STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007074	A. BUILDING: _____ B. WING _____	C 10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBRIDGE NURSING PAVILION	2242 NORTH KEDZIE CHICAGO, IL 60647

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S 000	Initial Comments Complaint Investigation : 2287685/IL151579, FRI of 9/16/22/IL151583 & FRI of 9/29/2022/IL151987	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1010h) 300.1220b)3 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These Requirements were NOT MET as	S9999		

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S9999	Continued From page 2 evidenced by: Based on interview and record review, the facility failed notify a resident's physician after resident's falls (R2); failed to ensure staff are aware of resident fall prevention interventions (R1); failed to implement fall prevention interventions for (R3). These failures affected (R1, R2, R3) reviewed for falls and resulted in: R2 being sent to hospital for evaluation of change in condition 14 days after falling. R2 was diagnosed with subdural hematomas (brain hemorrhages) subsequently expired. R1 fell and sustained left mandibular ramus fracture (lower jaw fracture). R3 fell and sustained a right humerus fracture (upper arm fracture) and intramuscular hematoma (bruise within the muscle). Findings include: 1) R2's medical record (Face Sheet) documents R2 is an 87-year-old admitted to the facility on 7/27/2022 with diagnoses including but not limited to: Atherosclerotic Heart Disease (ASHD), Dementia, Long Term (Current) Use of Aspirin, Cognitive Communications Deficit, Muscle Weakness, and Major Depressive Disorder. R2's MDS (Minimum Data Set, 8/3/2022) documents R2 is severely cognitively impaired and requires extensive assistance with all ADLs (Activities of Daily Living). Facility's initial incident report (8/22/2022) documents R2 was sent to the hospital for evaluation due to resident change in condition. Diagnosis: Subdural Hematoma, Chronic. 10/11/2022 at 1:35 PM, V7 (Licensed Practical Nurse-LPN) stated, she was the Nurse	S9999		

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S9999	Continued From page 3	S9999		

responsible for R2 at the time of both of R2's falls. "I don't know if R2 had prior falls, but I received R2 as a fall risk. R2 kept trying to get out of bed. We were doing close monitoring. I assessed after each fall, there was no obvious injury. I notified V6 (Nurse Practitioner-NP) and family of each fall the only thing I can say is we did what we could."

10/12/2022 at 1:12 AM, V5 (R2's Physician) stated: "The patient should have gone out at that time (after first fall). I didn't find out until later (that) R2 had fallen. If I had been notified that (R2) had fallen I would have sent R2 to the hospital because the falls were unwitnessed and R2 has dementia (you don't know if resident hit head). I discussed the CT scan with the radiologist at the hospital. The subdural hematomas were chronic, and my interpretation is that they were there for at least two months.

10/12/2022 at 3:45 PM, V6 (NP) stated: "Honestly, it was 1:00 AM in the morning. They woke me up. I didn't send (R2) out. There was no bruising/pain. I heard about the subdural hematomas. I feel that they had them prior to admission to the facility. R2 was falling at home. I wish I would have sent (R2) out. I'm sure I let V5 (R2's Physician) know."

R2's Death Certificate documents R2's cause of death as Complications of Intracranial Hemorrhages due to Fall.

Progress Notes:
On 8/1/2022 at 2:00 AM: Resident observed with periods of confusion and steady trying to get out of bed. Resident will be monitored q1hr by writer with aide seating close to resident's room.
On 8/3/2022 at 7:45 PM: Resident noted inside of

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S9999	Continued From page 4 her restroom (located in bedroom) sitting on the toilet with her foley removed. On 8/4/2022 at 6:44 AM: Resident noted with confusion and agitation in earlier part of shift. Resident requested, repeatedly, to go home, stating, "When can I go home? I want to go home!" Resident also attempts to transfer, independently, to the restroom, stating,"I have to pee!" Writer educated resident on placement and purpose of Foley catheter. Resident confused and did not understand purpose. Resident continued to ask the same questions, repeatedly. -8/6/2022 at 11:42 PM: At 11pm on rounds yelling called to room by cna, R2 on the floor lying flat on back stated was trying to get up slipped to the floor. Denies any pain or discomfort when asked stated did not hit head neuro check started. (V6-NP) and (family member) also notified. -8/7/2022 at 3:01 PM: Resident confused needs constant redirection. -8/7/2022 at 8:11 PM: close monitored during the shift to get out the bed redirected several times. -8/8/2022 at 12:48 AM: Call to room by cna on the floor (V6-NP) call informed of fall the home of (family member). -8/8/2022 at 12:55 AM: Post Fall evaluation: fall was unwitnessed. -8/22/2022 at 5:02 PM: Upon assessment noted lethargic, however responding to verbal and tactile stimuli. (V6-NP) called made aware of resident's condition. V6 ordered to send resident to local hospital. -8/23/2022 at 7:27 AM: Resident was transferred to (local hospital) for subdural hematoma. -823/2022 at 5:30 PM: On 8/23/2022 at 5:30 PM I had a phone conversation with the (family member) of (R2). I explained to (family member) in detail about the findings of the tests performed at (local hospital) on 8/22/2022 including the diagnosis of subdural hematoma. According to	S9999		

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the CT scan performed, subdural hematomas noted in (R2's) imaging were described as "chronic". I also explained that subdural hematomas can occur even after a minor head injury and that the amount of bleeding can be small and develop over several weeks. This type of subdural hematoma is often seen in older adults. These may go unnoticed for many days to weeks until symptoms are more apparent. And that it (is) difficult to establish a clear-cut timeline for their onset. (Family member) verbalized understanding and was satisfied with our discussion.

2) R1's medical record (Face Sheet) documents R1 is an 80-year-old admitted to the facility on 1/10/2008. R1 has diagnoses including but not limited to: Chronic Obstructive Pulmonary Disease (COPD), History of Falling, Schizoaffective Disorder, and Type 2 Diabetes Mellitus. R1's Minimum Data Set (MDS, 9/26/2022) documents R1 is severely cognitively impaired with continuous inattention, disorganized thinking, and altered level of consciousness.

Facility's final incident report (9/16/2022) documents in part, R1 sustained a fall inside their room resulting in a mandibular ramus fracture. Witness statements reveal that the resident has frequent behavior of "playing with water all the time."

R1's hospital record (Emergency Department Progress Note of 9/16/2022) documents R1 presented as trauma after ground-level fall at (Nursing Home). Found to have left mandibular fracture on imaging.

On 10/9/2022 at 9:58 AM, V8 (Registered Nurse-RN) stated, she was the nurse responsible

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S9999	Continued From page 6 for R1's when R1 fell on 9/16/2022. V8 stated R1 has a history of many recurrent falls and is known to play with water. V8 said they were doing rounds/passing medications and saw R1 was on the floor (in R1's), the water was on. V8 stated R1 could not tell V8 what happened but did tell V8 that R1 hit their head. When asked by Surveyor what fall interventions were in place for R1, V8 stated: "I don't know. They're in the chart, in the Progress Notes but you would have to dig through a lot (of Progress Notes) to find them (interventions). On 10/11/2022 at 2:48 PM, V4 (Restorative Nurse) stated, R1 is a fall risk with a history of prior falls, and behavior of playing with water (in hand sink in R1's room). V4 stated, residents' care plans are updated after each fall with interventions and staff are in-serviced. This information is kept in a binder on the units as well as the residents Kardex which is accessible to both Nurses and CNAs (Certified Nursing Assistants). V4 stated it is their expectation that staff review this information if they were not present for in-service or have questions. On 10/12/2022 at 2:22 PM, V12 (CNA) stated she was the CNA responsible for R1's care when R1 fell on 9/16/2022. V12 stated, "R1 plays with water at night. I saw R1 playing with water (around 1:00 AM, hand sink in R1's room). I turned off the water and put R1 back to bed. At 2:30 AM, I saw R1 standing by the sink, the water was on and had overflowed (onto the floor). I turned the water off, put R1 back to bed, and went to get a towel (to mop up the water). When I came back, (R1) was lying on the floor. When asked by Surveyor what fall interventions were in place for R1, V12 stated, R1 is not a fall risk so you can't restrain them. V4 told me I should turn	S9999		

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S9999	Continued From page 7 the water (intake valve under the sink) off. R1's at risk for falls care plan (undated) lists as an intervention "Keep environment free from clutter with unobstructed paths and dry floors." It does not list an intervention to address R1's behavior of playing with water. 3) R3's medical record (Face Sheet) documents R3 is a 69-year-old admitted to the facility on 3/22/2022 with diagnoses including but not limited to: End Stage Renal Disease, Hypertension, Cerebrovascular Disease, and Type 2 Diabetes Mellitus. R3's MDS (Minimum Data Set of 9/29/2022) documents R3 is moderately cognitively impaired, requires extensive assistance for all ADLs (Activities of Daily Living), and has a history of falls. Facility's final incident report (9/30/2022) documents R3 had an unwitnessed fall on 9/29/2022 at approximately 6:50 PM from rolling out of bed resulting in a right humerus fracture. Hospital Record (Progress Notes of 9/29/2022) document R3 sustained a right humerus fracture and intramuscular hematoma after fall. 10/9/2022 at 10:13 AM, V9 (Licensed Practical Nurse-LPN) stated: "The CNA (Certified Nursing Assistant) notified me that R3 fell out of bed. R3 was face down on the floor next to the bed. We assisted R3 back to bed. There was no obvious injury, no complaint of pain, R3 was unable to verbalize how (R3) fell. I assessed R3 and called the NP (Nurse Practitioner) who told me to send R3 out to the hospital for evaluation. R3 is a fall risk." When asked by surveyor what fall precautions were in place, V9 stated: "there were no fall precautions in place at the time of the fall.	S9999		

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S9999	Continued From page 8 R3 was in a different room, a room change had recently been made. So, I'm under the assumption that all of R3's equipment was not there. R3 needed side rails and floor mats. I lowered the bed to the lowest position and had my CNA make frequent rounds (every 30 minutes). 10/12/2022 at 2:30 PM, V10 (CNA) stated they did not remember the resident. "All residents at risk for falls should have floor mats and low bed. V10 stated "most times I find out that a resident is a fall risk by their wrist band." R3's "at risk for falls" care plan documents M-rails (side rails that aid in repositioning and sitting up) were initiated on 8/24/2020. (A)	S9999		