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
	IL6001051	A. BUILDING: ______ B. WING ______	C 11/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRMONT CARE	5061 NORTH PULASKI ROAD CHICAGO, IL 60630

(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) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: 2288820/IL152978	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.690a) 300.690b) 300.690c) 300.1210b) 300.1210d)6 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 300.690 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.	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1 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 300.695, 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 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. 300.1210b) 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. d) Pursuant to subsection (a), general nursing	S9999		

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S9999	Continued From page 2 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 Requirments were NOT MET as evidenced by: A. Based upon observation, interview and record review the facility failed to follow the fall prevention policy, failed to ensure that staff are aware of resident fall prevention interventions, and failed to implement fall preventions for four of four residents (R1, R2, R3, R4) reviewed for falls. The facility also failed to score (R1's) fall risk assessment properly and failed to timely transfer (R1) to the hospital post fall. These failures resulted in R1's (10/22/22) fall with subarachnoid hemorrhage and death. R1's (10/25/22) cause of death includes subarachnoid hemorrhage. Findings include: R1 was admitted to the facility on 10/17/22, transferred to the hospital on 10/22/22 and expired 10/25/22. R1's (10/22/22) BIMS (Brief Interview Mental Status) determined a score of 14 (Cognitively Intact). R1's (10/22/22) functional assessments affirms (1 person) physical assist is required for bed mobility, transfers, and toilet use. Mobility	S9999		

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S9999	Continued From page 3 devices: walker. R1's (10/18/22) care plan includes fall potential related to unsteady gait, poor muscle strength, and status post fall. Interventions include assist resident in transfers and ambulation. R1's (10/18/22) fall risk assessment determined a score of 4 (if the score is 6 or greater, the resident should be considered high risk). Gait and Balance is marked normal "0" however R1's care plan affirms unsteady gait and poor muscle strength were identified. Requires assistive devices (walker) was also not selected (as warranted) therefore the score is incorrect. On 11/10/22 at 9:51pm, surveyor inquired about R1's (10/18/22) fall risk assessment. V8 (Restorative Nurse) stated, in part "Gait and balance they scored her zero as normal. Predisposing diseases, they scored her a zero." Surveyor inquired about R1's gait/balance. V8 responded, "During her assessment she did have good balance when standing with an assistive device, a walker." Surveyor inquired why the walker was not selected on the assessment. V8 replied, "I'm not sure what the nurse's thought process was when she was doing the assessment. Maybe she just made an error." Surveyor inquired what a score of 6 indicates. V8 stated, "That they are not a high fall risk." Surveyor inquired about R1's (10/19/22) fall prevention interventions which may prevent harm from falls. V8 stated, anticipate needs, maintain safe environment." Surveyor inquired what fall prevention intervention would be appropriate for a resident with prior falls resulting in harm. V8 responded, "I don't know if you're like referring to a landing pad, but we typically need to see if they are ambulatory because it's a tripping hazard"	S9999		

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however (1 person) physical assist was required to transfer R1.

R1's initial incident report states on 10/22/22, resident was noted on the floor on her side in front of her bed. Resident was assessed and noted alert to self, unable to make needs known and unable to follow commands. Doctor notified order received to send to ER (Emergency Room) for further evaluation. Resident was admitted with subarachnoid hemorrhage, hypernatremia and seizure.

On 11/10/22 at 11:17am, surveyor inquired about R1's (10/22/22) fall V10 (Director of Human Resource) stated "I was manager on duty. I was doing rounds and saw her (R1) on the floor. She (R1) was laying on her right side with her hands under her head, it looked like she was sleeping. She was a little further than the bed, she may have been walking. She responded when I asked her if she was ok, she said yes." Surveyor inquired if floor mats were in use V10 replied "I cannot remember. I ran in the room pressed call light and the CNA (Certified Nursing Assistant) came with a cup of water. He (V9/CNA) said I just left her on the bed and brought water for her. I called for the Nurses." Surveyor inquired if R1 was transferred to the hospital immediately V10 stated "I left when the Nurses arrived" and affirmed she was unsure.

On 11/10/22 at 11:35am, surveyor inquired about R1's functional status prior to (10/22/22) fall V9 (CNA) stated "Before the incident happened, I don't really work with her cause normally I work with section 5. It was the first time I seen her" and affirmed he was unsure. Surveyor inquired if V9 was aware of R1's required fall prevention interventions V9 responded "Nope, I know the

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S9999	Continued From page 5 commode was nearby." Surveyor inquired if V9 was aware that R1 was at risk for falls V9 stated "Normally the nurse will let you know if the persons a fall risk they'll tell you to mind this person. No, I wasn't told." Surveyor inquired about R1's (10/22/22) fall V9 responded "When I went around with the water, she was lying on the bed she didn't say she needed anything. I went down the hall to change somebody's diaper and then I was called up by (V10) to see what was happening in the room. When I came to the room, she was lying on the floor on the right side perpendicular to the bed. She was mumbling, I could only make out the word pee. (V10) called two other nurses there to come see what happened. We got her back to the bed and when the Nurse in charge of the section came on, she called the hospital and booked an appointment for her I think they came around 10:20am or so and took her out." Surveyor inquired if a floor mat was in use prior to R1's fall V9 replied "There was no floor mat." On 11/10/22 at 1:51pm, surveyor inquired about the importance of scoring fall risk assessments accurately. V12 (Medical Director) stated, "It is important to prevent the fall." Surveyor inquired about potential harm to a resident who sustains an unwitnessed fall. V12 responded, "The injury, broken bones or head injuries." Surveyor inquired about an appropriate time frame for transferring a resident (post unwitnessed fall) to the hospital for evaluation. V12 replied, "We always call 911 for every fall and evaluate that, as soon as 911 arrives the patient is being transferred." R1's (10/22/22) progress notes exclude the incident and/or calling 911.	S9999		

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R1's (10/23/22) progress notes (entered the following day) state on call doctor notified and gave order to send resident to hospital for evaluation. Writer called report to registered nurse at ER. Ambulance notified gave estimated time of arrival 20 minutes [911 notification and/or actual time of these events were not documented].

On 11/14/22 at 1:56pm, surveyor inquired about R1's (10/22/22) incident. V15 (Licensed Practical Nurse) stated, "When I got that assignment (around 8-8:30am) the resident was in the bed. The RT (Respiratory Therapist) had said to me that she was off of her baseline (alert x1) not x3 her usual. I called the doctor to get a order for her to be sent out to the emergency room. I called ER to give report to the nurse. Then I called (Ambulance Service) to have her picked up, I told them that she had a reported fall and that she was off of her baseline." Surveyor inquired if 911 was called V15 responded, "No."

R1's (10/22/22) unusual occurrence report affirms the incident occurred at 8:30am.

R1's neurochecks were documented by facility staff from 8:30-10:15, therefore roughly 1 hour and 45 minutes elapsed before the transfer occurred.

R1's (10/22/22) history & physical states patient presents from nursing home after being found unresponsive on the floor next to bed. Patient arrived unresponsive. Seizure mostly left arm/leg shortly after arrival. Upon return from first CT (Computed Tomography) more seizure activity. Doctor requests CTA (Computed Tomography Angiography) head/neck but SAH (Subarachnoid Hemorrhage) pattern more likely traumatic.

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S9999	Continued From page 7 R1's (10/22/22) Neurosurgery consult states she came to ED with SAH and a small left frontal contusion without significant mass effect or midline shift. Repeat head CT shows worsening hemorrhage: massive enlargement of left frontal contusion encompassing the speech area causing moderate mass effect 6-7 millimeters midline shift. Patient is medically unstable for surgery and the prognosis even with surgery remains very poor. R1's (10/25/22) Certificate of Death affirms death occurred in a hospital (inpatient). Cause of Death: subarachnoid hemorrhage, congestive heart failure. R3's (10/7/22) BIMS (Brief Interview Mental Status) determined a score of 6 (severe impairment). R3's (10/7/22) functional assessments affirms (2 person) physical assist is required for bed mobility and transfers. R3's (11/4/22) fall risk assessment determined a score of 10 (high risk). R3's (7/20/22) fall care plan states alert and oriented x2. Unsteady standing balance/coordination, poor safety awareness. Tripping hazard: g-tube tubing. Intervention; maintain call light within reach while in bed. On 11/7/22 at 1:30pm, R3 was lying in bed without call light access. R3's call light was dangling from the over bed light and out of reach. On 11/7/22 at 1:35pm, surveyor inquired about the location of R3's call light V 4 (CNA) entered	S9999		

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S9999	Continued From page 8 the room and stated "I didn't put it up there, it's up on the light. Maybe the cleaning lady put it up there or something." R3's bed was notably elevated (thigh high). Surveyor inquired if R3's bed was in the lowest position. V 4 stated, "No, it was kinda up the way I had it" and proceeded to lower the bed. Surveyor subsequently inquired about R3's required fall prevention interventions V 4 stated, "lower bed. I never seen a mat in there. I never seen bolsters or anything it's just her in the bed." R2's (10/5/22) BIMS (Brief Interview Mental Status) determined a score of 99 (unable to complete interview). Cognitive skills for daily decision making; severely impaired. R2's (10/5/22) functional assessments affirms (2 person) physical assist is required for bed mobility and transfers. R2's (10/21/22) fall risk assessment determined a score of 14 (high risk). R2's (8/19/19) fall care plan states alert and oriented x2 with confusion. Poor standing balance/coordination. Intervention: maintain call light within reach while in bed. On 11/7/22 at 1:11pm, surveyor inquired about R2. V3 (CNA/Certified Nursing Assistant) responded, "She's not able to walk" and affirmed (R2) is somewhat confused. R2 was subsequently observed lying in bed without call light access. Surveyor inquired about the location of R2's call light. V3 stated, "It's right here on the table, it's supposed to be connected to her" then placed the call light button within reach. R2 responded, "Where did you find that at?" (Referring to the call light). V3 replied, "On the	S9999		

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S9999	Continued From page 9 table." Surveyor inquired about R2's required fall prevention interventions. V3 stated, "She got the landing pads." R4's (8/22/22) BIMS (Brief Interview Mental Status) determined a score of 3 (severe impairment). R4's (8/22/22) functional assessments affirms (2 person) physical assist is required for bed mobility and transfers. R4's (2/22/22) fall risk assessment determined a score of 10 (high risk). R4's (10/19/21) fall care plan states alert and oriented x1. Poor muscle strength. Intervention: provide personal alarms while resident is in bed or up in chair. On 11/7/22 at 1:50pm, R4 was lying in bed. A large mattress was adjacent R4's right side of bed however a floor mat on the left side of the bed was absent. On 11/7/22 at 1:56pm, surveyor inquired about R4's fall prevention interventions V7 (CNA) stated "Use the belt to pull her up and extra bed to save her (referring to the large mattress on the floor). Surveyor inquired if there was a floor mat on the other side of R4's bed. V7 responded, "No." Surveyor inquired if R4 has a history of falls. V7 replied, "That one, I'm not sure. I'm never permanent on this floor." R4 was subsequently assessed however an alarm was not in use. The fall occurrence prevention policy (revised 8/16/21) states a fall risk form will be completed on all residents upon admission readmission, quarterly, annual, post fall and on significant	S9999		

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change of condition. It includes a fall history and a list of risk factors. The main purpose of which is to prevent injury from falls. A resident identified being at risk for fall shall have a potential for fall care plan addressing risk for fall. Plan of care with goals and intervention will be communicated to staff.

B. Based upon record review and interview the facility failed report a serious injury to IDPH (Illinois Department of Public Health) within regulatory requirements for one of four residents (R1) reviewed for falls. R1 expired (10/25/22) due to subarachnoid hemorrhage.

Findings include:

R1's (10/22/22) BIMS (Brief Interview Mental Status) determined a score of 14 (Cognitively Intact).

R1's initial incident report states on 10/22/22, resident was noted on the floor on her side in front of her bed. Resident was assessed and noted alert to self, unable to make needs known and unable to follow commands. Doctor notified order received to send to ER (Emergency Room) for further evaluation. Resident was admitted with subarachnoid hemorrhage, hypernatremia and seizure. R1's fax cover sheet submitted to IDPH includes date 2/11/2013 [9 years prior to the incident].

On 11/9/22 at 1:39pm, V11 (IDPH Clerical) affirmed R1's (10/22/22) initial report was submitted to IDPH via facsimile on 10/24/22 [2 days after the incident].

R1's progress notes state (10/22/22) 3:49pm, resident is being admitted to (hospital) with

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S9999	Continued From page 11 diagnosis brain bleed which affirms the facility was aware of R1's injury on 10/22/22. R1's (10/25/22) Certificate of Death includes Cause of Death: subarachnoid hemorrhage. On 11/10/22, at 11:57am, surveyor inquired about the regulatory requirements for incidents resulting in serious injury V2 (Director of Nursing) stated "Anytime we have a fall with injury we have 2 hours to report to IDPH." The fall occurrence prevention policy (revised 8/16/21) states the department (Illinois Department of Public Health) will be notified of a fall incident with serious injury. (A)	S9999		