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 |
|---|---|---|---|
| | IL6006696 | A. BUILDING: ______ B. WING ______ | C 08/02/2023 |

NAME OF PROVIDER OR SUPPLIER: NORWOOD CROSSING

STREET ADDRESS, CITY, STATE, ZIP CODE: 6016 NORTH NINA AVENUE, CHICAGO, IL 60631

| (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 |
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| S 000 | Initial Comments<br><br>Facility Reported Incident of 5-8-2023 IL/159940 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610a)<br>300.1210a)<br>300.1210b)5)<br>300.1210d)6)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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. Restorative measures shall include, at a minimum, the following procedures:

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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.

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These requirements were not met as evidenced by:

Based on interviews and record reviews the facility failed to provide adequate supervision and failed to follow their fall policy by failing to develop and implement indivualized fall prevention interventions for one of three residents (R1) reviewed for falls on the sample list of three. This failure resulted in R1 sustaining a closed displaced fracture of the left femoral neck requiring surgical intervention.

Findings Include:

R1's clinical record documents: R1's medical diagnosis of displaced intertrochanteric fracture of left femur, Alzheimer's disease, dementia with behavior disturbances, anxiety, essential hypertension, unsteadiness on feet, reduced mobility, need for assistance with personal care, and history of falling.

R1's minimum data set [MDS] assessment Brief Interview Mental Status score= 99, which indicates R1 is severely cognitively impaired. R1's MDS section G documents R1 is total dependence for self-performance. Surface to surface transfer R1 is not steady, only able to stabilize with staff assistance. MDS section GG documents R1 is dependent with toileting needs.

R1's care plan indicated R1 had falls on the following dates:

1/7/23- R1 was observed sitting on the bathroom floor. R1 said she lost her balance. Intervention: Physical and occupational therapy.

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4/29/23-R1 was observed on the floor near the dining room laying on her left side, with the walker on the floor next to R1. Right thumb swollen. Intervention: X-ray of right thumb and physical and occupational therapy.

5/8/23-R1 was observed in another resident's room on the bathroom floor. 911 was called. R1 was admitted with diagnosis of a closed displaced fracture of the left femoral neck, left hip ORIF [open reduction and internal fixation] proximal femur peri-trochanteric fracture. R1 received surgical repair. Intervention: Physical and occupational therapy.

7/11/23-R1 observed on the floor in the hallway. R1 reported she fell and hit the back of her head. Intervention-start bowel and bladder program and will toilet her after meals and as needed.

The facility did not put any new interventions in place to prevent R1's falls.

R1's Fall Risk Assessment dated 4/29/23 documents:
- takes psychotropics,
- occasionally has urinary incontinence
- moving from seated to standing position R1 is not steady, only able to stabilize with staff assistance
- walking, R1 is not steady, but able to stabilize without staff assistance

R1's Facility reported incident final report form dated 5/15/23 documents:
Resident alert oriented with forgetfulness and confusion. Resident ambulates with a walker with unsteady gait. Resident able to make needs known and uses the toilet with assist. Resident with diagnoses of bilateral osteoarthritis of the

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| S9999 | Continued From page 4<br><br>knee, Alzheimer's disease, Osteoporosis, Anxiety, Depression, HTN (hypertension) and GERD (Gaston esophageal reflux). On 5/8/23 resident noted on the bathroom floor with the walker next to her after hearing resident calling for help. Full body assessment completed. No change in LOC (level of consciousness) with limited ROM (range of motion) to the left hip. Resident complaining of left hip pain. MD (physician) made aware and ordered the resident to transfer to ER (emergency room) for evaluation and treatment. Hospital completed x-ray of the left hip and revealed comminuted Basi cervical fracture of left femoral neck. Interview with the staff completed regarding the incident. Resident observed in the bathroom floor of another resident. The call light was not on, and resident used the toilet by herself. Resident did not ask or call for assistance. After the fall incident, resident noted confused and not able to give details of what happened. Resident not soiled and bathroom floor dry. Vitals remained stable. Resident's fall incident caused by her non-compliance of toileting herself without assistance and confusion. Plan of care will be updated upon resident's return to facility.<br><br>On 8/1/23 at 4:56 PM, V11 [Registered Nurse] stated, "On 7/11/23 I was (R1's) nurse. I made sure (R1) was in the dining room before I went on my break. I returned and (R1) had fallen in the hallway. The certified nurse assistant told me that she was in another room providing care when she heard (R1's) wheelchair alarm. The certified nurse assistant ran to the hallway, but it was too late, (R1) was on the floor. (R1) is confused and need close monitoring and reminders. (R1) also need to be taken to the bathroom after meals, but the certified nurse assistant was helping another resident. (R1) wanders around the unit all the | S9999 | | |

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time in and out of other resident's room, it's hard to keep up with (R1)."

On 8/1/23 at 2:45 PM, V12 [Licensed Practical Nurse] stated, "I was (R1's) nurse on 5/8/23. I was assisting another resident when I heard the other nurse yell out for help. I saw (R1) in another resident's bathroom on the floor crying out in pain holding her right hip area. I did not move (R1), and phoned 911. Physician, family, and director of nursing was made aware. (R1) is forgetful and wanders around the unit in other resident's room. Some of the nursing fall interventions is we have to monitor and supervise (R1) closely, and verbally re-direct her as much as possible, low bed, and keep the call light in reach."

R1's progress notes documents on 4/29/23 at 1:15 PM by V13 [Agency-Registered Nurse], found resident [R1] on the floor on her left side by the solarium [Dining room] with the walker laying by her side. Head to toe assessment done. v/s [vital signs] (blood pressure) 132/71 P [pulse] 67 T [temperature]-97.2 o2 sat [ oxygen saturation] 95@RA [room air] R [Respirations]18, range of motion rendered to both lower and upper extremities, no pain noted, no shortening noted on either extremity, right thumb slightly swollen. Resident [R1] complained of pain on the back of her head, head assessed-no bump nor swelling nor redness noted. LOC [level of conscious] intact, denies dizziness nor vomiting. Resident gotten up on the floor via Hoyer lift and sited back on the chair and taken in front of the nurse's station. Ice pack applied at the back of her head.

R1's progress notes dated 1/7/2023 3:40 PM documents, Resident [R1] noted sitting on bathroom floor, feet outstretched in front in seated position, res sitting on her buttocks.

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Resident wearing nonskid socks, resident's walker in front of her. Resident stated she "lost her balance". Resident assessed and no cuts or bruises noted. Denied hitting her head, no bump or redness noted. Res able to move all extremities WNL (within normal limits).

On 8/1/23 at 11:40 AM, V4 [Certified Nurse Assistant] stated, "I been working with (R1) since her admission to the facility. (R1) tries to get up out of her chair to use the bathroom. (R1) will tell staff if they are around that she has to go to the bathroom. I automatically take (R1) to the restroom when she gets up in the morning, before and after breakfast, lunch and one more time before I get off work. (R1) has not fallen with me, because I make sure she goes to the bathroom, and in closely monitored. (R1) wanders around the unit in and out of other resident's room."

On 8/1/23 at 11:46 AM, V5 [Registered Nurse] stated, "I been working here for 10 years, and familiar with (R1). (R1) needs close monitoring by nursing staff, because (R1) random wandering around the nursing unit in and out of other resident's room. I asked her was she trying to find her room, (R1) told me no. (R1) does not know to ask for help. Before her fall in May, she would use her walker to ambulate through the unit. Now (R1) is in a wheelchair and continues to wander the unit by propelling herself. Sometimes it's hard to keep up with (R1), when all the staff has other residents to take care of."

On 8/1/23 at 11:50 AM, V6 [Agency Registered Nurse] stated, "I am (R1's) nurse today. The last time I saw (R1) was around 8AM. (R1) ate breakfast and took her medication, then she went to therapy. I am not sure if she is back from

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therapy. When I received report this morning, the nurse told me (R1) was a high fall risk and need to make rounds on (R1) every two hours on the evening shift, not day shift. During the day shift she is okay. During the evening shift [3PM-11PM] (R1) has sun downing and need closely monitoring not now during my day shift."

On 8/1/23 at 1:02 PM, V2 [Director of Nursing/Fall Coordinator] stated, "I was the fall coordinator around March this year until June 2023. I hired a new fall coordinator, but I still oversee the fall incidents. I started last year in November 2023. (R1) is Spanish speaking, confused and impulsive getting up on her own. (R1) wanders around the nursing unit on her floor. On 7/11/23, (R1) fell in the hallway coming from the dining room after lunch. The nurse observed (R1) sitting on the floor next to her wheelchair. Fall intervention for 7/11/23 was to place (R1) on bowel and bladder program and after meals. (R1's) wheelchair alarm sounded, but staff was not close around. On 5/8/23 fall, (R1) fell around dinner time 5:30PM. The nurse heard (R1) yelling out for help. (R1) was in another resident's bathroom and complained of right hip pain, 911 was phoned. (R1) was transported to the emergency department. (R1) was admitted to the hospital for fracture and surgical repair. Upon (R1) re-admission to the facility, (R1) care plan was updated. The nursing intervention for 5/8/23 fall was physical therapy and occupational therapy to treat and evaluate. (R1) fell on 4/29/23 (R1) outside the solarium, which is the dining room, while ambulating with her walker. The fall intervention was physical therapy and X-ray of her right thumb, with negative results. (V8 - R1's Power of Attorney-Family Member] refused therapy because she wanted to save (R1's) therapy days. That was only fall intervention, also

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the nursing staff to supervise, and give verbal reminders. (V8) did not agree with the fall intervention, and I did not replace the fall intervention. Those were the only nursing interventions for 4/29/23 and 5/8/23 falls, honestly, I could not think of any more fall interventions due to (R1's) frequent falls. The staff continues to monitor (R1) by keeping her near the nursing station. The nurses and certified nurse assistances take care of other residents. In June (R1) was given a wheelchair and bed alarm, per the request of (V8). On 1/7/23 (R1) was observed sitting on the bathroom floor. (R1) said she lost her balance. Fall intervention was physical and occupational therapy. For 1/7/23 and 4/29/23 falls (V8) was notified of the fall interventions, and she declined both times. (V8) did not want physical therapy, because she wanted to save (R1's) therapy days. I did not know any other fall interventions to use for (R1)."

8/1/23 at 2:40 PM, V9 [Medical Director] stated, "I am the facility's medical director. I am familiar with (R1's) care. I was the physician phoned on 5/8/23 due to (R1's) fall and she complained of hip pain, I gave orders to send resident to the emergency department. (R1) did obtain a fracture. (R1) is forgetful with poor safety awareness and should be on the memory care unit. The nursing staff should provide supervision close as possible. The facility is not able to provide one-to- one care."

The facility Policy documents: Fall Protocol dated 6/20/23.
-Facility fall protocol is to decrease the number of falls and the severity of falls.
-The director of nursing and assistant director of nursing will review and investigate each fall.
- The director of nursing, assistant director of

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| S9999 | Continued From page 9<br>nursing, and restorative nurse will do periodic checks on all the units to ensure that interventions have been individualized for each resident and put in place.<br><br>A | S9999 | | |