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
	IL6002315	A. BUILDING: ____ B. WING ____	C 02/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW REHAB CENTER	**5888 NORTH RIDGE CHICAGO, IL 60660**

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S 000	Initial Comments Facility Reported Incident of December 4, 2023 IL167848 Facility Reported Incident of November 11, 2023 IL167855	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610 a) 300.1210 b) 300.3210 t) 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	S9999		

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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.

Section 300.3210 General
t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to provide supervision, failed to ensure that staff intervene timely, and failed to prevent a physical altercation for two of four residents (R3, R4) reviewed for abuse. These failures resulted in R4 sustaining a right eye abrasion.

Findings include:

The Preliminary Incident Investigation Report, dated 11/11/23, states Nurse reported R3 and R4 engaged in a physical altercation.

R4's incident report, dated 11/11/23, states, "writer heard a noise in the dining when passing medication. On reaching there resident and a co-resident were engaged in altercation. Resident alleged that co-resident hit him when dragging chair with him. Injuries observed at time of incident: right eye abrasion. No witnesses found."

R4's progress notes, dated 11/11/23, state, "writer heard a noise in the dining when passing medication. On reaching there resident and a

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co-resident were engaged in altercation. Writer separated both residents to prevent further physical aggression. Noted a little bleeding from residents right upper eye region. Order received from doctor to send resident to hospital."

The Final Incident Investigation Report, dated 11/11/23, states upon investigation, "The facility determined (R3) was watching television in the dining room. (R4) entered the room start maneuvering chairs and began changing the television station. (R3) walked to the television to switch the channel back to the news. Both residents were trying to change stations and made contact with one another in the process. Staff overhearing the commotion immediately intervened and separated the residents. (R3) received counseling services and remains on close monitoring. (R4) was aggressive, combative, unable to be redirected, and sent out for evaluation per his physician. Based on the known facts from medical record review and interviews, the following conclusions have been determined about the original allegation: Abuse is UNSUBSTANTIATED."

R4's diagnoses include vascular dementia, Parkinson's disease, slowness, poor responsiveness, and reduced mobility.

R4's BIMS (Brief Interview for Mental Status), dated 12/22/23, determined a score of 9 (moderate impairment) inattention is continuously present.

On 1/29/24 at 2:30 PM, surveyor attempted to interview R4; however he refused to respond.

R3's progress note, dated 11/11/23, states resident alleged co-resident first hit him, and he

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had to hit him back.

R3's diagnoses include schizophrenia, bipolar disorder.

R3's BIMS (Brief Interview Mental Status), dated 11/9/23, determined a score of 15 (cognitively intact).

On 1/29/24 at 2:09 PM, R3 stated, "I was straightening up the dayroom chairs. I moved the chair next to his (R4) table, he snatched it and almost hit me in the chin. He grabbed the chair, dropped it, hit me with his right hand, and I hit him with my left hand. Consequences led to consequences he (R4) hit me (R3), and I (R3) hit him (R4). That was it." R3 affirmed they struck each other in the face. R3 affirmed staff intervened after the altercation occurred.

On 2/1/24 at 11:54 AM, V1 (Administrator) stated, "I received a call from the nurse on duty (V13/Registered Nurse) who told me the residents had a altercation in the dining room. He (V13) said he heard a commotion, and they were going back and forth about the TV. (R4) started maneuvering chairs and changed the station, (R3) got up to change the station and they made contact while trying to change the station at the same time." Surveyor inquired about R3 and R4's "contact" V1 responded "They hit each others hand or so while trying to change the station back. The nurse (V13) was passing medication and the CNA (Certified Nursing Assistant) was rounding at the time. The expectation is to do frequent rounds on dining room and the units."

On 2/1/24 at 10:04 AM, surveyor inquired about potential harm to a resident that is hit in the face

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V12 (Medical Director) stated, "It could be local injuries, possible fracture, or bleeding."

The (undated) abuse prevention program states: "This facility affirms the right of our residents to be free from abuse. Establishing a resident sensitive environment will be accomplished by a comprehensive quality management approach involving staff supervision. On a regular basis, supervisors will monitor the ability of the staff to meet the needs or residents, staff understanding of individual resident care needs, and situations such as inappropriate language, insensitive handling or impersonal care will be corrected as they occur."

(B)

2 of 2

300.610 a)
300.1210 b)
300.1210 c)
300.1210 d)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

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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.

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 are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to implement care plan interventions, failed to repair equipment, and failed to ensure staff transfer residents safely for one of four residents (R1) reviewed for incidents/accidents. These failures resulted in R1 sustaining a right lower leg laceration on 12/4/23, which required 11 staples to repair.

Findings include:

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R1's diagnoses include dementia, cognitive communication deficit, weakness, and need for assistance with personal care.

R1's BIMS (Brief Interview Mental Status), dated 12/22/23, states resident was unable to complete the interview. R1's cognitive skills for daily decision making are severely impaired.

R1's functional assessment, dated 12/22/23, affirms substantial/maximal assistance is required for chair to bed transfer.

R1's care plan states, dated 11/3/23, documents ADL (Activities of Daily Living) Self Care Performance Deficit, Intervention: resident requires assistance when transferring (10/3/23) Resident demonstrates cognitive impairment related to diagnosis of Alzheimer's disease symptoms are manifested by becoming agitated during care and resisting necessary assistance. Intervention: If the resident is agitated or becomes agitated during care, "back off" and try to calm the resident with soothing words. If the resident remains agitated tell him that you'll come back when he is feeling better.

R1's progress notes, dated 12/4/23, state, "Writer was informed by the CNA (Certified Nursing Assistant) that resident's right lower leg is bleeding. Noted laceration (around 2 inches in length) on the side of the right lower leg. Resident assisted back to bed. Nurse Practitioner notified ordered to send to hospital for wound stitching. CNA together with the other CNA said that they were trying to transfer the resident back to bed, but the resident was refusing and fighting back, his leg scraped the screw of the bed." 12/5/23 "Received resident

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from emergency room. Right leg assessed and 11 staples present."

R1's management incident investigation, dated 12/4/26 (typographical error), states: "Does resident have a history of falls? Yes. Has resident been identified as a fall risk? Yes. Does resident display poor coordination/unsteady gait? Yes. Potential contributing factors: Alzheimer's disease/Dementia, foreign objects in pathway, resistive to care. Possible interventions for consideration according to classifications for falls, bruises, skin tears: Other: Bed with screw sticking out was fixed by maintenance. All beds in facility were checked for safety. Resident room was changed closer to nursing station as resident is also a fall risk." Assess for need of transfer aids was not selected.

R1's initial skin assessment, dated 12/5/23, includes right lateral, lower leg "surgical" wound 5.2 x 0.2 x (not measurable) centimeters. Probable cause of the skin alteration: trauma.

V10's 12/5/23 8:40 AM, typewritten "Witness Statement" includes the following: Was the resident resisting care when you were transferring the patient? "Yes." How did you transfer the patient? "Both of us hold (sic) the patient arms so he do not hit us because he was struggling." What happened? "Resident appeared to bumped his leg (sic) on the screw of the bed when we were transferring the patient."

V11's 12/5/23 11:25 A, typewritten "Witness Statement" includes the following: Sas the resident resisting care when you were transferring the patient? "Yes." How did you transfer the patient? "Both of us hold (sic) the patient arms so he do not hit us because he was

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struggling." What happened? "Resident appeared to bumped (sic) his leg on the screw of the bed when we were transferring the patient."

On 1/29/24 at 2:35 PM, V6 (CNA) was observed assisting R1 with repositioning in bed after transfer from the wheelchair. R1 was clearly unable to reposition himself. V6 stated, "I had (V7/Wound Care Nurse) help me"; however, a gait belt was not observed in the room and/or on R1. R1 stated, "I ain't doing good both my knees hurt and my neck." Surveyor inquired how R1 injured his leg R1 replied, "I don't know nothing. He was bringing it off the bum, you could see he was standing there"; however was unable to clarify what this meant.

On 1/29/24 at 2:41 PM, V7 (Wound Care Nurse) stated, "He's (R1) oriented times 2, he's confused and he's aggressive." Surveyor inquired how R1 is transferred. V7 responded "2 person assist". Surveyor inquired how R1 injured his leg. V7 replied, "They (staff) just said that during transfer he got injured. He was sent to the hospital and came back with the staples. I think it was like 9 (staples)."

On 1/30/24 at 2:29 PM, V9 (Restorative Nurse) stated, "He's (R1) times 1; he doesn't know where he is, or the date, the time, or the year. He's very non-compliant with care. He's very combative so we use 2 person with toileting, dressing, transfers, grooming. There's a care plan there that is ADL's that said he needs a lot of motivation and need assistance with transfer, dressing and grooming-- all the ADL's except for eating. If the resident is refusing, we talk to Social Service for him to be involved, and talk to the resident. If that doesn't work, the family can talk to him by phone, but the resident is confused

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so it might not be working for that one. So, I would say encouragement, but it takes a long time, but eventually he will do it." Surveyor inquired how R1 transfers from the wheelchair to bed. V9 stated, "Extensive assist, 2 person. Also, it's much better for you to use a gait belt."

On 1/30/24 at 3:15 PM, surveyor inquired if R1 can stand. V2 (Director of Nursing) replied, "With assistance." Surveyor inquired how staff transfer R1 from the wheelchair to the bed or vice versa. V2 stated, "So the CNAS when I saw him (R1), they (CNAs) actually have one person hold him and have the other one put him (R1) in the bed. One person was trying to guide him (R1) and the other person was trying to put him in the bed so he doesn't strike out." Surveyor inquired about R1's (12/4/23) incident which resulted in serious injury. V2 responded, "The patient (R1) has a laceration on the right leg. According to the CNAs when they were transferring the patient (R1) he was aggressive, and his leg accidentally hit the screw on the side of the bed. It was a bolt on the bed that was loose, and it hit his leg. He was sent to the hospital and came back; unfortunately there was some staples there." Surveyor inquired what the CNAS should have done if R1 was "aggressive". V2 replied, "They should have at least try to calm him down first and wait till he's not aggressive to put him back to bed. I told the maintenance the same day, please check the bed, and he came right away. I looked at the bed and there's probably maybe an inch screw that was fixed."

On 1/31/24 at 11:44 AM, V8 (Registered Nurse) stated, "He's (R1) alert and oriented times 1 to himself only. He's usually in the wheelchair, needs 2 man assist from bed to wheelchair or wheelchair to bed." Surveyor inquired about R1's

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S9999	Continued From page 10 12/4/23 incident. V8 responded, "I heard a call light and went there to his room. I saw blood so I asked them (V10/CNA & V11/CNA) what happen, they said they were trying to transfer him and he was trying to fight. He wanted to stay up late. I think it was some bolt or something that scratched his leg." Surveyor inquired where R1 was located when V8 entered R1's room. V8 replied, "He was actually on his bed at that time sitting." Surveyor inquired how staff transferred R1 to bed. V8 stated, "I don't know if they (V10 & V11) used the (mechanical lift) that time or they transferred him (R1) with the belt." On 1/31/24 at 12:57 AM, surveyor inquired how V10 and V11's statements were verbatim if interviewed on separate occasions V2 (DON/Director of Nursing) affirmed V10 and V11 were interviewed via phone and signed typewritten statements (documented by V2). On 2/1/24 at 10:59 AM,V12 (Medical Director) stated, "The patient should be calmed down before you do something, that's what it should be if that's what the care plan is telling you to do. If the patient is too aggressive, they (staff) need to call the physician." The Supervision and Safety policy, dated 3/15, states safety risks and environmental hazards are identified on an ongoing basis through employee training conducted upon hire, annually and as needed. The Fall Prevention policy , dated 2/28/14, states malfunctioning equipment will be immediately reported to maintenance for repair or removed from service. Transfer conveyances shall be used to transfer residents in accordance with the plan of care.	S9999		

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