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
	IL6002430	A. BUILDING: ______ B. WING ______	C 10/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERFORD CARE CENTER, THE	7445 NORTH SHERIDAN ROAD CHICAGO, IL 60626

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S 000	Initial Comments Facility Reported Incident of September 30, 2023 IL165206	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 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	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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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.

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 ensure a totally dependent resident requiring a two plus person assist for bed mobility

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was provided the necessary assistance by failing to obtain help from another staff during resident care, and the facility failed to ensure the care plan was revised for 1 (R3) of 4 residents reviewed for falls. This failure resulted in R3 falling from the bed and sustaining a closed displaced spiral fracture of the shaft of the right humerus.

Findings Include:

R3 has diagnoses not limited to History of Falling, Polyosteoarthritis, Chronic Pain, Displaced Spiral Fracture Of Shaft Of Humerus, Right Arm, Subsequent Encounter For Fracture With Routine Healing Personal History of Covid-19, Chronic Obstructive Pulmonary Disease With (Acute) Exacerbation, Acute and Chronic Respiratory Failure With Hypoxia, Acute and Chronic Respiratory Failure With Hypercapnia, Bipolar Disorder, Current Episode Mixed, Severe, With Psychotic Features, Type 2 Diabetes Mellitus With Hyperglycemia, Essential (Primary) Hypertension, Acute Embolism And Thrombosis of Right Popliteal Vein, Anxiety Disorder, Morbid (Severe) Obesity Due To Excess Calories, Hyperlipidemia, Type 2 Diabetes Mellitus With Diabetic Neuropathy, Major Depressive Disorder, Schizoaffective Disorder, Bipolar Type, Chronic Obstructive Pulmonary Disease, Asthma, and Senile Degeneration Of Brain.

R3's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 12, indicating moderate cognitive impairment.

R3's MDS, dated 09/21/23, documents: "Section G Functional Status: Bed Mobility: 4. Total dependence: 3. Two+ persons' physical assist. Transfer: 4. Total dependence: 3. Two+ persons' physical assist. Section H Bladder and Bowel:

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Urinary continence, 3. Always incontinent. Bowel Continence 3. Always incontinent."

MDS, dated 01/26/22, documents: Section G Functional Status: Bed Mobility: 3. Two+ persons' physical assist. MDS, dated 04/20/22, documents: Section G Functional Status: Bed Mobility: 3. Two+ persons' physical assist. MDS, dated 07/14/22, documents: Section G Functional Status: Bed Mobility: 3. Two+ persons' physical assist. MDS, dated 10/04/22, documents: Section G Functional Status: Bed Mobility: 3. Two+ persons' physical assist. MDS, dated 01/03/23, documents: Section G Functional Status: Bed Mobility: 3. Two+ persons' physical assist. MDS, dated 04/04/23, documents: Section G Functional Status: Bed Mobility: 3. Two+ persons' physical assist. MDS, dated 05/01/23, documents: Section G Functional Status: Bed Mobility: 3. Two+ persons' physical assist. MDS, dated 07/03/23, documents: Section G Functional Status: Bed Mobility: 3. Two+ persons' physical assist. MDS, dated 09/21/23, documents: Section G Functional Status: Bed Mobility: 4. Total dependence: 3. Two+ persons' physical assist. Transfer: 4. Total dependence: 3. Two+ persons' physical assist. Section H Bladder and Bowel: Urinary continence, 3. Always incontinent. Bowel Continence 3. Always incontinent.

R3's Progress note, dated 09/30/2023 at 21:38, documents: "During care, staff asked resident to turn to facilitate the diaper change, in the process resident made excessive turn that put half of the body (waist down) on the floor while upper body remains at the edge of the bed and both hands holding on to the rail and cabinet. When asked resident what happened, she said "I think I overturned myself and fell out of bed." Staff helped resident back to bed. Assessment made;

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ROM was compromised on both arms. Reported to physician, order was made to send resident to hospital to rule out fracture."

R3's Progress note, dated 10/01/23 at 14:35, documents: Nurses Note Text: "Complain of pain to the left and Right arm. Noted with a bruise and swelling on the Left hand. Right arm has a sling. Tramadol administered for pain with fair results. dx (Diagnosed) w (with)/ closed displaced spiral fracture of right humerus; splint/cast intact. - keep arm elevated as tolerated. Pt (patient) has a sling/cast on her right arm; states that she is in a bit of pain, 4/10."

R3's Incident Report Form IDPH (Illinois Department of Public Health) Notification, dated of Incident 09/30/23. Time of Incident 07:00 PM, documents: "Location of Incident: Resident's room. Resident is alert and oriented, states she overturned herself which caused her to a position placing the lower part of her body (from the waist down) on the floor while the upper body remained on the edge of the bed with both hands holding onto the rail and the bedside cabinet. (R3) was sent to the hospital for further evaluation due to compromised range of motion of both upper extremities. (R3) was seen and examined with diagnosis of closed spiral fracture of shaft of right humerus, initial encounter, closed fracture of right upper extremity, initial encounter. OT (Occupational Therapy) assessment completed, OT intervention 3x/week for 30 days to provide ADL (Activities of Daily Living) retraining. Resident has right arm sling that's worn at all times except during activities and care. Type of accident: Fall. Type of injury: Fracture."

R3's Root Cause Analysis, dated 10/01/23, documents: "During care staff asked the resident

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to turn to facilitate diaper change and, in the process, resident made excessive turn. Waist down/half body on floor. Verbalized that she (R3) overturned self and fell out of bed. Root Cause: 1. Overturned during bed mobility task."

Most recent documented weight dated 09/05/23 252.0 Lbs.

Care Plan documents in part: "(R3) is dependent on staff for meeting physical and emotional needs. (R3) has risk for an ADL self-care performance deficit. 10/02/23 Use of right arm sling for right arm pain/numbness. (R3) has limited physical mobility r/t (related /to) Weakness, L (left)/knee pain, DX.(Diagnosis) Asthma, COPD (Chronic Obstructive Pulmonary Disease), 01/14/21 resident reports 2 falls, 1) fell during transfer from bed to w/c (Wheelchair), reports slipped off bed, 2) transfer from w/c to toilet reports slid to floor, 01/21/21 reports fall, with staff assist was lowered to floor during transfer, reports while standing feet started slipping, 07/15/21 lowered to floor during transfer, legs weakened, abrasion R(Right)/upper back, 10/12/21 poor posture, poor positioning when up in w/c, 03/02/22 reports increased weakness, 2/10/23 decreased out of bed participation, caregiver dependency, total assist with ADL, 10/1/23 reports during care, made excessive turn and fell out of bed, sent to ER for evaluation. Intervention: 10/2/23 safety interventions: Staff to educate, review bed mobility support level, x2 staff assist with all positioning status, therapy for screening post fall for any changes, R/arm sling at all times, 04/26/23 safety interventions: x1-2 staff assist with ADL/mobility task, reclining chair, mechanical lift for mobility support, call light, assist rails."

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Side Rail, Safety Assessment dated 04/26/23 document in part: A. 3. The resident has a history of falls from bed. 4. The resident currently use assist rails for positioning or support. C. 3. Assist rails are indicated for safety to provide barrier to edge of bed."

After Visit Summary, dated 09/30/23, documents: "Diagnoses: Closed displaced spiral fracture of shaft of right humerus, initial encounter. Closed fracture of right upper extremity, initial encounter."

Side Rail, Safety Assessment, dated 04/26/23, documents: "A. 3. The resident has a history of falls from bed. 4. The resident currently use assist rails for positioning or support. C. 3. Assist rails are indicated for safety to provide barrier to edge of bed."

On 10/10/23 at 1:16 PM, V4 (Licensed Practical Nurse) stated, "(R3) uses a wheelchair and is incontinent. (R3's) fall from the bed was on the evening shift during patient care. (R3) is a two person assist with her care and uses the mechanical lift to transfer."

On 10/10/23 at 1:57 PM, V7 (Certified Nurse Assistant) stated, "(R3) is totally dependent, a two person assist with care, turning and repositioning. I was not taking care of (R3) when she fell out of the bed."

On 10/10/23 at 2:25 PM, V9 (Certified Nurse Assistant) stated, "I was not here when (R3) fell out of the bed. (R3) is sometimes a 1 person assist. Most of the time, I can handle (R3) on my own. We transfer (R3) with a mechanical lift and 2-person assist. I would give that extra push, and assist (R3) with turning."

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On 10/10/23 at 3:28 PM, V10 (Registered Nurse) stated, "(R3) is a two person assist with putting in bed, and supposed to be a two person assist all the time with turning and repositioning. On 09/30/23, I was at the nurse's station, and the CNA (V15, Certified Nursing Assistant) came to me afterwards, telling me that (R3) fell out of the bed when she was giving (R3) care. (R3) was trying to turn, when she was trying to change (R3's) diaper. When I went to assess (R3), she was in bed. (R3's) right arm was warm to touch, swollen, and (R3) complained of pain when I was trying to do an assessment. The back of the two middle fingers on the left hand were bruised. (R3) tried to move the right arm, but she was in pain, so I told her not to move the arm. (R3) was trying to turn, and must have overturned herself, was holding onto the side rail, her upper part of the body was not on the floor, just her bottom part was on the floor. (R3) must have twisted her arm while holding onto the side rail and gotten the fracture. (V15) was in (R3's) room by herself when the incident happened."

On 10/10/23 at 4:13 PM, V13 (Certified Nursing Assistant) stated, "On 09/30/23, I was there to help (R3) get back in bed. When I saw (R3), the lower part of (R3's) body was out of the bed. I was on my set, and the other CNA said that she (V15) needed help. We looked for a sheet and put (R3) back to bed using the sheet. (R3) was afraid that she was going to hit her head, because of her position, and there was a small drawer between bed one and bed two. The mechanical lift could not go all the way to the floor, so we used the sheet to pull (R3) back in the bed."

On 10/10/23 at 4:22 PM, V14 (Certified Nurse Assistant) stated, "On 09/30/23, (V15, Certified

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Nursing Assistant) was assigned to (R3). I was not assisting (V15) to change (R3). (R3) was not on the floor when I went to (R3's) room; (R3) was about to fall out of the bed. (V15) called me to help her, and we went and got (V13, Certified Nursing Assistant) and (V16, Certified Nursing Assistant). When (V15) called me, (R3) was already hanging onto the siderail. (R3) was hanging off the bed, and we used the blanket to pull (R3) back to the bed. (R3) was holding onto the siderail so that she would not fall on the floor. When I was assigned to (R3), I normally do it by myself. Each person normally works with (R3) alone."

On 10/11/23 at 9:34 AM per telephone interview, V15 (Certified Nurse Assistant) stated, "I was about to provide care for (R3), and I had not started. I was going to change (R3's) diaper; (R3) is incontinent. I don't know why (R3) turned. I was telling her to wait, but it was too late. (R3) is a two person assist with bed mobility. After (R3) fell off the bed, I went to get the nurse. It happened so fast, and I was not able to stop her. I always do two-person assist and always get someone to help me. (R3's) top part of her body was partially on the bed because she was still trying to hold on to the side rail. The bottom part, her knees, were on the floor. (R3) was holding onto the side rail and never let go. The nurse checked (R3) out, and that's when we put (R3) back on the bed. The nurse assisted putting (R3) back to bed. We put the sling under (R3) from the mechanical lift, and used the mechanical lift to put (R3) back in bed." V15 got silent after being told staff that assisted R3 after the fall had a different version of events. V15 stated, "I was waiting for (V14, Certified Nurse Assistant) because (V14) was busy. I told (R3) I was about to give her care. I told (R3) to turn, and when (R3) turned, that is

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S9999	Continued From page 9 when (R3) rolled off the bed. I went to get the nurse, (V10, Registered Nurse), but he was not coming right away. (V10) came in after (R3) was in the bed. (V13), (V14), and (V16) assisted me getting (R3) back in bed. We got (R3) in the bed using a sheet. (R3) is a 2 person assist for all her care." On 10/12/23 at 10:13 AM, V2 (Director of Nursing) stated, "My expectations are that the staff follow the plan of care and provide safe care. If the MDS documents the resident is a 2 + person assist for bed mobility, there should be at least 2 people. If more assistance is needed, usually they will ask for help. (V15) was the closest to (R3's) room and (V15) went in by herself. If there were 2 plus persons in the room the fall and injury I think could have been prevented. The care plan is updated by the MDS Coordinator." On 10/12/23 at 10:53 AM, V17 (Physician Assistant) stated, "I saw (R3) a couple of times, and I saw (R3) post fall for pain management. For (R3) to move the hand was painful. We kept (R3) on tramadol, but upped the dosage. (R3's) pain level with movement is pretty-high up there, moderate to severe, as expected post fall. (R3) had some bruising on the left hand, had a couple spots on the legs and right hand. (R3) had a decline with the fractured arm. If the MDS indicates that (R3) should be a 2+ person assist with bed mobility, there should have been 2 people providing care for (R3), likely I would agree. If there were 2 people providing care, it could have decreased the potential for a fall." On 10/12/23 at 11:15 AM, V20 (Licensed Practical Nurse/Restorative) stated, "(R3) is a fall risk. (R3) has upper and lower body weakness,	S9999		

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limitation of the shoulders because of pain. (R3) is a total assist as far as mobility, and the ADL (Activities of Daily Living) part. (R3) is supposed to be a two person assist with turning and repositioning. Because (R3) is obese and has upper and lower body weakness, she has difficulty turning by herself. The two-person assist is in place to help prevent any falls from the bed or injury. (V15) should have had at least 2 people assisting when providing care. Having a two-person assist could have potentially prevented (R3) from falling out of the bed and getting injured. (R3) is not in a regular bed; (R3) is in a full-size bed that is wider than the regular bed."

On 10/12/23 at 11:25 AM per telephone interview, V18 (MDS Coordinator) stated, "The information on the MDS should match with the care plan. The care plan is revised every quarter and if there is a significant change. (V20, Licensed Practical Nurse/Restorative) would be the one that code the Section G on the MDS. The information on the MDS should have been reflected and updated on the care plan. When there is a change on the MDS there should also be a change on the care plan."

On 10/12/23 at 1:26 PM, V2 (Director of Nursing) stated, "When they did the 7 day look back, (R3) required two people assist for care."

In-service titled "S/P (Status Post) Fall", dated 10/02/23, documents, "(R3's) bed mobility level of assist x2 staff and see posted instructions by bed."

Policy:

Titled "Care Plans, Person Centered", reviewed

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S9999	Continued From page 11 11/22, documents: "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implement it for each resident. Procedure: 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 7. The care planning process will: b. Include an assessment of the resident's strengths and needs. 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 14. The interdisciplinary team must review and update the care plan: a. when there has been a significant change and the resident's condition. d. At least quarterly, in conjunction with the required MDS assessment." Titled "Falls and Fall Risk, Managing", revised 03/18, documents: "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risk and causes to try to prevent the resident from falling and to try to minimize complications from falling. According to the MDS, a fall is defined as: Unintentionally coming to rest on the ground, floor, or other lower level, but not as a result an overwhelming external force." Titled "Fall Risk Assessment", revised 03/18, documents: "The nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information." Titled "Activities of Daily Living", dated 03/18,	S9999		

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
	IL6002430	A. BUILDING: ______ B. WING ______	C 10/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERFORD CARE CENTER, THE	7445 NORTH SHERIDAN ROAD CHICAGO, IL 60626

(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
S9999	Continued From page 12 documents: "2. Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: b. Mobility (transfer, bed mobility, ambulation, including walking)." (B)	S9999		