STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145614	A. Building B. Wing	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chateau Nrsg & Rehab Center	7050 Madison Street Willowbrook, IL 60521

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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34490 Based on interview and record review the facility failed to ensure fall interventions were in place for a resident who is at high risk for falls for 1 of 4 residents (R1) reviewed for safety in the sample of 6. This failure resulted in R1 falling out of bed and sustaining a laceration to her forehead requiring stitches. The findings include: R1's Minimum Data Set assessment dated [DATE] shows that her cognition is impaired and R1 has had one fall with no injury and two or more falls with injury since her prior assessment. On 1/21/25 at 11:11 AM, V3, Certified Nursing Assistant (CNA) said that on 1/3/25 he went into R1's room to get her up for the morning. V3 said that he removed her fall mat from the floor and removed her bed bolsters from the bed in order to provide incontinence care. V3 said that after incontinence care was provided, he lowered the bed and went to get the mechanical lift sling. V3 said that when he turned back around, he saw R1 with her upper body out of the bed and her head on the floor. V3 said that he repositioned her back into bed, put the floor mat back down and re-applied the bolster and then went and got the nurse. V3's typed and signed statement dated 1/3/25 shows, In order to provide incontinence care and personal hygiene I needed to move the thick floor mat out of the way. After performing care, I lowered the bed back down to the lowest position and prepared the resident for transfer. I went to retrieve the hoyer (mechanical lift) pad for the resident and during this time I noticed the resident began to roll off the bed. I attempted to guide the resident back to bed, but she ended up hitting her head on the floor On 1/21/25 at 12:24 PM, V4 (CNA) said that R1 was at high risk for falls and would be very active at times. V4 said that R1 had a fall mat and bolster on her bed to prevent her from falling out of bed and hurting herself. V4 said that the fall mat and bolster should be in place at all times when R1 is in bed. V4 said that staff should always be prepared with the supplies that are needed to provide care to R1 before they start the care. V4 said that if she did have to get something that she had forgot, she would place the fall mat and bolster back in place before leaving the resident's bedside. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/21/25 at 1:02 PM, V13 (Restorative Licensed Practical Nurse) said that R1 wiggled around' in bed a lot so they had an intervention of bolster placement on her bed to help her maintain proper body alignment while in bed. V13 said that R1 has had falls in the past out of bed so the fall mats were implemented to provide extra protection if she did fall out of bed to reduce injuries. V13 said that she did educate V3 that all supplies should be obtained before starting resident care and if he has to step away from the resident, fall prevention interventions (fall mat and bolster) should be re-applied. R1's Progress Notes dated 1/3/25 at 7:30 AM shows, Writer called to resident's room by CNA (Certified Nursing Assistant). CNA states that resident rolled out of bed during transfer to chair. Laceration noted to resident's forehead R1's Hospital Notes from 1/3/25 shows, This is a [AGE] year-old female with a past medical history of dementia, nonverbal, hospice patient, who presents to the emergency department with chief complaint of head injury and fall. Patient reportedly had rolled out of bed around 0730 hours this morning, this was witnessed by nursing home staff. Patient hit her forehead on the ground She did sustain a laceration to her forehead She has had a proximally 3 centimeter largely linear, slightly irregularly shaped laceration to her left upper forehead/frontal scalp 3-4 centimeter frontal scalp contusion on the left repaired with 3 simple interrupted sutures. R1's Fall Care Plan initiated 2/14/24 shows, Resident has a history of falls R/T (Related To) weakness, endurance, CVA, dementia and hx (history) of falls Interventions: Provide re-education to staff on safety device/appliance; Bed bolsters. Re-enforce bed bolsters R1 Bed Bolster Care Plan initiated on 4/3/24 shows, Resident has poor safety awareness r/t dementia, and other co-morbidities and requires bed bolsters to be applied Use bed bolsters to prevent senior from rolling off the bed. Using fall prevention tools such as bolsters and roll guards to reduce the chances of falling out of bed. R1's Care Plan does not mention the use of fall mats. The facility's Falls and Fall Risk, Monitoring Policy revised 8/2008 shows, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling .The staff, with the input of the attending physician, will identify appropriate interventions to reduce the risk of falls .Staff will identify and implement relevant interventions to try to minimize serious consequences of falling.