STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014856	A. BUILDING: _____ B. WING _____	C 12/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA AT WINDSOR PARK	2649 EAST 75TH ST CHICAGO, IL 60649

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S 000	Initial Comments COMPLAINT INVESTIGATION 2289733/IL154092	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 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 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest	S9999	Attachment A Statement of Licensure Violations	

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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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing 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 Requirements were not met evidenced by:

Based on interview and record review, the facility failed to develop and implement a plan of care and supervision to prevent falls for a resident that was assessed as a high risk for falls. This failure resulted in 1 of 3 residents (R1) reviewed for falls, falling while left unattended and sustaining a fractured hip requiring an ORIF (Open Reduction Internal Fixation) for right hip fracture.

Findings Include:

R1 was admitted to the facility on 11/05/22 with

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diagnosis not limited to Osteoarthritis, Abnormalities of Gait and Mobility, Weakness, Heart Failure, Essential (Primary) Hypertension, Major Depressive Disorder, Transient Alteration of Awareness, Displaced Fracture of Base of Neck of Right Femur, Subsequent Encounter For Closed Fracture with Routine Healing, Seizures, Pain in Right Hip, End Stage Renal Disease, Cognitive Communication Deficit and Lack of Coordination. R1 MDS (Minimum Data Set) Section C Cognition BIMS (Brief Interview for Mental Status) score of 11 indicating moderately impaired.

On 12/20/22 at 01:18 PM, V7 (Nurse Practitioner) stated "R1 used a wheelchair, was very weak prior to the fall and was not eating. R1 has Dialysis on Monday - Wednesday - Friday. R1 need to be seated and taken to places. R1 was ambulating by herself, that was on a Monday. R1 did not normally ambulate by herself and cannot ambulate by herself because R1 is too weak. The facility made me aware R1 was in the hallway. R1 is never in the hallway by herself, R1 is always in the room. R1 needs supervisor. We cannot control the residents; they are told to wait for the help, but people do what they do. If R1 had waited for help to go wherever she (R1) wanted to go the fall could have been avoided."

On 12/20/22 at 2:21 PM, V23 (Certified Nurse Assistant) stated "R1 requires cueing."

On 12/20/22 at 2:33 PM, R1 was observed lying in bed with a dressing to right hip. R1 stated "I fell trying to sit in my wheelchair. I was pushing the wheelchair walking down the hallway when I started feeling dizzy and felt myself falling. I tried to sit in the wheelchair, but I fell and broke my leg. I had to have surgery. I was supposed to

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have someone with me. The person that was with me was doing so many other things. I was trying to go to my dialysis."

On 12/21/22 at 10:20 AM, V9 (Certified Nurse Assistant/Dialysis Transporter) stated "R1 go to Dialysis on Monday - Wednesday - Friday. I let the residents know that I will be back to get them. I have to escort the residents to dialysis. The staff would get R1 up in the wheelchair. R1 uses the big brown recliner but before the fall R1 was in a wheelchair. I went to R1 room and told R1 that I will be right back. The next thing I know they said R1 would be going to the hospital. When R1 fell R1 was in the hallway kind of the middle of the hall. I pushed R1 there because I was going to get another resident at that time. R1 could self-propel the wheelchair. R1 got up and start walking, pushing her (R1) wheelchair. Therapy said R1 was not supposed to ambulate on her (R1) own. I have no knowledge of R1 having any other falls. When I went back to R1 she said she fell. I can take ambulatory residents and residents in the wheelchair to dialysis at the same time. Now we use a mechanical lift to transfer R1 and the dialysis chair."

On 12/21/22 at 11:14 AM, V13 (Restorative Nurse) stated "Prior to R1 fall R1 was supervision with ADL (Activities of Daily Living) care and transfers. The aides would give R1 the wash basin and clothes. I am not sure if R1 was walking long distances or able to transfer self. Based on the MDS (Minimum Data Set) for Locomotion dated 11/11/22, R1 was able to walk with supervision, it only occurred once or twice with one-person physical assist. Outside of the room basically R1 had someone to walk with and assist with walking and that occurred only once or twice that someone assisted R1 in the corridor.

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R1 was transported in a wheelchair. On 11/05/22 the Fall Risk assessment is a 6, anything 5 or above is considered a high fall risk. The Interventions are basically monitoring unless a resident has a fall, and we would not put anything in place besides monitoring. On 11/28/22 I am not sure if R1 medications changed and there is a diagnosis of depression that raised R1 fall score 11. All residents are considered a fall risk and should have at least one or two interventions to ensure the call light in reach and if they walk with an assistive device make sure it is within reach. Other interventions are the bed in lowest position and bed brakes are locked. All of the interventions are dated after R1's fall. R1 should have had more fall interventions on the care plan prior to the fall. She should have at least had those interventions on the care plan. The only intervention on R1 care plan prior to the fall was to anticipate the resident's needs."

On 12/21/22 at 11:58 AM, V14 (Certified Nurse Assistant) stated "R1 was able to ambulate prior to fall. The day R1 fell R1 was sitting outside her (R1) door waiting for V9 (Certified Nurse Assistant/Dialysis Transporter) to come pick her (R1) up for dialysis. R1 was in the hallway by her (R1) door by herself. The residents said that R1 is on the floor, and we ran to see what was going on."

On 12/22/22 at 8:25 AM, V18 (Certified Nurse Assistant) stated "I was one of the care givers on the floor the day R1 fell. R1 was trying to walk herself to dialysis when V9 (Certified Nurse Assistant/Dialysis Transporter) usually take R1 down to dialysis. I saw R1 on the floor and went to assist R1 up in the wheelchair."

On 12/22/22 at 9:24 AM, V20 (Occupational

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Therapist) stated "R1 decision making is poor and has a memory deficit. Therapy never approved R1 to walk and never issued a walker. R1 walk with staff only and use a wheelchair. R1 endurance is poor, cardiopulmonary endurance, shortness of breath and is unable to walk. Because of R1 endurance R1 was given a wheelchair. We do not tell residents to use a wheelchair to ambulate. R1 had Right knee pain and poor safety awareness."

On 12/22/22 at 9:31 AM, V21 (Physical Therapy Assistant) stated "We never instructed R1 to use a wheelchair to ambulate. R1 has a history of falling prior to admission and should always be supervised when up."

On 12/22/22 at 9:58 AM, V5 (Support to the Director of Nursing) stated "I do not know why R1 care plan is like that, to anticipate resident needs. For the Fall risk anything above a 5 is a high fall risk. A care plan is needed in order to know how to care for the resident. If it is not documented, it is not done."

On 12/22/22 at 10:35 AM (Director of Nursing) stated "I was informed R1 fell and started a fall investigation. R1 told to me she (R1) was ambulating behind the wheelchair and fell. R1 complained of pain and was sent out that is when we found about the fracture. I believe R1 transporting was with assistance and R1 was told she (R1) was not supposed to be ambulating. R1 was transported in a wheelchair. When a resident is admitted they have to be evaluated. When I saw R1, she (R1) was always in a wheelchair or dialysis chair. `R1 fall care plan was initiated on 11/06/22. The only one intervention I see on the care plan dated 11/06/22 is anticipate and meet the resident needs. The Fall assessment dated

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S9999	Continued From page 6 11/22 has a score of 6. Total score of 5 or above is a high fall risk. If we have an evaluation and they are a high fall risk anticipate and meet the resident needs is not considered resident centered for R1 personal needs." Initial Reportable dated 12/02/22 document in part: upon rounding was noted on floor in hallway. Resident complained of right leg pain. Resident sent to the Emergency Room for further evaluation. Resident admitted to hospital with diagnosis of right lower leg fracture with post ORIF (Open Reduction Internal Fixation). Final Reportable dated 12/09/22 document in part: Resident experienced fall after ambulating with wheelchair up in hallway against therapy recommendations. Fall Statement dated 11/28/22 document in part: I V9 (Certified Nurse Assistant/Dialysis Transporter) spoke with resident to let her (R1) know I will be back to transport her (R1) dialysis. Notes dated 11/28/22 document in part: Resident stated she was walking behind her wheelchair on her way to dialysis and fell. Resident was informed the dialysis aide was coming to transfer her to dialysis but felt she was strong enough to walk herself using the wheelchair as support. Focus: Care Plan document in part: R1 is at risk for falls d/t (Due/to) unsteady gait as evidenced by requiring extensive assist x's 1 staff for transfers. Actual Fall: 11.28.22 Date Initiated: 11/06/22. Goal: The resident will be free of minor injury through the review date. Date Initiated: 11/06/22. Intervention: W/C (Wheelchair) brakes locked when sitting in w/c Date Initiated: 12/15/22 All staff o -Bed in low position when in bed Date Initiated: 12/15/22 All staff o -Ensure bed brakes	S9999		

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S9999	Continued From page 7 are locked Date Initiated: 12/15/22 All staff o Anticipate and meet the resident's needs. Date Initiated: 11/06/22 All staff o Ensure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Date Initiated: 12/15/22 o Resident is currently receiving therapy and was informed to allow staff to assist in transferring. Resident was informed the dialysis aide was coming to transfer her to dialysis but felt she was strong enough to walk her self-using w/c as support. Resident was sent out to the hospital for further evaluation of rt. leg. Upon return resident will be educated to allow staff to transfer her and assist when needed. Resident to continue to work with Therapy and follow plan of care. 11.28.22 Date Initiated: 11/28/22. Care Plan document in part: The resident has an alteration in musculoskeletal status r/t (Related /to) fracture Date Initiated: 12/02/22. MDS (Minimum Data Set) Section G Functional Status dated 11/11/22 document in part: Mobility Devices Z. None of the above were used. B Transfer- Limited assistance, one-person physical assist. D. Walk in corridor- Activity occurred only once or twice, one-person physical assist. Progress note dated 11/28/22 12:40 PM document in part: *Fall Note Text: Resident noted laying on floor in hallway on right side of body alert and oriented times 4. Resident stated she (R1) was pushing her (R1) wheelchair heading to dialysis and she (R1) fell. Resident complains of pain and decreased movement to right leg. Resident noted with edema to right lower extremity. New orders given to send resident to hospital for evaluation.	S9999		

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S9999	Continued From page 8 Progress note dated 11/28/22 12:49 PM, document in part: Transfer Note: R1 Most Recent Admission: 11/05/2022 23:07 Manual Wheelchair. Ambulates with assistive device, Falls Progress note dated 11/28/22 1:00 PM (13:00) document in part: *Fall Risk Evaluation: This evaluation is being completed related to: post fall evaluation. Fall Risk Score is: 11 Fall risk scored above 5, resident is at a HIGH risk for falls. Progress note dated 11/28/22 4:18 PM (16:18) document in part: Fall in her room, injured R (Right) leg. HPI History/Physical): Pt (Patient) seen today for a fall follow up, pt. reports she (R1) injured her R leg, has significant amt (amount) of pain. Pt sent to ER (Emergency Room). Progress note dated 12/01/22 3:20 PM (15:20) document in part: *Health Status Note: Writer spoke with nurse on unit regarding follow up with resident. Nurse state resident is post ORIF (Open Reduction Internal Fixation) for right lower leg fracture. Progress note dated 12/02/22 9:31 PM (21:31), document in part: *Admission Summary: Resident has dressing noted to right hip with staples in place. Progress note dated 12/05/22 10:19 document in part: CHIEF COMPLAINT: Impairment of ADLs (Activities of Daily Living) and mobility 2/2 seizure disorder with muscle weakness and difficulty with functional mobility. The patient returned back to the facility. R1 had a dressing on her right hip with staples. She underwent ORIF for RLE (Right Lower Extremity) fracture. PHYSICAL EXAMINATION: 2. Neuromuscular weakness. 3.	S9999		

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S9999	Continued From page 9 Gait Abnormality. 6. Fall risks. Progress note dated 12/06/22 12:43 PM, document in part: Readmission after hospitalization for unwitnessed fall. Pt reported severe pain all over upon arrival to ER, diagnosed with R (Right) femoral fracture. Pt had Ortho surgery to repair completed on 11/30., stabilized and transferred. Progress note dated 12/08/22 11:42 AM, document in part: R1 had a dressing on her right hip with staples. R1 underwent ORIF for RLE fracture. Interval History: The patient was seen and examined today. Sitting up in wheelchair, non-ambulatory. Following her (R1) right hip precautions per nursing staff. Fall Risk Evaluation dated 11/05/22 document in part: 2. Resident have generalized weakness and limited/poor mobility. 8. Resident is receiving Anti-Epileptic. 10. Resident receiving 9 or more meds. Fall risk score: 6. Fall Risk Evaluation dated 11/28/22 document in part: 2. Resident have generalized weakness and limited/poor mobility. 7. Resident have symptomatic depression. 8. Resident is receiving Anti-Epileptic. 9. Resident receiving Benzodiazepines. 10. Resident receiving 9 or more meds. Fall risk score: 11. Hospital Records dated 11/28/22 document in part: Principal/Secondary Diagnosis: Fall, Femoral Head Fracture. Procedure(s) Performed 11/30/22 - right cephalomedullary nail. Chief Complaint: unwitnessed fall, Right femoral head fracture. History of present illness: Presents with acute right femoral following unwitnessed fall. R1 attempted to walk unassisted with her (R1)	S9999		

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S9999	Continued From page 10 wheelchair. R1 reported chest pain and dyspnea that began that day. X-ray femur 2 Views. Findings: Pelvis: There is a fracture at the base of the femoral head. The fracture is associated with apex lateral angulation between the proximal femur and femoral shaft. Impression: Acute right femoral basicervical fracture. Policy: Titled "Notification of Changes Guideline" effective date 11/28/17 document in part: Nurses and other care staff are educated to identify changes in a resident's status and define changes that require notification of the resident and/or their representative, and the resident's physician, to ensure best outcomes of care for the resident. Objective The intent of the guidelines is to provide appropriate and timely information about changes relevant to a resident's condition or change in room or roommate to the parties who will make decisions about care, treatment, and preferences to address the changes. 6. Update the resident's care plan, transcribe, and implement provider's orders. 7. Communicate the changes to the rest of the care team and inform the supervisor. Titled "Fall Evaluation Guideline" effective date 11/28/17 document in part: Purpose: to consistently identify and evaluate residents at risk for falls. To prevent and reduce injuries related to falls. Falling is an unintentional change in position coming to rest on the ground floor or onto the next lower surface. Falls include any fall regardless which setting it may have occurred. The intent of this guideline is the ensure this facility provides an environment that is free from hazards over which the facility has control and provides appropriate supervision to each resident	S9999		

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S9999	Continued From page 11 as identified through the following process: I. Identification of hazards and risks, II. Evaluation, III. Implementation, IV. Monitoring, V. Analysis. A fall evaluation is used to identify individuals who have predicting factors for falls. This evaluation is completed upon admission, quarterly, annually and with a significant change in condition. Fall prevention is achieved through an IDT (Interdisciplinary Team) approach of managing predicting factors and implementing appropriate interventions to reduce risk for falls. Involve Interdisciplinary team on: Need for supervision, Development, and implementation of interventions to reduce accidents. Fall Management: Develop and implement interventions, Ongoing evaluation of effectiveness of interventions. Residents who are evaluated as being at risk for falls will be identified and individualized fall precautions will be developed for each resident. Purpose: 3. To prevent or reduce injuries related to falls. 6. Individualize interventions for each resident. Guidelines for Evaluation May include Procedure: 2. If the evaluation finds the resident at risk, implement resident specific interventions/precautions. 3. Initiate, review and revise the fall care pan as appropriate, with new or discontinued interventions. 4. The Interdisciplinary team (IDT) will evaluate the resident's fall risk in conjunction with the care plan to develop, review and revise at a minimum quarterly with increased frequency as needed to reduce resident falls. 8. All residents identified as at risk for falls will be reviewed for individualized interventions. Titled "Care plan Standard Guideline" dated 11/28/17 document in part: the resident care plan will incorporate risk factors identified in preadmission assessment, hospital records and admission evaluations, with changes in condition,	S9999		

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S9999	Continued From page 12 reviewed and updated quarterly. 2. The interdisciplinary team will continue develop a resident/client centered care plan that includes problem, need, or strength statements, measurable goal statements and resident/client specific interventions. 4. Interventions should be specific to reflect specific goal. The intervention should be individualized to the resident. 6. The care plan is to be revised to reflect the current status of the resident. 7. The care plan will be reviewed throughout the resident's stay upon admission, quarterly and with change in condition. The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes. (A)	S9999		