STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008460	A. BUILDING: _____ B. WING _____	C 09/06/2023

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SELFHELP HOME OF CHICAGO	908 WEST ARGYLE STREET CHICAGO, IL 60640

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S 000	Initial Comments Complaint Investigation 2385324/IL161429	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)6) 300.1220 b)3) 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 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

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.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to follow their fall protocol, failed to provide adequate supervision, and failed to develop specific fall interventions for 1 (R1) of 3 residents

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S9999	Continued From page 2	S9999		

reviewed for falls. These failures resulted in R1 sustaining a closed displaced fracture of left femoral neck, and surgical arthroplasty of particle hip.

Findings inlude,

R1's clinical record documents R1 is a 68-year-old with the medical diagnoses of fracture of part of neck of left femur subsequent encounter for closed fracture with routine healing, aftercare following joint replacement surgery, dementia, Parkinson's Disease, urinary incontinence, type II diabetes, major depression disorder, hypertensive heart disease, moderate protein calorie malnutrition, adult failure to thrive, and delirium.

R1's Minimum Data Set (MDS) Brief Interview for Mental Status (BIMS) score, dated 4/3/23, of 10 indicates R1 is mildly cognitive impaired. MDS Section G (4/3/23) documents R1 needs extensive assist with toileting needs.

R1's care plan indicated:
(1) R1 had fall on 4/16/23 - R1 has an actual fall and was sent to the hospital via 911 (No fall intervention in place for 4/16/23 fall).
(2) R1 is a fall risk (4/3/23) related to gait and balance problems.
(3) R1 have impaired cognitive function, thought process (4/13/23). Intervention: to reorientate and supervise as needed.

R1's discharge hospital document, dated 4/22/23, indicated: "Reason for visit"-Reported (R1) fell with left hip pain and inward turning. "Diagnosis"-Closed displaced fracture of left femoral neck due to fall. Surgical repair (arthroplasty partial

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S9999	Continued From page 3 hip). R1's IDPH Facility Final Report, dated 4/21/23, documents: "Around 3:13 PM, staff heard a loud call for help. Staff observed (R1) lying on her left side. (R1) said she stood up to go to the toilet. (R1) complained of pain in her left hip. (R1) was assisted back to bed with 2 persons assist. Physician made aware of the fall and findings, gave order to send (R1) to hospital for further evaluation via 911. (R1) was admitted with a diagnosis of closed displaced fracture of the femoral neck." On 9/5/23 at 3:28 PM, V8 (Certified Nursing Assistant) stated, "(R1) is a pleasant resident, alert and oriented to self, place, but she is confused and forgetful. (R)1 would often try to stand up and walk to the bathroom. (R1) frequently wants to go to the bathroom. (R1) needs frequent monitoring especially when she is in her room. On 4/16/23 around 1pm, I was picking up all the lunch trays. I went into (R1's) room, and she was sitting in her wheelchair. I picked up her food tray. I few minutes later, I heard a loud sound like something fell, then heard (R1) yelling out for help. (R1) told me that she was trying to go the bathroom. (R1) was lying on her side. (V4, (Registered Nurse]) came in the room and asked(R1) some questions. (R1) just kept yelling out in pain, then (V4) instructed me and (V9, Certified Nursing Assistant) to help (R1) off the floor. I rolled (R1) off her side to her back. Me and (V9) both held on to (R1's) pants and underneath (R1's) arms to stand her up, but we were supporting her, then sat her on the bed. (R1) was on the in sitting position. (V4) left to call the doctor and (V9) left to pick up the other food trays. I stayed with (R1) because she would	S9999		

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S9999	Continued From page 4	S9999		

not stop yelling out in pain, until the ambulance got there. After (R1) left the facility, I thought about what happened. I should not have got (R1) off the floor; she should have stayed on the floor until 911 arrived. I got (R1) up off the floor because the nurse told me to. I figured she broke something because (R1) would not stop yelling out in pain."

On 9/5/23 at 1:57 PM, (V4, Registered Nurse) stated, "I've been working here for 3 years but, I have been a Registered Nurse for over 30 years. (R1) was alert and oriented with forgetfulness. (R1) needs close supervision because she will get up and try to walk alone. (R1) forgets she need assistance. I try to make frequent rounds, but I have other residents to take care too. On 4/16/23, around 1pm, I was at the nursing station and heard (R1) call out for help. I went into (R1's) room, and she was on floor lying on her left side next to the bed. (R1) said she wanted to go to the toilet. First, I checked (R1's) head and there was no injury noted. I asked was she hurt; she said 'No, I just want to go the bathroom.' (R1's) legs looked straight. (R1) said she was having pain in her leg, but (R1) has chronic pain, she always says she's in pain. I did not see any bruising, or open areas on her skin, and (R1) was alert and talking, but was wet with urine. (V8) and (V9) came and used a linen sheet, placed it under (R1) and lifted her off the floor into bed. Then I went and phoned (V10, R1's Physician), but I was not able to speak with him. I phoned the Director of Nursing (V3); she instructed me to call 911 and send (R1) to the hospital for evaluation. I returned to (R1's) room and (R1) said her hip was hurting. I gave her acetaminophen. 911 arrived and (R1) was transported to the emergency room. There is a mechanical lift on

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S9999	Continued From page 5	S9999		

every floor. I should have used the mechanical lift, to prevent further injury, but I thought it would have caused (R1) more pain. The best thing to do was to leave (R1) on the floor."

On 9/5/23 at 2:33 PM, V6 (Nursing supervisor) stated, "I've been working here for 26 years, and have been a Registered Nurse over 30 years. I not working the day (R1) fell. After I reviewed documents, (R1) fell trying to go to the bathroom. The nurse completed full body assessment and phoned the physician, received an order to send (R1) to the hospital per 911. The fall protocol is to complete head to toe body assessment, check for pain location, and any change of range of motion from the resident's baseline. If a resident is yelling out in pain, the nurse is it leave the resident on the floor and call 911 to prevent further injury. If the nurse assessment reveals no injury, the resident is assisted up off the floor using a mechanical lift to ensure there was not an un-noted injury. If a resident's leg is turned inward, that is a sign of a hip injury, and the resident should not be moved. When a resident falls, there should be a fall intervention placed in the resident's care plan. The intervention hopefully prevents the resident from falling again. I did not know (R1) that well; according to her MDS BIMS score, R1 is cognitively impaired, along with the diagnosis of Parkinson's disease. (R1) would need close monitoring and frequent reminders. The facility is not able to provide one to one 24 hours per day care just to one resident."

On 9/5/23 at 2:31 PM, V5 (MDS Coordinator/Registered Nurse) stated, "I been working here for one-year as a Minimum Data Set (MDS) coordinator. I place in a new fall

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S9999	Continued From page 6 intervention when a resident fall with the date of the fall. (R1) had a fall on 4/16/23, due to (R1) trying to go to the restroom. Fall interventions were to send (R1) to hospital via 911, neurological check, monitor for bruising, pain, change in health status, and continue the same interventions per (R1's) admission. Upon (R1's) readmission post fall back into the facility, the interventions remained the same. No, I did not place a new intervention in (R1) care plan related to 4/16/23 fall; I re-enforced the same initial intervention prior to (R1's) fall." On 9/6/23 at 10:28 AM, V10 (R1's Former Physician) stated, "I received a phone call regarding (R1's) fall in April, where she went to the hospital for further evaluation. When I spoke to the nurse, (R1) was on her way to the hospital. I usually recommend for the resident to stay on the floor and allow 911 to maneuver and transfer the resident off the floor to prevent worsening of injury. I was not present during the fall. In some cases, it is safe to move the resident if the resident slid to the floor or if there was no shortening of one leg, however, I'm not orthopedic. I cannot say moving (R1) from the floor to the bed caused (R1's) fracture to become dislocated or worse, because I was not there. Moving anyone after a fall could potentially cause an injury or make the injury worse. The standard practice is to attend to the resident on the floor and call 911 to transfer and transport the resident to prevent further injury. (R1) did have decline with her cognition over the length of her stay. Any resident that has deficit in their cognition would require close monitoring and supervision as possible. The nurses have other residents to take care of."	S9999		

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S9999	Continued From page 7 On 9/5/23 at 2:46 PM, V7 (Physical Therapist) stated, "I am familiar with (R1); I was her physical therapist. (R1) was alert and oriented, but confused and forgetful. (R1's) thought process was slow due to Parkinson's disease. (R1) was not reliable to use the call light for assistance due to her memory. (R1) needs close supervision. (R1) often wanted to go to the bathroom; while in therapy, I offered (R1) the bathroom before and after therapy. If not, she will try to go alone. (R1's) initial physical therapy evaluation was on 3/28/23. (R1) needed assistance with transfers from and bed, chairs, and toilet at from 25-50% staff assistance. (R1) was able to walk 35 feet with front wheel walker with contact guard assistance, someone had to be present when (R1) used the walker. I noticed a decrease in (R1's) cognition on 4/3/23, and informed nursing." Fall Incident Protocol, dated 4/23, documents -Resident is automatic High Fall Risk with medical diagnosis of Dementia, Parkinson's Disease. The staff should anticipate the patient's needs by frequent rounding, offering assistance in toileting and transfers. -Any staff member who found the resident on the floor or witness the incident must not attempt to move the person until charge nurse properly assess the person - Falls management investigations post fall tool must be completed by the nurse. Based on the outcome of the report, appropriate interventions and management shall be implemented to reduce falling or minimize the injury from falling. Transfer and Lift Care [No Date] -Injuries incidents- patient falling off bed or chair and staff manually pushed, pull, lifted, positioned patient back onto bed, or patient fell on floor and	S9999		

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S9999	Continued From page 8 nurses manually lifted patient from floor without the use of portable mechanical lift (A)	S9999		