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
	IL6015101	A. BUILDING: ____ B. WING ____	C 04/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS (NORTHBROOK)	3240 MILWAUKEE AVENUE NORTHBROOK, IL 60062

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S 000	Initial Comments Facility Reported Incident of March 12, 2022/IL145292	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.710 a) 330.710 c)3)A) through F) Section 330.710 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. c) The written policies shall include, but are not limited to, the following provisions: 3) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following: A) Analysis of the risk of injury to residents and nurses and other health care workers, taking into account the resident handling needs of the resident populations served by the facility and the physical environment in which the resident handling and movement occurs. B) Education of nurses in the identification, assessment, and control of risks of injury to residents and nurses and other health care workers during resident handling. C) Evaluation of alternative ways to reduce risks associated with resident handling,	S9999	**Attachment A** **Statement of Licensure Violations**	

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including evaluation of equipment and the environment.

D) Restriction, to the extent feasible with existing equipment and aids, of manual resident handling or movement of all or most of a resident's weight, except for emergency, life-threatening, or otherwise exceptional circumstances.

E) Procedures for a nurse to refuse to perform or be involved in resident handling or movement that the nurse, in good faith, believes will expose a resident or nurse or other health care worker to an unacceptable risk of injury.

F) Development of strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident.

This REQUIREMENT is not met as evidenced by:

Based on observations, interviews, and record reviews the facility failed to follow their fall prevention policy by not updating/modifying service plans to include comprehensive and personalized fall interventions for residents at risk for falls and experiencing multiple falls. This failure applies to three residents (R1, R2, and R3) in a total sample of three residents reviewed for falls.

Findings include:

1. R1 has diagnoses history of Dementia without Behavioral Disturbance and Parkinson's Disease who was originally admitted to the facility 12/13/2021.

04/04/2022 2:53PM V5 (Resident Caregiver) stated R1 was a fall risk. V5 stated R1 did not

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S9999	Continued From page 2 have a wheelchair but had a specialized walker for R1's Parkinson's. V5 stated R1 would have difficulties when ambulating with R1's walker due to having tremors. R1's most current service plan initiated 12/13/2021 documents R1 is able to transfer/ambulate with a walker. Has periods of weakness/unsteadiness where R1 may need to use a wheelchair with staff assistance; does not include fall related behavior interventions. R1's Progress note dated 02/06/2022 documents: Monthly progress note for January to present, R1 had COVID was on isolation and recovered with minimal symptoms, after isolation R1 has been exit seeking, combative with staff, when R1 tries to open exit doors, R1 is very strong when R1 is upset and will hit staff. It takes about an hour or two to redirect, worse at sundown, and others like tonight R1 will become fixated on picking lint off carpet, which is very dangerous, high risk for falls, constant monitoring from 4 to 7pm. able to make needs known, and R1 disposition varies greatly. R1's Progress note dated 02/08/2022 documents: R1 was observed sliding to the ground at bedside, caregiver called writer to room and full assessment completed by writer observed a skin tear noted to the left hand with mild bleeding noted. R1's Progress note dated 02/15/2022 documents: this writer was called R1's unit by the caregiver where R1 was observed sitting on the floor near the foot of R1's bed wearing shoes with socks on. R1 was observed with a swollen bump on R1's upper left forehead.	S9999		

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S9999	Continued From page 3 R1's Hospital report dated 03/12/2022 documents: he presented to the hospital from the facility with complaints of pain in his right hip area and was found to have a fracture; V9 (Family Member) states its possible he may have fallen; R1's mechanism of injury was unknown. 2. R2 has a diagnoses history of Dementia with Behavioral Disturbances, Major Depressive Disorder (Recurrent), and Parkinson's Disease, who was originally admitted to the facility 09/04/2019. On 04/04/2022 at 11:48AM observed R2 ambulating with an unsteady gait to the dining area while using a walker. Observed R2's gait to be unsteady while transferring from walker to chair in dining area. On 04/04/2022 at 2:53PM V5 (Resident Caregiver) stated R2 is a fall risk and had fallen to R2's knees today. On 04/04/2022 at 3:08PM V6 (Certified Nursing Assistant) stated there are no special instructions that she is aware of for any residents on R2's unit. V6 stated residents with Parkinson's such as R2 need more monitoring. R2's most current service plan initiated 09/04/2019 documents R2 is able to transfer/ambulate independently, on some days. Is unsteady on R2's feet and lacks safety awareness. Sometimes R2 requires a wheelchair for ambulation; revised 11/10/2021 to include Encourage participation in programs that will increase strength and mobility. Ensure that the resident is wearing appropriate-fitting clothing and footwear. Provide resident with safe environment: clutter free; support/assistive devices are	S9999		

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available and in good repair; does not include fall related behaviors interventions.

R2's Progress note dated 02/06/2022 documents: called by caregiver to the unit. According to caregiver R2 was standing by the kitchen countertop and R2 lost R2's balance and fell on R2's left side. R2 observed with a small abrasion on R2's left knee.

R2's Progress note dated 03/12/2022 documents: R2 had a fall in hallway by nurses' station at approximately 9am heard calling for help, caregiver and activities responded. R2 landed face first, full body extended, approximately 30 minutes later was called to VVV hallway who saw R2 fall again, bruise noted to right knee with quart size abrasion in center of right knee.

R2's Progress note dated 03/16/2022 documents: Observed R2 lying on the floor in the dining room on R2's left side. R2 denied hitting R2's head. R2 couldn't relate how R2 fell but stated R2 hit R2's left elbow.

R2's Progress note dated 03/21/2022 documents at around 12:45 pm activity aides reported R2 found sitting on floor at studio room.

R2's Progress note dated 03/23/2022 documents: R2 ambulating using walker as usual with slow steady gait. R2 has a habit of falling on R2's knees and after some time R2 gets up on R2's own and walk away. Offered knee pad to be worn to avoid injury to both knees, R2 refused to wear them.

3. R3 has a diagnoses history of Dementia without Behavioral Disturbance, Diastolic Congestive Heart Failure, Chronic Kidney

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S9999	Continued From page 5 Disease Stage 3, Atherosclerotic Heart Disease, and Peripheral Vascular Disease who was originally admitted to the facility 08/07/2020. On 04/04/2022 at 11:58AM observed R3 sitting in the dining area. V7 (Resident Caregiver) stated there were no residents in the unit where R3 resides that were fall risks. On 04/04/2022 at 3:10PM observed R3 standing in front of a chair in the lounge area with an unsteady balance looking for a place to throw away R3's empty pudding container. Observed R3 sit down in a chair with an imbalance in R3's gait. On 04/04/2022 at 3:12PM V8 (Certified Nursing Assistant) did not identify R3 as a fall risk when asked if there were any residents on the unit that are fall risks. On 04/04/2022 at 3:14PM V4 (Resident Caregiver) stated there were no residents on the unit that R3 resides that are fall risks. V4 stated if there were any residents that are fall risks, she would have to monitor them closely or sit with them or provide them with a walker or cane. R3's current service plan documents R3 is able to transfer/ambulate independently, does not use an assistive device but may become unsteady at times. R3's Progress note dated 02/04/2022 documents: Upon completing rounds R3 was observed sitting upright on the floor with R3's feet facing the wall and R3's back to the back of the bed, R3 was attempting to get in the bed and slipped down to the ground possibly hitting R3's right forearm on the nightstand inadvertently producing the two	S9999		

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small skin tears noted to the right forearm.

Progress note dated 03/05/2022 documents: R3 was ambulating in the TV room on R3's unit and the care giver heard a thud and observed R3 lying on the floor on R3's back.

On 04/04/2022 at 12:46PM V2 (Director of Nursing/Resident Services Coordinator) stated fall risk assessments are only completed when residents are admitted to the facility.

On 04/05/2022 from 10:07AM - 10:35AM V2 (Director of Nursing/Resident Services Coordinator) stated a few days before R1's fracture, R1 had been a little bit weaker and would use a wheelchair. V2 stated R1 had a walker V9 (Family Member) brought for R1 that had a seat on it. V2 stated R1's Parkinson's Disease was determined to be the root cause of R1's falls as well as impulsive behavior. V2 stated R1 was impulsive and lacked insight when R1 was admitted. V2 stated R1 was admitted with Parkinson's and developed Dementia later. V2 stated R1 would become quite impulsive in the afternoon, had poor safety awareness, and would run down the hall at times without R1's walker and R1 would attempt to get out of the fire door at the end of R1's unit. V2 stated the R1's Dementia contributed to R1's impulsive behavior. V2 stated on 12/17/2021 R1 became weaker. V2 stated she doesn't recall if R1 was evaluated by the physical/occupational therapy department. V2 stated she did not find any physical therapy notes in R1's medical record. V2 stated R1 could have possibly been evaluated by the physical/occupational therapy department regarding R1's falls. V2 stated R2's falling is mostly affected by R2's Parkinson's Disease. V2 stated R2 freezes up and will fall down on R2's

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S9999	Continued From page 7 knees. V2 stated sometimes R2 places self on the floor. V2 stated she bought R2 knee guards, but R2 declined them. V2 stated sometimes R2 will just lower self to the floor. V2 stated R2 is quite attention seeking especially when there are new people on the unit. On 04/05/2022 at 10:42AM V2 (Director of Nursing/Resident Services Coordinator) stated R2 has had a fair number of actual falls. V2 stated sometimes R2 is in a wheelchair, uses R2's walker, and at times becomes impulsive and walks without R2's walker. V2 stated R2 does not resist getting in a wheelchair but may not remain in it. V2 stated R2 may refuse R2's Parkinson's medications from time to time. V2 stated R2 does not participate in activities much. V2 stated she's sure R2 has been evaluated by the therapy department but it may have been a while ago because R2 was on hospice. V2 stated R2 has a history of UTI's (Urinary Tract Infections) and gets them frequently. V2 stated R2's last UTI was 01/06/2022. V2 stated R3 has no circulation in R3's legs due to comorbidities of vascular diseases. V2 stated R3 had been placed on hospice 02/16/2022. V2 stated the facility is still responsible for fall prevention care for R3. V2 stated most likely R3 falls are due to R3's legs giving out. V2 stated R3 is stiff when R3 walks. V2 stated R3 was found on the floor when R3 had R3's most recent fall which indicates R3 may have slid off the bed or possibly fallen. V2 stated intermittent claudication pain when due to blood supply being cut off could possibly cause R3 to lose R3's balance. V2 stated the facility uses service plans, a resident information book kept in the cupboard above the sink in the residents' units which includes their service plans are used to communicate resident care needs. V2 stated other sources of communication for residents'	S9999		

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care needs include a 24-hour communication book located in one of the drawers near the computer in the kitchen area of the units, verbal instructions of care as well as notes posted at the desk areas in the kitchen area of each unit hallway. V2 stated all of these sources revolve around the personalized care needs for each resident. V2 stated all of the contributing factors for R1's falls including impulsiveness should be included in R1's service plan. V2 stated she had not considered disease entities in relationship to falls being included in service plans. V2 stated the need for monitoring health conditions which may contribute to falls should be included in the service plans. V2 stated any behaviors that contribute to falls should be specified in their behavior care plan.

The facility's Fall Prevention Policy reviewed 04/04/2022 states:
The purpose of the policy is to "Evaluate the health, safety and welfare of our residents and implement measures to attempt to prevent falls and minimize the risks that serious injury will result."
"Whenever possible, the staff implements precautionary measures to reduce the risk of falls by individualizing resident needs."
"In the event that a resident is at risk for falls, interventions are incorporated into the resident's Service Plan."
"There are multiple contributing factors when examining the reason, a resident falls and interventions should be geared toward the interaction of all those contributing factors."
"Review, modify, and evaluate the effectiveness of the interventions. Keep staff informed of any changes."

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