

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145606	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/03/2025
NAME OF PROVIDER OR SUPPLIER  Covenant Living - Windsor Park		STREET ADDRESS, CITY, STATE, ZIP CODE  110 Windsor Park Drive Carol Stream, IL 60188	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide assistance and utilize gait belt during a toilet transfer for a resident identified as requiring assistance.</p> <p>This resulted in a fall in which R1 sustained multiple rib fractures and other injuries.</p> <p>This applies to 1 of 3 residents (R1) reviewed for fall incident in the sample of 5.</p> <p>The Finding includes:</p> <p>According to the Electronic Medical Record (EMR), R1 is a [AGE] year-old with diagnoses including chronic obstructive pulmonary disease (COPD), muscle weakness, muscle wasting, history of falls, major depressive disorder, diabetes mellitus, bilateral knee replacement, left hip arthroplasty, compression fracture, and restless leg syndrome. R1 was admitted on [DATE].</p> <p>The Minimum Data Set (MDS) dated [DATE], documented R1 as cognitively intact and requiring moderate assistance for toilet transfers and ambulation. This level of assistance is defined as staff lifting or holding the resident's trunk or limbs.</p> <p>The care plan, dated March 16, 2025, identified R1 as high risk for falls due to her medical history and functional impairments. Interventions included staff assistance during toileting, instructions that R1 should not walk or stand unassisted, and use of a rolling walker with staff assistance for ambulation. The staff assignment sheet (Care Plan Kardex) dated March 15, 2025, specified that R1 required one-person assistance for transfers.</p> <p>According to the facility's incident report dated May 19, 2025, at approximately 7:30 A.M., R1 was walking with a rolling walker to the bathroom in her room. After taking three steps with a walker, R1 lost her balance and fell backward, striking her back against a dresser. Emergency Medical Services were called, and R1 was transported to the hospital for evaluation.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On May 30, 2025, at 10:30 A.M., in the presence of V2 (Director of Nursing) and V4 (Nurse), R1 was lying in bed and was noted with a six-inch dark purple-blue bruise on the right flank, extending from above the right hip to the mid-lateral back. R1 stated, I have this bruise because I fell more than a week ago and it's still painful. I can't move myself in bed. I fell when I was walking with a walker. (V3/CNA/Certified Nurse Assitant) got me out of bed, gave me a walker, then she went to the bathroom. She left me walking alone, while on my way to the bathroom. That was when I fell and hit the dresser.</p> <p>On May 30, 2025, at 11:00 A.M., V4 confirmed that V3 had notified him of R1's fall and found R1 sitting on the floor against the dresser, complaining of pain and shortness of breath. V4 said EMS (Emergency Medical Response) was called, and R1 was transported to the hospital.</p> <p>On May 30, 2025 at 12:19 P.M., during the phone interview in the presence of V2, V3 confirmed she had assisted R1 out of bed and provided her with a walker prior to the fall on May 19, 2025 around 7:20 A.M. V3 admitted she did not remain with R1 during ambulation, stating she stepped into the bathroom to retrieve gloves when the fall occurred. V3 also acknowledged that a gait belt was not used during the transfer or ambulation.</p> <p>On May 30,2025, at 12:45 P.M., V2 confirmed that facility protocol requires the use of a gait belt during all resident transfers and ambulation to ensure safety.</p> <p>The hospital report dated May 19, 2025, documented R1's injuries sustained post fall:</p> <ul style="list-style-type: none"> <li>-small right hydropneumothorax</li> <li>-Laceration of the right lower lung with atelectasis and pulmonary contusion</li> <li>-Displaced fractures of the right lateral 6th through 9th ribs</li> <li>-Comminuted fracture of the right posterior 10th rib</li> <li>-Non-displaced fractures of the right anterior 4th through 8th ribs</li> <li>-Mild hemorrhage of the right chest wall</li> </ul> <p>Progress notes showed that R1 returned to the facility on May 22, 2025.</p> <p>On June 2, 2025, at 9:30 A.M., V5 (R1's primary physician) stated that R1 was alert, oriented x 4, but exhibited poor safety awareness. V5 confirmed that all sustained injuries as described above were the result of the fall on May 19, 2025.</p> <p>Facility policy on toilet transfers, dated February 2018, requires the use of a gait belt during transfers for resident safety. The Fall Prevention Training, dated May 21, 2025, emphasizes that a gait belt must always be used during transfers and ambulation.</p>		