the night. V5 stated that while V5 was rounding on assigned residents, V5 found on R2 on floor. V5 stated that R2 is alert, and oriented times three. V5 stated that when R2 fell, R2 was unable to reach the call light cord. V5 stated that R2's call light cord was at the head of the bed and R2 was on the floor at the foot of the bed. V5 stated that R2 informed V5 that R2 fell during the night. V5 stated that R2 is paraplegic and has decreased sensation to lower body; did not complain of right leg pain.

V31, V32, and V33 were unavailable for interview during this survey.

Review of R2's MDS (minimum data set), dated 11/11/2020, notes R2's BIMS (brief interview of mental status) score is 14 out of 15.

R2's falls risk review, dated 10/19/2020, notes R2 is at high risk for falls.

Review of R2's incident report, dated 10/16/2020, notes R2 was transported to the hospital due to change in condition. Facility received a call from hospital stating R2 has a fractured right femur. This facility determined fracture due to fall on 10/6/2020. R2 returned to this facility after surgical intervention to repair right femur fracture.

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Review of R2's falls care plan, initiated 2/8/2020, notes R2 is at risk for falls related to paraplegia, decreased strength and endurance. Interventions identified include: R2 educated on the importance of using call light for assistance, be sure call light is within reach, staff to respond promptly to all requests for assistance, and anticipate and meet the needs of R2

b. R4:
On 1/12/2021 at 3:15pm, V3 (social services) stated that V3 knows R5 from R5's prior facility. V3 stated that R5's behaviors can be stable one minute and then change quickly; R5 reacts to internal and external stimuli. V3 stated that on 12/18/20, R5 informed V3 that R5 does not remember the event of running through the halls on the nursing unit and hitting another resident; only remembers what staff told him.

On 1/12/2021 at 4:45pm, V6 LPN (licensed practical nurse) stated that R4 is an older Spanish speaking only resident with dementia. V6 stated that R4 was very confused at times, needed constant re-direction.

On 1/14/2021 at 3:05pm, V12 CNA (certified nurse aide) stated that V12 gave R4 a sponge bath with another CNA; did not observe any alterations in skin integrity, bruising. V12 stated that V12 was off couple of days and when V12 returned to work, the nurse pointed it out to her that R4 had a black eye. V12 stated that V12 is unsure of the date, but incident occurred before Christmas.

Per staffing sheets, V12 CNA worked 12/18 and then 12/21. V12 was not scheduled to work on 12/19 and 12/20.

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Review of the medical record notes R4 was admitted to this facility on 12/11/2020 with diagnoses including: metabolic encephalopathy, hepatic failure, alcoholic cirrhosis of liver, dementia with behavioral disturbance, chronic obstructive pulmonary disease, dysphagia, weakness, multiple sclerosis, disorder of adrenal gland, anemia, vitamin D deficiency, major depressive disorder, anxiety disorder, and history of falling.

Review of R4's medical record, dated 12/26/2020, V15 LPN, noted upon rounds V15 noticed a bruise around the R4's left eye. R4 was assessed and no other open areas were noted on the R4's body. R4 denies any pain or discomfort. Vital signs are stable and R4 is functioning at his baseline.

Review of R4's care plan, dated 12/26/2020, notes R4's history reveals a previous suspected abuse and/or neglect or factors that may increase susceptibility to abuse/neglect. R4 demonstrates observable signs of distress. Nursing noted discoloration of R4's eye. Goal: R4 will be treated with respect and dignity and will reside in the facility free from mistreatment. Interventions identified include: R4's physician notified with orders for hospital evaluation, R4 encouraged to notify staff, observe R4 for signs of fear and insecurity during delivery of care, and take steps to calm R4 and help R4 feel safe.

Review of R4's police report, dated 12/26/2020 at 1:33pm, notes R4's family contacted the local police department alleging R4 was assaulted at this facility. The police officer noted R4 was observed with bruising to left eye with swelling. The police officer attempted to speak with several nurses regarding this incident and ended with

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negative results. The nurses and other staff involved in this incident were not at this facility at this time. EMS (emergency medical services) were called to this facility to evaluate R4. A second police officer, bilingual in English/Spanish spoke with R4 in R4's primary language, Spanish. R4 reported that R4 was struck in the eye by another resident. R4 reported that R4 was hit with a fist. R4 reported that the back of head, left eye, and left ear hurt. EMS determined R4 should be transported to the hospital for further evaluation. While R4 was walking with paramedic and police officer to the elevator, R4 pointed to R5 and reported that R5 is the person that hit R4. A third responding police officer noted V15 LPN reported that 4-5 days ago, R4 was battered by R5 in the hallway on the fourth floor nursing unit just outside R4's room. V15 reported that V15 believes R5 was having a panic attack due to R5 seeming distressed and pacing back and forth in the hall. V15 advised the police officer that R5 was walking past R4's room when R4 stepped into the hall at which point R5 struck R4 in R4's left eye with a closed fist causing bruising around the struck area. V15 stated that R4 and R5 were separated.

Review of this facility's accident incident reporting policy, dated 08/2017, notes if a resident is involved in an accident/incident an immediate assessment of the resident is completed. The nurse is to notify the attending physician/nurse practitioner and resident's family.

(A)

2of 2

300.610a)
300.1210b)

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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.

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Section 300.3240 Abuse and Neglect

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resident. (Section 2-107 of the Act)

These requirements were not met evidenced by:

Based on interviews, and record reviews, this facility failed to provide effective basic life support/cardiopulmonary resuscitation for one resident (R1) who required resuscitative care. R1 was found to be non-responsive without a pulse and was only receiving ventilations via tracheostomy when EMS (emergency medical services) arrived.

Findings include:

On 1/14/2021, V14 RT (respiratory therapist) stated that V14 received R1 from the hospital on 12/26/2020. V14 stated that V14 connected R1's tracheostomy to the ventilator and left R1's room to gather tracheostomy care supplies. V14 stated that when V14 returned to R1's room, R1 appeared paler than usual, unable to obtain a pulse, called a code blue, and instructed staff to call 911 EMS (emergency medical services). V14 stated that paramedics arrived and took over CPR (cardiopulmonary resuscitation).

On 1/19/2021, this surveyor reviewed the EMS report for 12/26/2020 with V14. V14 acknowledged that staff were not performing chest compressions when the paramedics came in R1's room. V14 stated that initially chest compressions were performed but then staff stopped. V14 was providing ventilator support via R1's tracheostomy and is unsure how much time elapsed from when staff stopped chest

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compressions and when paramedics arrived.

On 1/19/2021 at 4:20pm, V20 CNA (certified nurse aide) stated that V20 worked on the third floor nursing unit evening shift on 12/26/2020. V20 stated that all of the staff responded to R1's room when the code blue was called. V20 was not able to state if a staff member was performing chest compressions. V20 stated that V20 did not assist with CPR.

On 1/21/2021 at 3:10pm, V24 LPN (licensed practical nurse) stated that V24 was the nurse supervisor working the evening shift on 12/26/2020. V24 stated that V24 was also working as a floor nurse on the dementia nursing unit. V24 stated that V24 worked with V29 LPN on 12/26 and V29 responded to the code blue and V24 stayed on the dementia unit to monitor residents. V24 stated that there is no reason not to respond to a code blue if the resident is a full code. V24 stated that there is a code blue book noting who is DNR and who is not; this book is kept at each nurses' station. V24 stated that a resident's code status is also documented in the resident's electronic medical record. V24 stated that when a code blue is called, the crash cart is brought to the resident's room, the resident is assessed for vital signs, CPR is initiated, and V1 (administrator), EMS, and V2 DON (director of nursing) are notified. V24 stated that code blue sheets are kept on top of the crash cart. V24 stated that staff should be doing CPR until EMS arrives and takes over the care of the resident.

On 1/21/2021 at 3:30pm, V29 LPN stated that on the evening of 12/26/2020 a code blue was paged overhead on a different nursing unit and V29 responded to it. V29 stated that R1 had just arrived at this facility when the code blue was

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called. V29 stated that when V29 arrived at R1's room, V29 asked if staff confirmed R1's code status and V21 LPN stated yes. V29 stated that V29 instructed staff to stop CPR until V29 confirmed R1's code status. V29 stated that V29 went to the nurses' station, confirmed R1's code status, printed up R1's face sheet for EMS, and then returned to R1's room. V29 stated that V29 took over chest compressions but does not recall who V29 took over for or if anyone took over for V29. V29 stated that one nurse was checking R1's vital signs, one nurse was documenting on the code blue sheet, and one nurse was checking R1's blood sugar level; V29 is unable to identify who was doing what and what the results were. V29 stated that CPR should continue until EMS arrives.

On 1/26/2021 at 5:47pm, V30 (EMS paramedic) stated that V30 responded to cardiac arrest on the evening of 12/26/2020 at this facility. V30 stated that upon entering R1's room, V14 RT was performing ventilation via R1's tracheostomy. V30 stated that R1's trachea was clear and without any secretions. V30 stated that there were 2-3 staff members surrounding R1's bed not performing chest compressions or assessing R1 for vital signs. V30 stated that a staff member informed V30 that R1 was new admission to this facility one hour ago and they did not have any information on R1 to provide to EMS. V30 stated that R1 was immediately placed on heart monitor; monitor showed asystole (no contraction of the heart muscle and no blood flow to the rest of the body). The paramedics performed CPR for 20 minutes before obtaining a pulse. V30 does not recall the names of the staff present.

Review of the medical record notes R1 was admitted to this facility on 11/2/2018 with