(X3) DATE SURVEY

Illinois Department of Public Health

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: A. BUILDING: | | | COMPLETED | | |
|--------------------------|--|--|---------------------------|---|---------------|--|--|
| IL6014856 | | B. WING | C 04/15/2021 | | | | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, 8 | STATE, ZIP CODE | | | |
| VILLA AT WINDSOR PARK | | | ST 75TH ST D, IL 60649 | | | | |
| (X4) ID PREFIX TAG | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE COMPLETE | | |
| S 000 | Initial Comments | | S 000 | | | | |
| | Complaint Investiga | ation: 2182233/IL00132382 | | | | | |
| S9999 | Final Observations | | S9999 | | | | |
| | Statement of Licens | sure Violations: | | | | | |
| | 300.610a) 300.1210b) 300.1210)d)6) | 8 | | 9 | | | |
| | Section 300.610 Re | esident Care Policies | | | | | |
| | procedures governi facility. The written be formulated by a Committee consisting | | | 12 | | | |
| ill o | medical advisory co of nursing and othe policies shall compl The written policies the facility and shall | dvisory physician or the ammittee, and representatives or services in the facility. The y with the Act and this Part. shall be followed in operating be reviewed at least annually documented by written, signed of the meeting. | | | | | |
| | Section 300.1210 (Nursing and Persor | General Requirements for half Care | | | | | |
| | and services to atta practicable physical well-being of the res each resident's com plan. Adequate and | irovide the necessary care in or maintain the highest , mental, and psychological sident, in accordance with aprehensive resident care properly supervised nursing | | Attachment A Statement of Licensure Violations | | | |
| inois Depar | tment of Public Health | | | | | | |

(X2) MULTIPLE CONSTRUCTION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING IL6014856 04/15/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2649 EAST 75TH ST VILLA AT WINDSOR PARK** CHICAGO, IL 60649 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 1 S9999 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: 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. These requirements were not met evidenceed by: Based on interview, and record review, the facility failed to provide necessary care and services to monitor and prevent injury for one resident (R1) reviewed for unknown injury in the sample. This failure affected R1 who was found with a swollen left leg. R1's X-Ray showed that R1 had acute oblique fracture to distal femur with dorsal displacement distal fragment, resulting in R1 being sent to the local hospital and had an Open Reduction and Internal Fixation left femur surgery on 4/06/21. Findings include: On 04/12/21, R1's admission record showed that R1 was admitted to the facility on 9/08/2019 with last initial admission date 11/24/2019 with diagnosis that includes but not limited to Unspecified Dementia with behavioral Disturbances, unspecified Osteoarthritis, Anemia, Weakness, History of falling, Altered Mental

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| | NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | | | |
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| | | | 7.1 SOLESINO. | | | c | |
| | IL6014856 B. | | B. WING | | | 04/15/2021 | |
| NAME OF PROVIDER OR SUPPLIER STREET ADI | | | DRESS, CITY, | STATE, ZIP CODE | | | |
| VILLA A | F WINDSOR PARK | | T 75TH ST), IL 60649 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE | |
| \$9999 | Continued From pa | ige 2 | S9999 | | | | |
| | Cervical Vertebra so fracture with Nonun unspecified, and othe was sent out to the injury resulting in ar | Displaced fracture of second ubsequent encounter for nion, Rheumatoid Arthritis her Lack of Coordination. R1 local hospital for unknown oblique fracture distal to orsal placement distal | | | | | |
| | R1's hospital record documented that R1 has an open reduction internal fixation left femur surgery on 04/06/21 then R1 returned to the facility on 04/09/21. | | | | | | |
| | 04/07/2021 docume | cal record presented dated ented that R1 is s/p open nal fixation left femur on | | | | | |
| | date 11/03/20 score on 04/09/2021, score high level of risk base | uation Report with effective ed 16, on 11/24/19, scored 7, red 13. R1's category rated as sed on Acute Chronic which poses a threat to life or | iş əvr | | | | |
| | V10 LPN (Licensed about a year ago R1 to attempt to get up staff. V10 stated R1 ADL's (Activity of Da that she was the nur R1 to the hospital. V (Certified Nurse's Ai to R1's room to assesswellen and R1 was assessment the left area (pointing to her | opm, interview conducted with Practical Nurse) stated in part 1 was prone to fall and tends by-self without assistance of needs total assistance with aily Living). V10 confirmed rse on duty 4/5/21 who sent /10 explained that the CNA ide) identified as V6 called her ess R1's left leg because it is in pain. V10 stated upon leg was swollen from the hip own left leg in description), was screaming to touch R1's | | | | | |

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STATEMENT OF DEFICIENCIES (X1) PRO

| | | OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3 | (X3) DATE SURVEY COMPLETED | |
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| | | | IL6014856 | B. WING | | | С | |
| ŀ | NAME OF 1 | PROVIDER OR SUPPLIER | | | | | 04/15/2 | 2021 |
| l | | | | T 75TH ST | STATE, ZIP CODE | | | |
| l | VILLAA | WINDSOR PARK | |), IL 60649 | , | | | |
| | (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE | TION SHOULD BE THE APPROPRIA | | (X5) OMPLETE DATE |
| | | and V12 NP (Nurse V12 ordered an X-F stated after about 2 showed that R1 had "send R1 to the hos asked V10 about th first time during her gave R1 her mornin V10 stated she coul asked to check the was documented th medication were ad (Registered Nurse) surveyor that the inf the surveyor and the (Administrator) or V. This was brought to As of 4/15/21 at 10:35 who worked with R1 shift, V17 stated "in with R1 all the time I appointment's when explained that on 04 using a lifting device any accident with R7 worked on the same was not the CNA for the night there was a problem". On 04/15/21 at 10:5 conducted with V15 from 11pm to 7am s in part that she is fait through-out the nigh accident or incident. | she called the unit supervisor Practitioner) immediately. Ray, and Doppler test. V10 minutes, the X-Ray result fracture and V12 stated spital". The surveyor then e first time she saw R1 for the shift. V10 replied when she ag medication after breakfast. Id not recollect the time. When computer for the time that it at R1's am (Morning) | S9999 | | | | |

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PRINTED: 05/27/2021 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C B. WING IL6014856 04/15/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2649 EAST 75TH ST** VILLAAT WINDSOR PARK **CHICAGO. IL 60649** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S9999 Continued From page 4 S9999 walks rounds are made every hour to make sure the resident did not fall. On 04/15/21 at 12:39PM telephone interview with V19 (LPN) regarding R1's health status on 04/04/21. V19 was unable to recall any accident or incident during the shift. V19 stated she did not work directly with R1. At 12:46PM, telephone interview conducted with V18 (LPN), V18 stated in part that he worked with R1 but there was no incident or accident and no abnormal occurrence with R1. V18 stated he made rounds every 1-2 hours. V18 stated "R1 does not ambulate around" stating "(R1) cannot walk, needs to be transferred with a (lifting transfer device)." V18 could not recollect the last time he physically saw R1. On 04/15/21 at 1:13pm, telephone interview with V12 (NP), V12 stated in part that the oblique fracture for R1 can be connected to osteoporosis because osteoporosis causes the bones to be soft. V12 stated any little thing (Referring to trauma) can cause someone to have fracture. On 04/15/21 at 1:55pm, telephone interview with V16 (Restorative Aide) for third floor stated on Sunday (4/4/21) she helped transfer R1 from bed to the wheel chair during the 7am to 3pm shift and she performed ROM (Range of Motion) with

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assistance of another staff with R1. V16 stated R1 did not complain of pain during the ROM. When the surveyor asked how the transfer was done V16 stated one staff was on one side (Referring to left side) and the other side

(Referring to right side). The surveyor asked what type of transfer device was used in transferring R1? V16 replied that no device was used. because R1 can help in transferring. The

Illinois Department of Public Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: A. BUILDING:

> B. WING ___ IL6014856

04/15/2021

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| (3.4.4) 15 | | , IL 60649 | | |
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| (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) COMPLETI DATE |
| S9999 | Continued From page 5 | S9999 | | |
| | surveyor then clarified with V16 about use of transfer devices. V16 replied, (R1) can stand no device was used. V16 could not precisely remember what time the transfer was done but she stated, "it was before lunch." | | | |
| | R1's plan of care for transfer focus initiated 11/24/2019 documented that (R1) has a self-care deficit in transfers related to generalize weakness. Interventions includes but not limited to use of gait belt with extensive assistance. | | | |
| | On 04/15/21 at 2:09pm, interview conducted with V8 (Restorative Nurse Director) stated regarding devices needed in transferring R1 from bed to wheelchair. V8 stated in part that R1 needs to be transferred with a gait belt and a walker. The surveyor asked should the lift, gait belt, or walker have been used for transfer. V8 replied it is required because R1 is not in a transfer program. | | | |
| | Review of facility investigation interview statement dated 4/5/2021 at 10:00am states V2 DON (Director of Nurses) explained that she conducted the interview and V8 did not say anything about the transfer device but V8 is expected to make use of transfer device when transferring any of the resident's. | | | , , , , , , , , , , , , , , , , , , , |
| | According to the Facility Investigation Interview/Statement Record dated 4/5/21 at 10:00am shows V2 DON (Director of Nurse's) conducted the interview with V8, and V8 did not say anything about the transfer device but V8 is expected to make use of a transfer device when transferring any of the residents. | | | |
| | On 4/4/21 at 2:45pm, surveyor conducted telephone interview with V12 (NP). Surveyor asked V12 if a resident with a diagnosis of | | | |

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STATEMENT OF DEFICIENCIES (X1) PRO

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY COMPLETED | |
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| | | | A. BUILDING: | | | | |
| , | | IL6014856 B. WING | | C 04/15/2021 | | | |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, | STATE, ZIP CODE | | | |
| VILLAA | WINDSOR PARK | | T 75TH ST , IL. 60649 | | | | |
| (X4) ID PREFIX TAG | X (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOUL) TAG CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY) | | | (X5) COMPLETE DATE | |
| S9999 | osteoporosis or oste the bed to a wheeld stated in plan of car fracture? V12 replie you it is not possible bone itself, the bone R1's facility assess 2020 section G cod (Activity of Daily Livithat R1 needs exter person's assistance Mental Status) of 06 assessment dated M scored R1 3/2 for tracket extensive assistance BIMS of 08. The facility policy or Mistreatment and M Property with effecti Injury of Unknown C source when both or not met: i. The source of by any person or the not be explained by ii. The injury is s | ecoarthritis is transferred from hair with no transfer device as e, can that cause an oblique d, "It is possible. I cannot tell because of the nature of the e is very, very fragile." ment tool dated December 3, ed R1 3/3 for transfer for ADLing) assistance which showed asive assistance with two. BIMS (Brief Interview for 6. The most resent March 5, 2021 section G ansfer that showed R1 needs e with one-person assistance. Abuse, Neglect, isappropriation of Resident we date 11/28/2017 defined origin as injury of unknown of the following conditions are for the injury was not observed a source of the injury could the resident. Suspicious because of the injury of the injury was not observed the resident. | S9999 | | | | |
| T TYPING MALE. | vulnerable to trauma | n) or the number of injuries ticular point in time or the | | | | | |