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
	IL6004725	A. BUILDING: ______ B. WING ______	C 12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN BARR GOLD COAST	66 WEST OAK STREET CHICAGO, IL 60610

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S 000	Initial Comments Complaint Investigation 23810086/ IL167407	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)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. 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	S9999	Attachment A Statement of Licensure Violations	

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nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

These requirements were not met as evidenced by:

Based on interviews and record review, the facility failed to immediately transfer a resident (R2) on blood thinning medication to a local hospital for emergent services after a fall with head injury. This failure affected one resident (R2) of three reviewed for falls and as a result, there was a delay of 39 minutes in R2 receiving treatment for an acute subdural hematoma and subsequently died nine days later.

Findings include:

According to Electronic Medical Record, R2 is 86 year old with diagnosis including but not limited to: Unsteadiness on feet, Lack of coordination, Venous Insufficiency, Chronic Venous Hypertension, Heart Failure and Unspecified Right Bundle- Branch Block.

R2 was admitted to the facility on 10/22/2023 and assessed to be a High risk for falls based on assessments dated 10/22/2023 and 11/03/2023.

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On 12/11/23 during investigation, Surveyor inquired about R2's fall incident that occurred on 11/07/2023.

On 12/11/23 at 10:55 AM, V12 (R2's daughter) said," My mom (R2) passed on 11/16/2023 at 2:54 PM in the hospital. She (R2) fell twice in the facility on 11/3/23 and 11/7/23. My mom passed after the 11/07/23 fall. On that day (11/7/23) at 7:51 PM, V16 (LPN/Licensed Practical Nurse) called me to say that there was a horrible accident with my mom. V16 said that after my mom was put to bed, he (V16) witnessed her (R2) standing up from her bed after her bed alarm went off. My mom (R2) was stumbling towards the bathroom. He (V16) tried to run and catch my mom (R2) but it was too late. My mom (R2) had fallen and hit the right side of her head on the floor. V16 told me that my mom had fallen 30-40 minutes before he called me and that he had to follow protocol and call administration and the doctor before sending her (R2) to the hospital. At that time, I asked to speak with my mom. She (R2) got on the phone and said, 'Its cold, I just want to get off the floor and in the bed'. I (V12) asked V16 why my mom (R2) was not sent to the hospital. At 8:09 PM, V16 told me that he had to get off of the phone because the EMT (Emergency Medical Technicians) were there. I (V12) later found out that the EMT did not arrive to the facility until 8:23 PM, and my mom fell before V16 called me at 7:51 PM. When I (V12) later retrieved the medical records from the hospital, it stated that my mom (R2) had arrived at the hospital at 8:55 PM on 11/07/2023.
After my mom (R2) had arrived at the hospital, I received a call at 10:28 PM, informing me that an emergency brain scan revealed hemorrhaging all over her (R2's) brain and that she will need surgery. Shortly after the first call, V23

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(Neurosurgeon) called me back at 11:05 PM and said that there was too much bleeding and swelling and that there was nothing that could be done. Surgery would not make a difference. My mom was placed on hospital hospice service on 11/8/23 and passed on 11/16/23 in the hospital."

On 12/12/23 at 1:10 PM, V16 (LPN/ Licensed Practical Nurse) said, "On 11/7/23, I was not assigned to R2, but I was looking after her because the other nurse was on break. I am not really familiar with R2 and was not sure of her capabilities. I (V16) knew that she (R2) was a fall risk. R2's room was across from the nurses' station. I heard an alarm and when I came out of the nurses office (in back of the nurse's station) I saw R2 standing near her bed. I ran to go to her room. R2 had already taken a couple of steps and had fallen on the floor. I (V16) know that R2 hit her head because she fell on her right side. The protocol in our facility is that when a person is on blood- thinner, we send the patient out 911. R2 was on blood thinners and had a hematoma on the right side of her head. I started to take R2's vitals and make sure she was ok. I called the daughter, I called the Doctor, and I called 911. I think that she was on the floor around 30 mins. I gave her a pillow and made sure she was still conscious. R2 was on the phone with her daughter the entire time before she left the facility."

Surveyor inquired about the time of R2's fall versus the time of the fall documentation.

On 12/12/23 at 1:10 PM, V16 (LPN) said, "I documented the fall after R2 left the facility to the Hospital but I don't remember what time R2 fell. I was able to change the time on my documentation to 7:38 PM. I believe this was the

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time that R2 fell. Whatever time is on the report is the time that she fell. I'm not sure what time she left the facility."

On 12/13/23 at 10:42 AM, V19 (Nurse Practitioner) said, "V16 (LPN) let me (V19) know that R2 had fallen and was a little confused. I (V19) remember that R2 had a prior recent fall and was on lovenox (blood thinner) so I (V19) gave V16 orders to send R2 out 911 (emergency). I (V19) don't remember if R2 had hit her head. I'm not sure what time V16 called but it is documented on the incident report."

Surveyor inquired about the expectations regarding the order to send R2 out 911.

On 12/13/23 at 10:42 AM, V19 said, "I would expect that 911 be called as soon as the nurse hung up the phone with me because it was an emergency. The results could be delayed medical attention and care."

On 12/13/23 at 11:02 AM V20 (Medical Doctor) said, "I am familiar with R2. Her daughter was so involved with her mom and was here all the time. V19 (NP) did what she was supposed to do. V19 gave order to send R2 out 911 for CT scan to rule out bleed or fracture."

Surveyor inquired about the expectations regarding the order to send R2 out 911.

On 12/13/23 at 11:02 AM V20 (Medical Doctor) said, "Immediately. 911 should be notified right away. With the blood thinner and head trauma, the risk for bleeding is increased."

On 12/13/23 at 3:10 PM, V14 (Director of Nursing) said, "I (V14) remember receiving a call

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about R2's fall. I was not here but I know that she was sent to the hospital. When a patient has a head injury and a patient is on blood thinners, they are sent out 911 because they are at increased risk for bleeding."

R2's Physician Order Sheet documents orders for the following medication: Enoxaparin Sodium Injection daily (anticoagulant/ blood thinner); and Aspirin daily (Antiplatelet).

R2's care plan dated 10/22/2023 documents, R2 has potential for bruising, hemorrhage due to anticoagulant use.

R2's care plan dated 10/22/2023 documents, R2 is at risk for falls.

Facility's Fall report documents the following: R2 fell at 7:38 PM on 11/07/2023; R2 noted with bump to right side of head; Alert and oriented x 1-2 with confusion."

Facility's Post- Incident report documents, V19 (Nurse Practitioner) was notified of R2's fall on 11/07/2023 at 7:44 PM.

Facility's Post- Incident report documents, V12 (R2's daughter) was notified at R2's fall on 11/07/2023 at 8:10 PM. (Per V16/ LPN, Daughter spoke with R2 on the phone at that time).

Local Fire Department Patient Care Report documents the following timeline on 11/07/2023: Dispatch called at 8:17 PM; EMT (Emergency Medical Technicians) arrived on scene (Nursing Facility) at 8:23 PM, EMT left the facility at 8:42 PM, Patient (R2) transfer of care (to Emergency Department Staff) at 8:54 PM.

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Per documentation, 911 was called approximately 39 minutes after the witnessed fall.

Hospital Medical record dated 11/7/23 documents, R2's date of service 11/07/2023 at 8:53 PM;
R2 brought in by EMS (Emergency Medical Services) from her SNF (Skilled Nursing Facility) after a witnessed fall. R2 fell from standing with positive head strike but no LOC (Loss of consciousness).

Hospital progress note authored by V23 (Neurosurgeon) documents, "On arrival, R2 was responsive, denying headaches or chest pain. R2's exam progressively worsened until she (R2) became unresponsive. CT brain showed a multi-compartment acute ICH (Intracerebral hemorrhage). Neurosurgery responded to the ICH code. R2 on aspirin 81 milligrams daily and lovenox (blood thinner) prophylaxis.

Hospital progress note dated 11/8/2023 at 11:27 AM documents the following: Spiritual Care Service with family; Emotions of Grief/ Loss.

Facility Reported Incident dated 11/13/2023 authored by V14 (DON) documents, hospital records by neurology team says Acute Multi-compartmental Intracranial Bleed could be secondary to trauma versus stroke in setting of antiplatelet and prophylactic anticoagulant use complicated by interventricular extension with communicating Hydrocephalus. Patient (R2) still at the hospital. No surgical intervention recommended and plan to transition to hospice care.

Facility Reported Incident dated 11/13/2023 authored by V14 (DON) documents, V19 (Nurse

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S9999	Continued From page 7 Practitioner) made aware of fall and ordered to send to hospital for evaluation. Time Physician was notified: 7:44 PM. Facility policy titled Head and Hip guidelines documents, It is the policy of this facility to send residents to the hospital for further evaluation in an event where an incident or accident occurs which involve overt signs of injuries on their head or hip; Notify the resident's attending physician immediately and transfer the resident to the hospital ER (Emergency Room) for further evaluation and management. (A)	S9999		