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	ASL510499	A. BUILDING: _____ B. WING _____	C 01/21/2025

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RADCLIFF AT WOOD DALE	276 EAST IRVING PARK ROAD WOOD DALE, IL 60191

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A 000	Initial Comment FRI 9/22/24 IL177631 substantiated Complaint 2477758/IL178492 substantiated Complaint 2477758/IL178492 Unsubstantiated Violations 295.6010 295.4010 295.4060	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation Section 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. b) The service plan shall be developed by: 1) The resident, resident's representative or any individual requested by the resident; c) The service plan shall be signed and dated by all individuals involved in its development. d) The service plan, which shall be reviewed annually, or more often as the resident's	A4010		

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A4010	Continued From page 1 condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000) These Requirements are not met as evidenced by: Based on interview and record review, the facility failed to update the service plan to include interventions to address one resident's(R1) confusion combined with unsteadiness on feet even despite a walker out of 3 reviewed for falls and failed to follow fall policy and procedure to develop interventions to minimize the risk of incidents. R1 suffered a fall with right hip fracture as a result of these failures. Findings include: R1 facility record documents a date of admission of 9/19/24 with diagnoses including but not limited to Dementia, Cerebral Microvascular disease, Benign Prostatic Hypertrophy, cardiomegaly, and central vascular congestion. History of previous "hip surgery" documented which is listed on page 2 of 9 from unknown date. The printout date is 9/13/24. Copies were obtained from facility and page 1 of this medical record was not included. Fall assessment date 9/19/24(admission) and 10/15/24 assesses R1 as high risk for falls with score of 13 and 17 respectively. Confusion,	A4010		

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A4010	Continued From page 2	A4010		

limited mobility, diagnosis medications, history of falls and incontinence lead to score of 17 on 10/15/24.
R1 had a total of 2 falls while in the facility; one unwitnessed fall without injury on 9/29/24 at 5:00 pm in the dining room according to the nursing note of 9/29/24 and a second fall on 11/19/24 resulting in injury with surgical treatment.
Based on Incident Report of 11/19/24, at 3:40 pm, "(R1) was participating in (east side) activities (in memory care unit) when (R1) got up from chair, lost (R1) balance and fell." Under injury description, R1 "complained of right hip pain with movement of right leg" with "right leg shorter than left - Bulge noted right hip." R1 was sent to the hospital emergently and according to incident report was diagnosed with "fracture of right hip."
Based on interviews with staff, R1 has a pattern of unsteady gait even with a walker and confusion making R1 a safety risk. Neither the unsteady gait even with a walker and confusion are service planned.
On 1/14/25 at 10:30 am E4(LPN) recalls (R1) as "always unsteady with gait ...Not cognitively understanding how to use walker. (R1) never walked well with walker and (R1) wouldn't walk with walker. Very unsteady with walker." E4's recollection of not being able to walk well with the walker are consistent with E8's recollection of R1 as wobbling with the walker.
On 1/14/25 at 10:34 am E8(Activity Aide on 3rd floor/C.N.A) stated in part, "Sometimes I would see (R1) wobbly with walker. Look like falling."
Based on interview with E2(Director of Nursing) and chart review, R1 has 1 service plan developed by the facility dated 9/19/24. In all activities of daily living, R1 is assessed as needing 1 person assist except for mobility. Under heading, "Mobility/Fall risk," R1 is checked for "Walker" with goal "interventions in place will

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A4010	Continued From page 3 lessen injury risk," and intervention to maintain "pathways clear of clutter." Although staff including E4(Licensed Practical Nurse) and E8(Activity Aide/Certified Nursing Assistant) assess R1 as unsteady even with the walker no interventions are in place in the service plan to address the unsteadiness. Facility service plan signatures do not include R1's representative. A 9/29/24 fall which did not result in injury is identified in service plan of 9/19/24 but although the service plan documents "interventions will be added to prevent future falls," no additional interventions to address the fall are included. According to facility policy titled, "Accidents and Incidents," the purpose of the facility's guidance is "to establish a plan with interventions to minimize the risks of accidents and incidents." Facility did not follow fall guidance by failing to address R1's unsteadiness even with the walker.	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Type 2 Violation Section 295.4060 Alzheimer's and Dementia Programs h) An establishment that offers to provide a special program for persons with Alzheimer's disease and related disorders shall: 6) Provide an appropriate number of staff for its resident population. The establishment shall provide staff sufficient in number, with qualifications, adequate skills, education, and	A4060		

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A4060	Continued From page 4	A4060		

experience to meet the 24-hour scheduled and unscheduled needs of the residents and who participate in ongoing training, to serve the resident population. At a minimum, at least one staff member shall be awake and on duty at all times.

These Requirements are not met as evidenced by:

Based on interview and record review, the facility staff during activity failed to demonstrate the necessary skills to mitigate the risk of a fall with injury for 1 resident(R1) out of 3 reviewed for falls. The failure to respond to R1's confusion, unsteady gait even with a walker and repetitive behavior of getting up lead to a fall with right hip fracture for R1.

Findings include:

R1 facility record documents a date of admission of 9/19/24 with diagnoses including but not limited to Dementia, Cerebral Microvascular disease, Benign Prostatic Hypertrophy, cardiomegaly, and central vascular congestion. History of previous "hip surgery" documented which is listed on page 2 of 9 from unknown date. The printout date is 9/13/24. Copies were obtained from facility and page 1 of this medical record was not included.
Fall assessment with date of 9/19/24(admission) and 10/15/24 assesses R1 as high risk for falls with score of 13 and 17 respectively. Confusion, limited mobility, diagnosis medications, history of falls and incontinence lead to score of 17 on 10/15/24.
R1 had a total of 2 falls while in the facility; one unwitnessed fall without injury on 9/29/24 at 5:00 pm in the dining room according to the nursing note of 9/29/24 and a second fall on 11/19/24

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A4060	Continued From page 5	A4060		

resulting in injury with surgical treatment.
Based on Incident Report of 11/19/24, at 3:40 pm, "(R1) was participating in (east side) activities (in memory care unit) when (R1) got up from chair, lost (R1) balance and fell." Under injury description, R1 "complained of right hip pain with movement of right leg" with "right leg shorter than left - Bulge noted right hip." R1 was sent to the hospital emergently and according to incident report was diagnosed with "fracture of right hip."
E2 (Director of Nursing) was asked if an investigation was completed into R1's fall.
E2(Director of Nursing on 1/14/25 at 2:00 pm stated, "No investigation, but should have even though unwitnessed. Should have investigation to determine root cause or how to prevent injury in future." (who would be responsible for that investigation) E2 stated she would assume that responsibility or maybe nurse on duty.
Facility accident/incidents policy and procedure on page 2 states, "An evaluation of the key factor that led to the incident and determining the root cause of the incident will be conducted by the Director of Nursing or Administrator."
E2 was asked if witness statement should have been obtained given facility accident and incident policy states in part, "Internal incident reporting process will be initiated by completing an investigation conducted as needed," and "witness statements will be gathered if the incident was witnessed by anyone." The fall occurred in common area during an activity being monitored by facility staff. E2 responded yes, an investigation with interviews should have been completed. Facility failed to complete an investigation into R1's reportable fall with injury on 11/19/24 and failed to adequately supervise/intervene when R1 was showing signs of ongoing restlessness, unsteady gait even with walker, and confusion for extended period based

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A4060	Continued From page 6	A4060		

on staff descriptions.
On 1/14/25 at 10:30 am, E4 stated in part explaining the nurse's responsibility includes completing a nursing note and incident report when unwitnessed. E4 believes E8(activity aide/C.N.A) or Z2(former Memory Care lead) called her to the memory care unit.
E4(LPN) recalls (R1) as "always unsteady with gait ...Not cognitively understanding how to use walker. (R1) never walked well with walker and (R1) wouldn't walk with walker. Very unsteady with walker." E4's recollection of not being able to walk well with the walker are consistent with E8's recollection of R1 as wobbling with the walker.
On 1/14/25 at 10:34 am E8(Activity Aide on 3rd floor/C.N.A) reports being an activity aide for the last 3 months and prior to that being a C.N.A for 3 ½ years in the 3rd floor memory care unit. E8 was running the activity when R1 fell on 11/19/24 sustaining a hip fracture.
E8 described R1 as requiring redirection throughout the morning of 11/19/24 during activity because R1 kept standing up and go the opposite direction from where the walker was located. R1 was seated at a table of 4. R1 needed constant reminder to use the walker. At 2:00 pm, during activity R1 was restless with E8 counting R1 attempting to get up 20 times. E8 saw (R1) was not steady when standing up stating, "(R1) would wobble a little bit." When R1 fell, E8 had arms full with games and back turned to counter directly behind R1. E8 states she heard something and (R1) was falling to ground.
E8 recalled, "Turned my back on everybody. Put boxes on counter-top exactly 2 - 3 feet away the most. While I turn around (R1) was already falling. (R1) had used the walker to get up because the walker was behind another resident. (R1) must have gotten up with walker but lost balance. Sometimes I would see (R1) wobbly

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A4060	Continued From page 7 with walker. Look like falling. (R1) should have been 1:1. (R1) should have been wheelchair." E8 recalls calling the caregiver to take R1 to the bathroom twice but R1 continuing to stand up even after bathroom breaks. Facility staff including E8 did not show necessary skills to appropriately intervene to protect R1 given his unsteadiness even with walker and frequent standing up behavior during activity.	A4060		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: Type 2 Violation Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting a) When the establishment has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the establishment shall: 2) Investigate and develop a written report within 14 days after the initial report. The establishment shall send the written report to the Department within 24 hours after it is completed and shall maintain a copy of the written report on the premises for 12 months after the date of the report. b) A written report of the investigation conducted pursuant to subsection (a)(2) shall contain at least the following: 1) Dates, times, and description of the alleged abuse, neglect or financial exploitation; 4) Any actions taken by the licensee;	A6010		

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A6010	Continued From page 8 5) A list of individuals and agencies interviewed or notified by the establishment; 6) Names of witnesses to the alleged abuse, neglect, or financial exploitation; and 7) If the abuse, neglect, or financial exploitation is substantial, a description of the action to be taken by the establishment to prevent the abuse, neglect or financial exploitation from occurring in the future. Findings include: Based on interview and record review, the facility staff failed to provide one resident (R1) out of 3 reviewed for falls, the necessary supervision and interventions to mitigate the risk of a fall with injury and failed to investigate the circumstances leading to the fall with injury. As a result of this deficient practice, R1 fell and broke his right hip and facility failed to correct staff practice which contributed to R1's fall with injury. Findings include: R1 facility record documents a date of admission of 9/19/24 with diagnoses including but not limited to Dementia, Cerebral Microvascular disease, Benign Prostatic Hypertrophy, cardiomegaly, and central vascular congestion. History of previous "hip surgery" documented which is listed on page 2 of 9 from unknown date. The printout date is 9/13/24. Copies were obtained from facility and page 1 of this medical record was not included. Fall assessment with date of 9/19/24(admission) and 10/15/24 assesses R1 as high risk for falls with score of 13 and 17 respectively. Confusion, limited mobility, diagnosis medications, history of	A6010		

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A6010	Continued From page 9	A6010		

falls and incontinence lead to score of 17 on 10/15/24.
R1 had a total of 2 falls while in the facility; one unwitnessed fall without injury on 9/29/24 at 5:00 pm in the dining room according to the nursing note of 9/29/24 and a second fall on 11/19/24 resulting in injury with surgical treatment.
Based on Incident Report of 11/19/24, at 3:40 pm, "(R1) was participating in (east side) activities (in memory care unit) when (R1) got up from chair, lost (R1) balance and fell." Under injury description, R1 "complained of right hip pain with movement of right leg" with "right leg shorter than left - Bulge noted right hip." R1 was sent to the hospital emergently and according to incident report was diagnosed with "fracture of right hip."
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E2 was asked if witness statement should have been obtained given facility accident and incident policy states in part, "Internal incident reporting process will be initiated by completing an investigation conducted as needed," and "witness statements will be gathered if the incident was witnessed by anyone." The fall occurred in common area during an activity being monitored by facility staff. E2 responded yes, an investigation with interviews should have been

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A6010	Continued From page 10	A6010		

completed. Facility failed to complete an investigation into R1's reportable fall with injury on 11/19/24 and failed to adequately supervise/intervene when R1 was showing signs of ongoing restlessness, unsteady gait even with walker, and confusion for extended period based on staff descriptions.
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E8 recalled, "Turned my back on everybody. Put

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A6010	Continued From page 11 boxes on counter-top exactly 2 - 3 feet away the most. While I turn around (R1) was already falling. (R1) had used the walker to get up because the walker was behind another resident. (R1) must have gotten up with walker but lost balance. Sometimes I would see (R1) wobbly with walker. Look like falling. (R1) should have been 1:1. (R1) should have been wheelchair." E8 recalls calling the caregiver to take R1 to the bathroom twice but R1 continuing to stand up even after bathroom breaks. Facility staff including E8 did not show necessary skills to appropriately intervene to protect R1 given his unsteadiness even with walker and frequent standing up behavior during activity.	A6010		