STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013809	A. BUILDING: _____ B. WING _____	C 09/12/2022

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LYNWOOD TERRACE	2317 EAST 207TH STREET LYNWOOD, IL 60411

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Z 000	COMMENTS Facility Reported Incident of 7/31/22/IL150524	Z 000		
Z9999	FINDINGS Statement of Licensure Violations: 350.610a) 350.1210b) 350.1230b) 350.1230d)1)2)3) 350.3240a) Section 350.610 Management Policies a) The facility's governing body shall exercise general direction of the facility and shall establish the broad policies and procedures for the facility related to its purpose, objectives, operation, and the welfare of the residents served. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following: b) Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent. Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following:	Z9999	Attachment A Statement of Licensure Violations	

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Z9999	Continued From page 1 The DON shall participate in: d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 2) Basic skills required to meet the health needs and problems of the residents. provide sufficient direct care staff to respond to injuries, and emergencies 3) First aid in the presence of accident or illness. Section 350.3240 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 were not met as evidenced by: Based on record review and interview, the facility failed to provide immediate nursing and medical service to investigate the extent of injuries and protocols necessary after an unwitnessed fall for 1 of 1 (R2) in the sample who obtained a fractured hip and leg. The facility failed to: 1) Implement policies to prevent neglect for 1 of 1 residents (R2) who sustained a fractured hip and fractured leg after two falls in one day.	Z9999		

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Z9999	Continued From page 2 2) Ensure R2's injurious falls were thoroughly investigated. Findings include: Facility Policy number 5.24 titled Investigation Committee dated April 2019 states "The investigation committee shall be responsible for the following: A. To identify, review and determine if alleged violations of any individual's rights including abuse and neglect have occurred. C. to protect individuals from further harm." Facility Policy number 5.24, dated August/2017 titled, "Investigation Committee" states, " The Administrator considers the report and takes Administrative action." "E. The committee members shall meet to review the allegations, conduct interviews and examine the information available that is pertinent to the incident." Review of the census for the facility on 8/20/22 at 12pm list 6 residents, R2 is currently not living in the home but in an inpatient rehabilitation skilled nursing facility. Review of incident report dated 7/31/22 at 6:40pm to 7pm written by E1, Direct Support Person (DSP) states R2 fell twice while staff was helping other individual (R1). "Fell on floor from bed" "call 911 and send to hospital" Review of Illinois Department of Public Health notification letter dated 8/1/22 written by E4, Administrator states "On July 31, 2022, R2 fell in his room. Staff helped him up. R2 asked to sit on his bed. Shortly thereafter R2 attempted to get	Z9999		

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Z9999	Continued From page 3 out of bed and fell again. R2 was taken to local hospital where he was admitted with a diagnoses of right hip fracture and fracture to right lower leg. The investigation fails to include: a) Interview of all pertinent staff to the resident injuries. E6, Registered Nurse who was contacted by E1, DSP after fall was not interviewed. b) Summary and recommendations failed to address if staff to resident ratio was appropriate to meet the needs of R2 at time of R2's injury. c) After R2's first fall if any safety measures or change in supervision should have been put in place and if so, why not. d) Why the nurse was not called after R2's first fall. e) If R2 had shoes on or off when he fell and as his safety plan recommends nonskid shoes. f) documentation of physical environment such as if there were any obstacles in R2's path of fall and description of the lighting in the room at the time of R2's fall. g) Time period between first fall and second fall. h) Whether R2's wheelchair was locked when he fell. Review of hospital records for R1 dated 7/31/22, Sunday written by Z4 emergency department (ED) physician states R2 has a "Intertrochanteric right hip fracture" and a "Comminuted proximal tibia and fibular diaphyseal fracture" Z5 ED	Z9999		

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Z9999	Continued From page 4 physician documents on 7/31/22 at 10:35pm "This 64 year old male" "who presents from a group home for right leg pain secondary to unwitnessed fall. The patient staff found him on the ground complaining of leg pain, but no other history can be obtained "Swelling, tenderness, deformity and signs of injury present." "Patient winces in pain when his right leg is moved." Review of Physician Order Sheet (POS) written by Z2, (physician) dated 3/10/22 documents R2 is a 64-year-old male with several diagnoses including Abnormalities of gait and mobility, weakness, cerebrospinal fluid drainage device, Major Depression, Asperger's Syndrome, Aphasia, Hydrocephalus, history of Traumatic Brain Injury, Unspecified Convulsions. The same POS list R2 have the following adaptive equipment wheelchair, shower chair, eyeglasses, incontinent briefs, hospital bed, gait belt and special mattress. R2' Individual Service Plan dated 3/10/22 list an IQ (Intellectual Quotient) of 70 and overall age of 5 years old. R2 have utilized a wheelchair since 2019 for ambulation but can transfer independently. Review of documentation of a previous fall in the home, Nursing note dated 3/29/22 written by E6, Registered Nurse (RN) states, "R2 returned back home post assessment after unwitnessed fall in bathroom. Laceration to outer right eye." 4/11/22 quarterly Health status review written by E6, RN documents, "3/29/22, seen at local hospital emergency department for unwitnessed fall in bathroom." Review of R2's supervision level dated 3/10/22	Z9999		

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Z9999	Continued From page 5 titled Individual Risk Assessment Tool written by E9, Regional Trainer and Qualified Intellectual Disability Professional states, R2's general household supervision is "on site" E4, Administrator was asked on 8/31/22 at 11:41am to clarify what on site defines, "On site means that staff need to be in the same location. For example, they need to be in the home while he is inside the home. Likewise, if he was to move to the patio, staff need to be outside with him." 4/11/22 - Quarterly Health Status review for R2 written by E8, Licensed Practical Nurse states R2 have "some generalized weakness". " Bilateral lower extremity weakness." "Use wheelchair for mobility due to bilateral lower extremity weakness. Able to self-propel." Facility Policy number 5.57 dated 05/19 "Physical Injury and Illness/Individual Medical Emergencies" Neglect: Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." "In the event that an individual sustains an injury or illness, staff on duty shall conduct observations and take appropriate action consistent with the following: B. Observe the individual to determine basic information necessary for nurses or physicians to make further judgements. C. Notify the Registered Nurse for consultation and Qualified Intellectual Disability Professional or Administrator for direction." Review of R2's record failed to show evidence that the nurse was notified after the first fall per policy requirement. Review of R2's Nursing Care Plan dated 4/4/22 written by E6, Registered Nurse states R2	Z9999		

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Z9999	Continued From page 6 "problem or need Risk for fall related to fall history, seizure disorder." "Short term goal reduce risk for falls". The same care plan also includes several directives to staff including, " Remind R2 to tell staff if he feels dizzy or has concerns about transfers due to pain, weakness, or lightheadedness." Interview by telephone with E6, Registered Nurse on 9/7/22 at 11:18am. E6 was asked if R2 should be dependent upon to remind staff that he has concerns about transfers with an IQ of 70 and overall age of 5 years old. E6 states R2 can tell staff his needs sometimes "but it is something to think about." Interview with E1, Direct Support Person on 8/29/22 at 10:12am. E1 was asked what happened the day R2 fell. "I was in the bathroom with R1 changing him into his pajamas when R2 starts calling for help. So, I stop what I'm doing and go to him and R2 says "I just fell, I'm ok". E1 continues "I checked him over real quick and got him up and placed him back in bed all the way back to the middle of the bed. I go back to the bathroom and finish up with R1 who already dressed now and R2 calls again. I go back to R2's room and he is on the floor again, but he is saying his leg hurts. This time his legs are under him like both legs together off to the side. I picked him up and placed him back in bed and by that time another staff, E3 (DSP) was coming in and she stayed with R2 while I called 911." E1, DSP was asked if she knew about R2 history of falls with injuries. "No, I didn't find out about his falls until I talked to E3, DSP that same night. I was never told of his fall history, the information you are giving me and E2 told me."	Z9999		

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Z9999	Continued From page 7 Interview by telephone with E5, DSP on 8/29/22. E5 states she was off the day "it happened" verified with E5 she was referring to 7/31/22 when R2 fell. "R2 tries to get up and use the bathroom during the night, you have to watch him." "I was told he was fragile." Interview with E6, Registered Nurse (RN) on 8/29/22 at 12 noon. E6 was asked what should have happened after R2 fell the first time? E6 states she "did tell her (E1, DSP) she should not have picked him up after the fall." and when he fell once "I would have sent him out." Interview with E7, QIDP on 8/29/22 at 12:30pm, "R2 does what R2 does. He can go to the bathroom on his own, he needs help in the shower. He can do a lot for himself; but will try to get up on his own. He will stand up sometimes and says he wants to walk. " Surveyor asked E7 if she knew R2 have a history of falls with injuries. E7 states, "I know he was hospitalized for his shoulder that's the only thing I really know about him. E7 was asked about 2nd shift duties, "they have to prepare dinner, wash dishes, showers, change residents to pajamas." E1, DSP was asked if she knew about R2 history of falls with injuries. "No, I didn't find out about R2's falls until I talked to E3, DSP that same night. I was never told of his fall history, the information you are giving me and E2 told me." Interview with E4 on 8/20/22 at 11:40am. E4 states R2 does have shoes that have grip but was not able to definitively address if R2 had shoes on or off when he fell or type of shoes R2 was wearing. E4 confirmed on 8/29/22 at 11:50am that E6, RN should have been included	Z9999		

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Z9999	Continued From page 8 in interview. E4 was asked why adequate staffing was not included in the investigation. E4 states., "even if there was another staff member present, the staff would most likely have been with the other individuals in the milieu. R2 would go back and forth to him room constantly and was able to independently transfer from chair to bed and bed to chair, therefore it was not uncommon for him to be in his room alone." (B)	Z9999		