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	IL6009856	A. BUILDING: _____ B. WING _____	C 03/05/2025

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WENTWORTH REHAB & HCC	201 WEST 69TH STREET CHICAGO, IL 60621

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S 000	Initial Comments Complaint Investigation: 2581228/IL186362	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.690a) 300.690b) 300.690c) 300.1210b) 300.1210d)6) 300.1220b)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 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be	S9999		

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recorded in the progress notes or nurse's notes of that resident.

b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.

c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

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.

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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.

Based upon observation, interview, and record review the facility failed to follow policy procedures, failed to ensure that fall risk assessments are accurate, failed to develop and/or implement preventive interventions, failed to report R5's actual injuries, failed to ensure that

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R2's initial incident/accident notification was dated correctly, failed to ensure that R2's final report includes a date, and failed to notify the State Agency of serious injuries within regulatory requirements, and failed to provide supervision to two of three residents (R2, R5) reviewed for falls. These failures resulted in the following: R5 sustained (12/31/24) fall resulting in intracranial hemorrhage and traumatic head injury requiring 4 staples. R1 sustained (1/10/25) fall resulting in left eyebrow laceration requiring 6 sutures.

Findings include:

R5 was admitted (11/25/24) with diagnoses which include Alzheimer's disease, glaucoma, (1/8/25) traumatic subarachnoid hemorrhage and fall, subsequent encounter.

The fall incident log affirms R5 fell on 12/31/24, 2/3/25, 2/17/25, and 2/23/25.

R5's (2/23/25) post fall risk assessment determined a score of 8 (indicating at risk) however R5 fell 3 times in February [therefore is high risk].

R5's (1/17/25) BIMS determined a score of 5 (severe impairment) with inattention behavior continuously present.

R5's (1/17/25) functional assessment affirms resident requires partial/moderate assistance with sit to stand and chair/bed to chair transfer, walking was not attempted due to medical condition or safety concerns.

R5's (11/26/24) care plan includes risk for falls related to poor balance, cognitive deficits, poor safety awareness and wandering behaviors.

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Interventions: (12/8/24) Resident will be within arm length of staff monitoring dining/day room.

R5's (12/31/24) incident report states injury of unknown cause: resident noted with blood at the back of her head at about 6:30am at the nursing station. Upon assessment, writer observed a cut. Resident unable to give an account of incident. Resident sent to the hospital for further evaluation. The resident wanders with an unstable gait and is non-redirectable.

R5's progress notes state (12/31/24) Writer noticed a cut with dried blood on resident's occiput [A descriptive injury ie: abrasion, laceration was excluded] the time and cause of the incident are unknown. Order was received to send resident to the hospital. Writer contacted hospital to follow-up on resident. Resident being admitted with a diagnosis of intracranial hemorrhage. (1/6/25) Received resident back from the hospital. Four staples at the back of her head.

R5's (12/31/24) initial report submitted to the State Agency on 12/31/24 states: the resident was observed to exit her room with a small cut with dried blood on the back of the resident's head.

R5's (12/31/24) final report states the facility has determined that the resident endured a fall due to unsteady gait while pulling the windows open.

On 2/25/25 at 11:13am, surveyor inquired about R5's location V12 (Licensed Practical Nurse) stated "She (R5) had a fall, she's in the hospital. She was sent there Sunday (2/23/25)."

On 3/3/25 at 12:13pm, surveyor inquired about

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R5's cognitive status V3 (ADON/Assistant Director of Nursing) responded "I would say that she alert and oriented x/times 2. She's oriented to her name and location of her room." Surveyor inquired about R5's (12/31/24) injury of unknown origin V3 replied "It happened at 6:30 in the morning, she (R5) came from her room and walked to the Nurse's station. That's when the Nurse observed that she (R5) had a cut on the back of her head [therefore the incident was not witnessed]. She (R5) was unable to give an account of what happened." Surveyor inquired if R5's fall care plan was reviewed and/or revised on or about 12/31/24 to prevent additional falls V3 reviewed R5's electronic medical records and stated "No, I don't see it updated for that one. I don't see a intervention for that to reflect December 31st. No, I don't see nothing for an intervention for her falls care plan."

On 3/4/25 at 12:52pm, surveyor inquired about R5's (12/31/24) injury of unknown origin V1 (Administrator) stated "I got a call from the Nurse (V18/Registered Nurse) in regard to (R5) and what he (V18) observed. He made me (V1) aware that the resident (R5) came out of the room, and he noted some dried blood to the back of her (R5) head. He (V1) contacted the doctor and got orders to send the resident out." Surveyor inquired if R5's injuries were reported to the State Agency V1 responded "Yes." Surveyor inquired what injuries R5 sustained V1 replied "I know that she had some stitches to the back of the head." Surveyor inquired why "stitches" were not on R5's final report (submitted to the State Agency) V1 stated "She was still in the hospital when I had to send the final" [R5 returned to the facility on 1/6/25 per progress note, the final wasn't due until 1/7/25]. Surveyor inquired why R5's intracranial hemorrhage (documented

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12/31/24) was not reported to the State Agency V1 affirmed he was unaware.

On 3/4/25, surveyor requested the injury of unknown origin policy, at 12:18pm, V1 (Administrator) stated "We don't have a policy for injury of unknown origin."

On 3/5/25 at 12:37pm, surveyor inquired about potential harm to a resident that sustains an unwitnessed fall V19 (Medical Director) stated "Anybody with an unwitnessed fall with a head injury they can have a bleed." Surveyor inquired what type of injury requires staple repair? V19 responded "Superficial cuts which are deep enough they will need staples or sutures." Surveyor inquired what the facility should implement post falls V19 replied "If the resident falls, then the facility has fall protocols which they can implement." Surveyor relayed concerns that the State Agency was not made aware of R5's (12/31/24) intracranial hemorrhage and/or skin tear repaired with staples which were documented by facility staff V19 (Medical Director) stated "They (staff) should have reported it."

On 2/14/25, the State Agency received allegations that R2 is supposed to have frequent/constant monitoring by staff however fell 3 times in the last 10 months. On 1/10/25, R2 fell and sustained a head wound.

The fall incident log affirms R2 fell on 4/12/24, 5/15/24, and 1/10/25.

R2's diagnoses include dementia, hemiplegia/hemiparesis affecting right dominant side, and history of falling.

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R2's (11/9/21) admission fall risk assessment determined a score of 8 (at risk).

R2's (2/10/25) BIMS (Brief Interview Mental Status) affirms short term memory problem and cognitive skills for daily decision making is severely impaired.

R2's (2/10/25) functional assessment affirms resident is dependent on staff for sit to stand, and chair/bed to chair transfer, walking was not attempted due to medical condition or safety concern.

R2's (1/10/25) incident report states resident in room sitting in her wheelchair. Upon rounds Nurse observed resident in lying position on the floor. Resident has laceration above left eyebrow. Resident non-verbal unable to give description. Predisposing situation factors: ambulating without assist.

R2's initial incident/accident notification states Date: 1/11/25 (the incident occurred on 1/10/25). Upon rounds Nurse observed resident lying in prone position on the floor in her room. Laceration noted above left eyebrow. The State Agency was notified on 1/13/25 (3 days after incident).

R2's (undated) final report states per hospital record resident laceration to eyebrow was sutured.

R2's (1/14/25) progress note states resident has 6 sutures on the left eyebrow.

R2's (4/30/24) care plan includes risk for falls due to hypotension, cognitive deficits related to developmental disability, poor balance, poor

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safety awareness, unsteady gait, impulsivity, and inability to follow instructions. Interventions: placement of call light within reach. Rounding at a minimum of every 2 hours.

On 2/25/25 at 12:08pm, R2 was observed lying in bed and the call light was noted to be on the floor (out of reach). R2's left foot was on the floor and the right foot was near edge of the bed. R2 was alone in the room.

On 2/25/25 at 12:10pm, surveyor inquired about R2's fall prevention interventions V13 (Licensed Practical Nurse) stated "She has floor mats, her call light, and has her bed in lowest position." V13 subsequently entered R2's room (as requested). Surveyor inquired about the location of R2's call light V13 responded "On the floor now." Surveyor inquired if R2 can walk V13 replied "No, she's a 2 person assist. She will try to get out the bed on her own that's why we have to keep putting her in the bed" then placed R2's left leg on the bed. Surveyor inquired if R2 can communicate V13 stated "She's non-verbal."
On 2/26/25 at 1:20pm, surveyor inquired about the regulatory requirement for reporting serious injuries V2 (Director of Nursing) stated "Within 24 hours report the injury to the State Agency." Surveyor inquired about R2's (1/10/25) fall V2 responded "She (R2) fell in her room that was the report I (V2) got. We (staff) sent her to the hospital and couldn't get any information from them until the following day which was 1/11. When we found out that she had sutures on 1/11 we sent over the reportable." Surveyor inquired why R2's laceration (documented prior to hospital transfer) was not reported to the State Agency within 24 hours V2 responded "She had a laceration, but we didn't know that it required sutures." Surveyor inquired if lacerations are only

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reported if they "require sutures" V2 stated "What I'm saying is, if it's a major injury with repairs we report it." Surveyor inquired when R2's (1/10/25) laceration was reported to the State Agency V2 replied "We reported it on 1/11." Surveyor advised that the facility provided evidence that R2's (1/10/25) laceration was initially reported to the State Agency on 1/13/25 (per fax transmission received). V2 then referred to a document which states "From: (facility email). Sent: January 11, 2025. To: V14 (Restorative Nurse). Subject: successful fax delivery" and affirmed that V14 provided her (V2) the document on Monday (1/13/25) upon return to work. After V2 reviewed the document (which affirms the State Agency was not notified), V2 sent the initial report to the State Agency on 1/13/25 (3 days after the laceration was identified).

On 3/3/25 at 11:35am, surveyor inquired about R2's (1/10/25) fall V3 (ADON) stated "She (R2) was in her room, the nurse made rounds and observed her (R2) on the floor with a laceration to her head. It was a unwitnessed fall." Surveyor inquired about concerns with R2's (1/14/25) post fall risk assessment V3 responded "#2 predisposing condition, is supposed to be hypotension, it wasn't marked. That would have gave 2 points if it was marked. The next thing is the mentation, they (staff) put confused but in my opinion, I would have put impaired memory overall it would have been a higher score if they picked impaired memory. The assessment wasn't correct actually it would have been higher. The medication, I'm not sure about that." Surveyor inquired about R2's fall risk score which indicates at risk (instead of high risk) V3 replied "It do say 5 which means at risk, but I can say overall it's not correct." Surveyor inquired about R2's fall prevention interventions (post 1/10/25

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fall) to prevent additional falls V3 stated "She's being supervised like her room is close to the Nurses station. She actually do get out of bed and has a mind of a 2-year-old, so we (staff) try to do what we can to protect her."

The (09/20) abuse policy states in part: serious bodily injury is an injury involving extreme physical pain, requiring medical intervention such as surgery, hospitalization. Initial reporting of allegations shall be completed immediately upon notification of the allegation. The written report shall be sent to the Department of Public Health. If the events that cause the reasonable suspicion result in serious bodily injury, the report must be made immediately after forming the suspicion (but no later than 2 hours after forming the suspicion). Otherwise, the report must be made not later than 24 hours after forming suspicion.

The (08/2020) management of falls policy states the facility will assess hazards and risks, develop a plan of care to address hazards and risks, implement appropriate resident interventions, and revise the resident's plan of care in order to minimize the risks for fall incidents and/or injuries to the resident. Complete a fall risk assessment upon admission, re-admission, with significant change, post-fall, quarterly, and annually. Develop a plan of care to include goals and interventions which address resident's risk factors. Risk factors may include but are not limited to the following: contributing diagnoses/disorders/disease processes/active infections/other comorbidities, history of fall incidents, incontinence, medications, assistance required with ADLS, gait/ transfer/ balance issues, behaviors, and/or cognitive status. Review and modify the resident's plan of care at least quarterly and as needed in order to

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S9999	Continued From page 11 minimize risk for fall incidents and/or injury. (A)	S9999		