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
	IL6015648	A. BUILDING: ____ B. WING ____	C 06/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SNR LVG OF HAZEL CREST	3701 WEST 183RD STREET HAZEL CREST, IL 60429

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S 000	Initial Comments Complaint Investigation: 2294634/IL147960 - 330.710a)C)2)3)F), 330.780a)b)c)	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.710a) 330.710c)3)C)F) 330.780a) 330.780b) 330.780c) 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. The policies shall comply with the Act and this Part. 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:	S9999	**Attachment A** **Statement of Licensure Violations**	

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C) Evaluation of alternative ways to reduce risks associated with resident handling, including evaluation of equipment and the environment.

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.

Section 330.780 Incidents and Accidents

a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.

b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.

c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 330.785, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is

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S9999	Continued From page 2 unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. These requirements were not met as evidenced by the following: 1) Based upon record review and interview the facility failed to document and/or submit an accurate descriptive summary to IDPH (Illinois Department of Public Health) for R3's (6/16/22) injuries & R4's (5/27/22) laceration repair and failed to notify IDPH of reportable incidents/injuries within regulatory requirements for three of four residents (R2, R3, R4) reviewed for falls. 2) Based upon observation, interview and record review the facility failed to ensure that resident fall risk assessments were accurate, failed to provide adequate supervision and failed to revise care plans/interventions (post fall) to decrease risk for additional falls/injuries for four of four residents (R1, R2, R3, R4) reviewed for falls. These failures resulted in the following falls/injuries: R3 fell (4/16/22) and sustained a right upper arm skin tear. R3 fell (4/24/22) and sustained a right hand fracture with skin tears. R3 fell (6/16/22) and sustained a large left periorbital hematoma, a laceration under left eye and lacerations to right fingers. R4 fell (5/27/22) and sustained a left humerus fracture and laceration (over left eye) requiring staple repair.	S9999		

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R2 fell (5/10/22) and sustained a forehead laceration requiring dermabond treatment.

Findings include:

R3 is a 96 year old diagnosed with dementia and history of falls.

The facility incident report log states R3 sustained an (unwitnessed) fall 4/16/22 and incurred a (right upper arm) skin tear. R3 sustained (witnessed) falls on 4/24/22 (incurring right hand skin tear/fracture) and 5/11/22.

On 6/16/22, R3 also sustained a fall (during this survey) and incurred additional serious injuries.

R3's (4/16/22) progress note states resident observed lying on back (on bathroom floor). Small skin tear noted on the side of upper right arm.

R3's (4/24/22) incident report states resident fell in bedroom while caregiver was performing care hitting right hand causing a skin tear to the right hand. Diagnosis: right hand fracture with skin tears. R3's (4/24/22) initial incident transmission verification report is dated 4/26/22 (2 days after the incident) and the fax transmittal timestamp states 1/27/2013 (9 years ago).

R3's (5/11/22) fall risk evaluation determined a score of 10 (12 or greater = at risk for falls) therefore not as risk however decreased muscular coordination was not selected as warranted. In addition, 1-2 falls (in past 3 months) was selected (not 3 or more as warranted).

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On 6/15/22 at 11:20am, surveyor inquired about R3's fall prevention interventions V4 (Caregiver) stated "The mats are on the floor, and she sits with me out here" (referring to the TV area).

R3's (5/19/22) care plan includes high fall risk. Hourly checks. Interventions: resident to be in common area during waking hours, frequent checks, and started physical therapy/occupational therapy. [Bathroom supervision and floor mats were excluded].

On 6/15/22 at 11:29am, R3 was observed (unsupervised) in the TV room while V4 was assisting R4 (in the room). A large bruise (yellow and brown discoloration) was noted on R3's left cheek. R3 affirmed she was unsure how she got the bruise. V4 (Caregiver) subsequently returned to the TV area, surveyor inquired about R3's bruise V4 responded "She been like that, its still healing from when she fell months ago. She had a cast on her arm." Surveyor inquired if V4 was working alone on the unit V4 replied "They have a person called a floater when I have to leave. The other caregiver is on break right now."

R3's (6/16/22) initial incident report states received resident laying on shower room floor. Blood was on the floor noted to be coming from resident's head. Resident did not lose consciousness. Unable to obtain vials. 911 was called for emergency transport to hospital. [R3's progress notes include similar information]. IDPH was notified of R3's (6/16/22) incident (within roughly 2 hours) however R3's physical assessment and/or injury were excluded from the documentation. R3's (6/16/22) final report was submitted to IDPH on 6/17/22 swelling to the left eye and bruising to left hand were reported (however lacerations were excluded).

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S9999	Continued From page 5 R3's (6/16/22) emergency department triage note states patient has bruising and laceration under left eye. Patient also has some lacerations to right fingers. R3's (6/16/22) history & physical includes diagnosis fall, contusion of face. Head CT (Computed Tomography) impression: large left periorbital hematoma and soft tissue laceration. On 6/21/22 at 12:25, surveyor inquired about R3's (6/16/22) injuries V1 referred to R3's (6/16/22) final report and stated, "I do know about the left eye swelling but overall, she's doing ok." Surveyor inquired if R3 sustained any other injuries on 6/16/22 V1 responded "and bruising to the left hand." On 6/21/22 at 12:45pm, R3's left cheek, left forehead, left temporal area and left orbital area were completely bruised. R3's right cheek and right orbital area were also bruised. Dried blood was observed near R3's left eyebrow. Bandaids were observed on R3's right fingers (3rd, 4th, 5th digits). R3 recalled falling in the bathroom but was unable provide details of what occurred prior to falling on 6/16/22. R4 is an 87 year old diagnosed with cognitive communication deficit and hemiparesis. The facility incident report log states R4 sustained a (unwitnessed) fall on 5/27/22 incurring laceration to the left eye, pain in upper/lower extremities and unable to move left arm without complaining of pain. R4's (5/27/22) final incident report states resident	S9999		

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was admitted to the hospital with diagnosis of left humerus fracture with left arm cast. Sutures were applied to laceration over left eye.

R4's (6/6/22) fall risk evaluation determined a score of 8 (not at risk) however decreased muscular coordination was not selected as warranted. Also, R4's diagnoses include hemiparesis (weakness or inability to move one side of the body).

On 6/15/22 at 11:24am, surveyor inquired about R4's fall prevention interventions V4 (Caregiver) stated "she has her wheelchair and we help her get up." Surveyor inquired about R4's location V4 responded "She's in her room." R4's door was closed, she was alone in the room sitting in a wheelchair and her call light was on the bed (out of reach). R4 had a bruise below her left eye, a cast on left arm and laceration with staples (not sutures) near her left eyebrow. Surveyor inquired about R4's injuries R4 stated "I was in the chair, I went to turn, the wheels were not locked, and I fell. I broke my arm and got a cut on my eye." Surveyor inquired about R4's call light V4 stated "She got a call light thing I see it on her bed, she took it off."

R4's care plan (last updated 12/28/21 - prior to fall) excludes fall and/or fall prevention interventions.

R4's initial incident transmission verification report cover sheet is (undated) and the fax transmittal timestamp states 1/10/2013 (9 years ago).

R2 is a 98 year old diagnosed with mixed

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dementia.

The facility incident report log states R2 sustained (unwitnessed) falls on 4/8/22, 4/24/22, 4/25/22, and 5/17/22. R2 also sustained a (witnessed) fall on 5/10/22 incurring serious injury.

R2's (5/10/22) incident report states caregiver witnessed resident falling forward out of her wheelchair and hitting her head on dining room floor. Resident sustained a small laceration to forehead. Returned (from the hospital) with dermabond to laceration.

R2's initial incident transmission verification report is dated 5/13/22 (3 days after the incident) and the fax transmittal timestamp states 1/3/2013 (9 years ago).

R2's (5/26/22) fall risk evaluation determined a score of 11 (not at risk) however decreased muscular coordination was not selected as warranted and R2 fell five (5) times.

On 6/15/22 at 10:58am, surveyor inquired about R2's fall prevention interventions V3 (Caregiver) stated "She has the mats for the floor, and we place her by the TV area so she can be seen." R2 was subsequently observed in the dining area supervised by staff however she appeared to be falling asleep, leaning to the right in a wheelchair (without foot pedals). R2 was also wearing ted hose (socks) with legs crossed therefore increasing risk for fall. Surveyor inquired if R2 was able to walk V3 responded "Not really, she's not very steady on her feet she used to use a walker" and affirmed she's currently wheelchair bound. R2 was brought to her room for further inspection surveyor inquired where R2's floor mats were located V3 searched her room to no

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avail and stated, "They must be in the other room, maybe the night shift may have moved it." V3 affirmed that she would look for the floor mats then left R2 asleep in the wheelchair (unattended by staff) in the room.

R2's care plan (updated 5/19/22) includes fall intervention - observation 2x daily however floor mats (as stated) and/or additional preventive interventions to prevent falling (from the wheelchair) are excluded.

On 6/15/22 at 11:07am, V5 (Licensed Practical Nurse) entered R2's room surveyor inquired about R2's fall prevention interventions V5 stated "We keep her out in the TV area, so we have eyes on her at all times." Surveyor inquired about concerns with R2's risk for fall while asleep (unattended) in the wheelchair V5 responded "She doesn't have her footrests and she's leaning over to the side."

R1 is an 80 year old with diagnoses which include Alzheimer's Dementia.

The facility incident report log states R1 sustained a fall (unwitnessed) on 5/14/22 and was observed lying on the floor beside her bed.

R1's (5/24/22) fall risk evaluation determined a score of 10 (not at risk) post fall.

R1's care plan (updated 5/24/22) excludes the fall and/or fall prevention interventions.

On 6/16/22 at approximately 2:55pm, V7 (Health Wellness Director) stated "Fall risk assessments are done on admission, every 3 months, for change in condition and if they fall." Surveyor inquired about fall care plans V7 replied

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S9999	Continued From page 9 "Sometimes they won't technically score for a fall risk, but I can put yes they are a fall risk and put interventions." Surveyor inquired about R1's (5/24/22) fall risk evaluation and fall prevention interventions V7 responded "She's (R1) not a fall risk because she (R1) rolled from her bed" [R1's fall was unwitnessed and she's diagnosed with Alzheimer's]. Surveyor inquired about R2's fall risk V7 stated "She (R2) fell (5/10/22) and had a UTI (Urinary Tract Infection). She (R2) was started on antibiotics and is not trying to get out of the chair" then affirmed that (R2) frequently sleeps while up in the wheelchair however, R2's (5/26/22) fall risk evaluation determined a score of 11 (not at risk). Surveyor inquired about R3's fall risk V7 stated "I put her (R3) for a high fall risk for being put in the common area during waking hours and frequent checks. The facility she (R3) came from said that she (R3) fell a lot of times" however R3's (5/11/22) fall risk evaluation determined a score of 10 (not at risk). Surveyor inquired about R4's fall risk V7 stated "from what I understand, she's (R4) alert and oriented x3 and able to transfer herself safely [R4's diagnoses include hemiparesis]. She (R4) was trying to transfer herself and she (R4) fell because the wheels were not locked. Surveyor inquired about R4's fall care plan V7 responded "I think I may have charted it in the evaluation, but it didn't populate to her (R4) care plan." Surveyor inquired about R4's (6/6/22) laceration repair V7 replied "She (R4) got staples because they're to be removed tomorrow. Unfortunately, they documented sutures, but she (R4) has staples." The assessment and service plans policy (revised 11/2021) states; a comprehensive assessment will be completed, and a service plan, will be developed at move-in and updated at least annually, or with change in condition. The	S9999		

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following assessments will be completed, per the schedule in Appendix A, and maintained as part of the resident's record: fall risk assessment.

The fall prevention policy (revised 10/2021) states potential fall hazards need to be identified, reported, and managed. Residents are screened for mobility risk within 72 hours of admission or re-admission, quarterly, with a change in condition that may affect the risk of falling, and/or as required by regulatory standard. The fall risk assessment tool is used for this screening. Appropriate interventions identified will be documented in the resident individual service plan.

On 6/16/22 at 9:40am, V1 (Executive Director) presented LTC (Long Term Care) Regulations (effective 1/1/20) and affirmed this was the facility policy for reportable incidents. The regulations include accident that results in injury such as fracture or head trauma to be reported as soon as possible or by close of business day. If the incident report does not meet specified criteria, report cannot be recorded and will not be counted as a received incident report. Please contact the office to ensure your report has been received and recorded.

On 6/16/22 at 2:34pm, surveyor inquired about the regulatory requirement for reportable incidents/accidents V7 (Health Wellness Director) stated "when there's serious injury that gets reported to IDPH. The initial one is supposed to be reported within 24 hours and the final is I just recently learned it was in 5 days."

On 6/16/22 at 3:45pm, surveyor relayed concerns with the facility reporting serious injuries to IDPH

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S9999	Continued From page 11 V1 stated "I spoke with (V6 - Illinois Department of Public Health Clerical) and she confirmed that our emails were not going through. She (V6) got the initial reports (which were faxed) but she didn't get the finals they didn't come through" (referring to all aforementioned incidents - which occurred prior to 6/16/22). (B)	S9999		