| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145942 | A. Building<br>B. Wing | 01/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Oak Lawn Respiratory & Rehab | 9525 South Mayfield<br>Oak Lawn, IL 60453 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41758<br><br>Based on interview and record review, the facility failed to follow their abuse policy by not identifying or determining how residents sustained injuries of unknown origin. This affected two of three residents (R1, R2) reviewed for injury of unknown origin. This failure resulted in R1 being found with discoloration to left arm with discomfort with movement which resulted in an acute wrist fracture. R1 was also observed with a large dark purple discoloration consist with a bruise on the right flank measuring 16 centimeters long and 8.5 centimeters wide. In addition, R2 complained of pain and was found with swelling to the right upper thigh, which resulted in right hip fracture.<br><br>Findings Include:<br><br>R1 was diagnosis with muscle weakness and the need for assistance with personal care. Minimal data set section C (cognitive patterns) dated 1/22/25 documents a score of eight which indicate cognitive moderate cognitive impairment. Incident report dated 1/9/25 document: discoloration noted to left arm. R1 states she did not fall. (1/13/25) documents: R1 verbalized that when attempting to reposition herself in her wheelchair, her left hand fell towards the wheel part of the chair. Final Facility reportable dated 1/13/25 documents: documents staff did not witness any incidents or accidents. Resident (R1) when interviewed, verbalized that when attempting to reposition herself in her wheelchair. Her left hand fell towards the wheel part of the chair. Resident had no pain and upon noting discoloration to the left arm was immobilized.<br><br>On 1/23/25 at 3:42pm, V2 (don) completed a body assessment for R1. R1 was unable to report what happened to her left arm or right posterior flank. R1 was observed with a large discoloration dark purple to the right posterior flank/side with light purple red fading discoloration connection under the right lateral breast. V2 and V1 (administrator) both report they was not aware of R1 right flank bruise.<br><br>Skin assessment dated [DATE] documents: open area to right lower leg yellowish in color, right chest extending down under right arm and right lateral arm, discoloration yellowish and purplish in color to right arm and right leg, discoloration to left leg left arm splint board and ace wrapped for radius fracture in place. -No documentation submitted during this survey for the right posterior (back) flank.<br><br>On 1/24/25 at 10:21AM, V4 (cna) said, R1 is able to sit upright in the chair. R1 cannot reposition herself. R1 is confused. R1 may be able to report what's going on from time to time.<br><br>(continued on next page) |

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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145942 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/31/2025 |
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| NAME OF PROVIDER OR SUPPLIER Oak Lawn Respiratory & Rehab | | STREET ADDRESS, CITY, STATE, ZIP CODE 9525 South Mayfield Oak Lawn, IL 60453 | |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | On 1/24/25 at 12:59PM, V11 (previous ADON) said, R1 was noted with discoloration to left side. R1 did not have any falls. R1 favors the left side while in bed. R1 leans to left side while in the wheelchair. R1 has to be repositioned by staff.<br><br>On 1/28/25 at 3:04PM, V18 (medical doctor) said, R1 had osteopenia. R1 could have sustained a fracture by slamming her hand down the table or being moved from side to side or hitting her hand on the bed rail. V18 said, R1 was lucky she didn't have more fractures.<br><br>On 1/29/25 at 1:22pm, V24 (orthopedic surgeon) said, R1's type of fracture is associated with a fall.<br><br>On 1/31/25 at 3:14pm, V1 (administrator) said, R1's injury was of an unknown origin.<br><br>Nurse practitioner service note dated 1/10/2025 documents: left wrist and hand pain. R1 was being seen for reports of discoloration and complaint of pain to left wrist and hand. R1 seen in bed alert and oriented times two. R1 noted guarding her hand and when asked to raise her hand and wrist she reports too much pain. R1 denies falling and unable to state how injury might have happened.<br><br>X-ray result dated 1/10/25 documents: Impression: Acute intra-articular distal radial fracture.<br><br>Hospital paperwork dated 1/13/25 documents: R1 fell with outstretching hand present with chief complaint of left wrist swelling and pain found to have closed distal radial impacted comminuted facture had splint in place in ED from a likely fall at skilled nursing facility. R1 had multiple skin excoriation suggestive for past falls. Skin:bruising<br><br>Facility policy titled Abuse Prevention Program revised 1/2019 documents under injury of unknown origin: An injury should be classified as an injury of unknown origin when both of the following conditions are met: The source of the injury was not observed by any person or the source of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or the location of the injury( the injury is in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. The final report shall include facts determined during the process of the investigation, review of medical records and interview of witnesses. The final investigation shall also include a conclusion of the investigation based on known facts.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | R2 was diagnosed with Cerebral Palsy, lack of coordination, abnormalities of gait/mobility, abnormal posture, repeated falls, muscle wasting/atrophy, history of falls, age related osteoporosis without current pathological fractures and history of fractures. Minimal data set section C (cognitive pattern) dated 1/6/24 documents a score of six which indicates severe cognitive impairment. Nursing noted dated 12/26/24 documents: R2 complain of pain to Right hip. Nursing note dated 12/27/24 documents: Writer made aware that resident had a change in condition due to pain and discomfort. Discomfort observed upon range of motion with right hip area. R2 verbalized she fell in her room on the side of her bed while attempting to get in wheelchair. R2 stated she got back into bed. R2 educated on the importance of not attempting unassisted bed transfers due to needing supervision or limited assistance (education unsuccessful). Final Facility Reportable dated 12/27/24 documents: Type of Incident: Change in condition. The facility completed its investigation. Staff were interviewed and medical records were reviewed. Resident (R2) did not have a recent fall at the facility and resident did not complain of pain. Resident had a diagnosis of osetoprosis and the x-ray completed at the facility showed ostenopenia. Nurse practitioner notified and verbalized that this was a spontaneous pathological fracture that occurred with movement.<br><br>On 1/23/25 at 3:02pm, R2 was alert and orient to person and place, said she fell and got herself up.<br><br>On 1/24/25 at 3:57pm, V16 (cna) said, she reported to work on the evening shift, V16 said, she was getting R2 out of the bed to take her to dinner. V16 said, R2 was soiled with bowel movement. V16 said, R2's right leg was swollen. R2 said, her leg was broken. R2 has a behavior of laying on the floor. V16 said, she asked R2 what happen, R2 replied, she fell . V16 said, she informed V20 (nurse).<br><br>On 1/28/25 ay 4:27pm, V2 (don) said, R2 reported having a fall and getting up herself. Per the investigation, R2 did not have a fall. V2 said, she completed risk management for R2 as an injury of unknown origin.<br><br>On 1/29/25 at 1:17pm, V24 (orthopedic surgeon) said an intertrochanter femur is the position of the fracture. It's a common fracture for elder people caused by a trip ground level fall or a fall out of the wheelchair. V24 said, he would expect R2's fracture to be from a fall. V24 said if looked at R2's x-ray without any background information, he would report that R2 had a fall. V24 said, it is difficult to say it R2 fracture was pathological due to the potential poor bone quality. R2's fracture was too severe for nothing to have happen.<br><br>On 1/31/25 at 3:14pm, V1 (administrator) said, R2's injury was of an unknown origin.<br><br>E-Interact SBAR note dated 12/27/24 documents: The change in condition/s on this CIC evaluation are/were: Falls.<br><br>Nursing progress note dated 12/27/24 documents STAT x-ray results received results revealed fracture to right femur (hip).<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Hospital Paperwork dated 12/17/24 documents: Chief complaint: Patient presents with Fall/Leg injury. Patient presented to the emergency department from nursing home after an unwitnessed fall. Present for right hip pain. R2 alert to person and place. R2 reports that while at the nursing home, she slipped on her socks and fell on to her right hip, which started to cause pain. Per chart review, there have been different stories as to the way she fell . R2 reports being wheelchair-bound and can stand for transfers. X-ray of the femur showed acute comminuted right intertrochanteric fracture with varus angulation and 3.8 centimeter (cm) of lateral displacement and 3 cm of overriding of the fracture fragments. Given fentanyl 25mcg x 1 in ED. Review of systems: Musculoskeletal/right hip: Positive for arthralgias (right hip pain). General swelling, tenderness, deformity and sign for injury present. Right lower leg: edema present. Comments: right leg shortened and externally rotated. Skin Erythema (redness/right hip present.<br><br>Facility policy titled Abuse Prevention Program revised 1/2019 documents under injury of unknown origin: An injury should be classified as an injury of unknown origin when both of the following conditions are met: The source of the injury was not observed by any person or the source of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or the location of the injury( the injury is in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. The final report shall include facts determined during the process of the investigation, review of medical records and interview of witnesses. The final investigation shall also include a conclusion of the investigation based on known facts. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>41758<br><br>Based on observation, interview and record review, the facility failed to provide appropriate care for residents with incontinence by not ensuring that incontinence care was provided at least every two hours. This affected one of three residents (R10) reviewed for incontinence care. This failure resulted in R10 being left soiled and saturated in urine for over five hours and feeling cold.<br><br>Finding Include:<br><br>R10 was diagnosis with hemiplegia and hemiparesis following cerebral infraction affecting left non-dominant side, functional quadriplegia, reduce mobility and need for assistance with personal care. Minimal data set section C (cognitive pattern) dated 11/1/24 documents a score of twelve which indicates moderate cognitive impairment. Section GG (functional abilities) documents: R10 has impairments on one side to the upper and lower extremity. R10 is dependent (helper does all of the effort) for toileting hygiene. Section H (bowel and bladder) dated 11/6/24 documents: Always incontinence of urine. Care plan dated 5/3/22 documents: R10 is incontinent of bladder/bowel. This problem is related to poor cognition skills, inability to communicate need for toileting. Intervention: Administer appropriate cleansing and peri-care after each incontinent episode.<br><br>On 1/28/25 at 12:38pm, R10 was observed with V6 (cna). R10 was observed in bed with a strong smell of urine. R10 said, he was cold. R10 was observed laying on a wet chuck/pad with a large dark brown irregular shape ring extended to the edges of the pad. R10's entire adult brief was saturated with dark yellow urine. V6 said, R10 was last changed at 7:30am. V6 said, R10 was a heavy wetter. Residents are supposed to be checked and changed every two hours.<br><br>On 1/28/25 at 12:41pm, V23 (nurse) said, R10 was soiled and saturated with strong smelling urine, a wet pad and a brown dried urine ring on the pad. V23 said, R10's adult brief was saturated with orange-yellow urine.<br><br>Incontinence Care policy undated documents: To ensure that resident's receive as much assistance as needed for cleansing the perineum and buttock after an incontinent episode or with routine daily care. Frequency depends on bladder diary result and or routine minimal every two hours checks as well as care planning. |