| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **146136** | A. BUILDING _____ B. WING _____ | **03/12/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **RADFORD GREEN** | **960 AUDUBON WAY LINCOLNSHIRE, IL 60069** |

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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review the facility failed to provide assistance in activities of daily living (ADL's) to 1 of 18 residents (R127) reviewed for ADLs in the sample of 18. The findings include: R127's Physician order [REDACTED]. A facility assessment dated [DATE] shows R127 has no cognitive impairment. The same assessment shows R127 needs extensive assist of 2 or more staff for bed mobility, transfers, toileting and ambulation. On 3/9/2020 at 9:55 AM, R127 was in bed. R127 was upset. R127 said he needed assistance to get up, cleaned up and be assisted to his wheelchair since this morning. R127 said he put his call light on. R127 said a staff member came in the room but turned his call light off and left his room. The staff did not help him. R127 said this happens most of the time. R127 said he does not get the assistance he needs. R127 said yesterday, he sat for almost hour on his commode, no one came to help him. R127 said he called his daughter to let her know that that the staff were not assisting him. On 3/9/2020 at 10:30 AM, V5 (Certified Nursing Assistant) said she was R127's CNA. V5 said this morning she saw R127's call light was on. V5 said she went to R127's room and turned R127's call light off. V5 said she did not assist R127. V5 said she was busy. V5 said R127 needs 2 assist and there was no other staff available to help her with R127 at that time. On 3/10/2020 at 11:00 AM, V7(family member) said R127 had called her more than once to let her know that the staff won't provide the assistance that R127 would need. On 3/11/2020 at 12:05 PM, V6 (Registered Nurse) said staff should not turn the call light off unless the resident has been helped. V6 said V5 should have informed her or asked for assistance with R127. R127's latest careplan shows R127 has self care deficit, bed mobility, dressing grooming, feeding, toileting, transfers, locomotion on and off unit related to decrease strength, endurance and balance. R127's careplan intervention shows, assist with ADL's (bathing, grooming, toileting, feeding, ambulating.) |
| F 0684<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide appropriate treatment and care according to orders, resident's preferences and goals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review the facility failed to ensure a dressing was in place to a pressure ulcer on a residents buttock. This applies to 1 of 2 residents (R19) reviewed for wounds in the sample of 18. The findings include: 1. On March 9, 2020 at 12:44 PM, V9 and V10 (Both Certified Nursing Assistant's) provided incontinence care to R19. R19 was soiled with stool. R19's left buttock had a open area without a dressing in place. V9 said R19 is supposed to have a dressing to her left buttock.It must've fallen off. On March 9, 2020 at 1:21 PM, V4 said if there is a new wound a new order should be obtained and staff should assess the wound. V4 said R19 did not have a wound treatment in place. V4 said skin checks should be done weekly. V4 confirmed R19's last skin assessment was on 2/27/20 (12 days ago). On March 9, 2020 at 1:28 PM, V8 (Licensed Practical Nursing Assistant) said on March 6th, (3 days ago) the CNA reported to her an open area on R19's left buttock. V8 said she applied a foam dressing to her left buttock. V8 said R19's wound is moisture associated skin damage. R19's skin assessment dated [DATE] shows she has no wounds. R19's next skin assessment was on March 9, 2020 (12 days later). The nursing note dated March 9, 2020 shows she has moisture related area to her left buttocks with peeling skin. The Physician order [REDACTED]. (3 days after the wound was identified). |
| F 0688<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review the facility failed to ensure a resident's knee immobilizer was in place during a transfer. This applies to 1 of 7 residents (R32) reviewed for mobility in the sample of 18. The findings include: The Physician order [REDACTED]. R32 has a [DIAGNOSES REDACTED]. The same report shows R32's orders include to be non weight bearing to her right leg and may remove her right knee immobilizer when at rest and for therapy. The Physical Therapy note dated March 9, 2020 shows her right lower extremity should be non weight bearing with a knee immobilizer in place for 8-10 weeks from 1/28/2020. (8 weeks from 1/28/2020 shows she should have the knee immobilizer in place until March 24, 2020). The orthopedic physician note dated March 9, 2020 show R32 does not have orders to discontinue her knee immobilizer. On March 9, 2020 at 11:48 AM, R32 was sitting in her wheelchair without a knee immobilizer on. V10 (Certified Nursing Assistant) transferred R32 and did not put her knee immoblizer on. On March 10, 2020 at 11:54 AM, R32 said she has not worn the knee immobilizer for a while. R32 said the staff do not put it on her at all. R32's knee immobilize was found buried at the bottom of her closet. On March 10, 2020 at 2:04 PM, V11 (Physical Therapy Director) said R32 should wear her knee immobilizer during transfers. The facility's Assistive Devices and Equipment policy dated revised July 17 states, Our facility provides, maintains, trains and supervises the use of assistive devices and equipment for residents. |
| F 0689<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review the facility failed to ensure a safe transfer and failed to ensure a resident at risk for aspiration was served thicken liquids this applies to 2 of 18 residents (R36, R175) reviewed for safety in the sample of 18. The findings include: 1. The Physician order [REDACTED]. The Minimum Data Set assessment dated [DATE] shows R36 requires two person assist during transfers and tolieting; and has limited range of motion affecting one side of her body. On March 9, 2020 at 11:38 AM, V9 and V10 (Both Certified Nursing Assistant's) were assisting R36 to the bathroom. V9 placed R36's right arm wrapped around her neck and stood her up transferring her to toilet. R36's left arm was left dangling to her side with her left fist clenched. V9 transferred R36 back to her the wheelchair in the same way with R36's right arm wrapped around her neck. V9 stated to R36 Give me a nice big hug again. V10 stood next to V9 and did not assist R36 during the transfers. On March 10, 2020 at 2:25 PM, V13 (Physical Therapist) said when transferring a resident staff should instruct the resident to push from their wheelchair/bed to a standing position. The facility's Resident Transfer/Lift Procedures policy dated August 2019, states, . In accordance to our no lift policy Radford Green is committed in taking all possible measure to insure the safety of all its residents by utilizing the most appropriate techniques for |

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

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.

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| F 0689<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>transferring resident .<br><br>2. R175's March Physician order [REDACTED]. On 03/09/20 at 1:07 PM, V14 Certified Nursing Assistant (CNA) was feeding R175 at the dining room table. R175 had non thickened cranberry juice in front of him. V14 gave R175 the cup of cranberry juice and R175 drank half of the juice. At 1:17 PM, R175 finished the rest of the juice in the cup and coughed. On 03/11/20 at 9:17 AM, V15 Licensed Practical Nurse (LPN) said R175 is on nectar thick liquids and pureed diet. V15 said R175 came here from a behavioral health facility on aspiration precautions. 03/11/20 at 9:04 AM, V10 CNA said there is a list of special diets in the pantry and it says it in computer. V10 pointed to the therapeutic diet list in pantry. This list shows R175 is pureed - nectar. On 03/11/20 at 9:07 AM, V14 said she was not sure if V175 was on thickened liquids. R175's Care Plan shows R175 is at risk for aspiration receives a mechanically altered diet pureed diet. Nectar thick liquids. R175's Geropsych<br>Note dated 03/09/20 shows R175 is not safe to be on thin liquids. |
| F 0761<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review the facility failed to ensure resident's medications were not expired for one of 5 residents (R36) reviewed for medications. The findings include: On [DATE] at 9:28 AM, in the 2 East medication room fridge, R36's bottle of [MEDICATION NAME] 2mg/ml was and labeled with an open date of [DATE]. On this same bottle there was a pharmacy sticker that showed discard 90 days after open. There was no expiration date written on the bottle. On [DATE] at 9:35 AM, V8 Licensed Practical Nurse said R36's last dose of [MEDICATION NAME] was [DATE]. V8 stated we date the bottle when it's opened. V8 (pointing to the sticker on the bottle) stated on the bottle it shows it expires 90 days after it's opened. V8 looked at R36's bottle of [MEDICATION NAME] and said it expired in January (90 days would be [DATE]). V8 then put the bottle back in the fridge. R36's Controlled Drug Receipt/Record/Disposition Form for [MEDICATION NAME] shows the first dose was given [DATE] and the last dose was [DATE]. |