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S 000	Initial Comments Complaint Investigation 1844568/IL104143 1844779/IL104367	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210d)6) 300.1220)b)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on interview, observation and record review, the facility failed to develop/implement effective care plans to prevent falls, failed to ensure safety devices were in place, failed to provide adequate supervision and safe transfers were used for 3 of 6 residents (R7, R8, R9) reviewed for falls in a sample of 10. These failures resulted in R9 having multiple falls with a laceration requiring staples in his head sustained in a fall on 7/16/18 and in R7 falling on 7/19/18	S9999		

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resulting in a fractured right hip requiring surgery/closed reduction.

Findings include:

1. A. R9's Profile in the Electronic Health Record (EHR) documents R9 is a 74 year old male admitted to the facility on 5/11/18. The Minimum Data Set (MDS) dated 5/18/18 documents R9 to have short/long term memory with cognitive deficits. The MDS also documents R9 to require extensive assist of one staff for bed mobility, transfers, walking in/out of room, and on/off unit. The MDS documents R9's balance during transitions and walking to be "not steady, only able to stabilize with staff assistance." The MDS identifies no mobility devices used for R9 at the time of admission. R9's room on admission is listed on the secured dementia unit.

A Fall Risk assessment dated 7/16/18 identifies R9 to be high risk for falls.

The care plan dated 5/18/18 identifies R9 "is at risk for falls related to diagnoses of Parkinson's disease, Anxiety, Dementia with Behavioral disturbances, Resident receives Depakote for behaviors. Resident is incontinent of bladder at times. Resident ambulates independently throughout unit and will attempt to walk quickly or run to the door to get out of unit." The goal is R9 "will not have any falls through next review 9/2/18." Interventions include therapy as needed, monitor for unsteady gait, notify physician if resident has unsteady gait, resident to have proper foot wear, environment free of clutter, redirect resident as needed" and "explain to resident he needs to slow down when walking fast/running by redirection." The falls prevention plan fails to address needed assistance as

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indicated in the MDS and supervision when getting up unattended due to his instability.

An Incident Report documents R9's first fall following admission occurred on 7/5/18 at 9:30am and documents "activities director heard res (resident) hollering for help. Res was found lying on floor between bed and w/c (wheelchair) in room 55. When writer entered room, res was in sitting position attempting to get up. Writer trying to assist res & res stated 'I got it' and got himself off the floor. Res was wearing grippy socks. Floor was dry." The immediate action following the fall was to monitor wandering behavior, redirect to common area as appropriate, and offer snacks and activities when res is up wandering. There is no evidence the facility identified the root cause of R9's fall in the report. The care plan's added intervention following his fall on 7/5/18 was to monitor for signs/symptoms of pain, check for proper foot wear even though the report documents he had grippy socks on at the time of the fall.

On 8/9/19 at 2:00pm, V2 (Director of Nursing) when asked if they determined the cause of the fall, stated she wasn't sure and when asked about added proper footwear on the care plan when it was already on it and R9 had grippy socks on when he fell, stated they would consider grippy socks appropriate footwear if the grippy part was face down. V2 did not identify R9 getting up unassisted to be a causative factor.

Progress Notes in the EHR dated 7/6/18 at 2:19pm document "res has been exit door seeking most of the day."

Progress notes in the EHR dated 7/6/18 at 3:19pm document R9 was "up independently

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throughout the unit this evening."

Progress notes dated 7/9/18 at 10:15pm document "physician stated he would like to dc (discontinue) Aricept and begin Seroquel as long as family was ok with decision..."

On 7/12/18, the progress notes in the EHR at 7:52am document "Resident was up multiple times during the night wandering in hallways and went into peer resident room several times. Staff tried to redirect and res became agitated and yelling/threatened to punch female CNA... was up hitting on door and wall trying to exit, trying to get behind nurses desk and take chair using inappropriate language and threatening to hit female CNA.s Staff would offer food, toilet, resting, TV (television), calling wife, became more agitated with suggestions so staff left him along to decrease agitation."

On 7/13/18 at 7:44pm, the progress notes in the EHR document "was reported res was disoriented at times with increase confusion" with a request to decrease Seroquel.

There were no revisions to R9's Fall Prevention plan in regards to the addition of Seroquel and the possible side effects increasing his fall risk factor.

On 7/16/18 at 1:20pm, V24 Licensed Practical Nurse (LPN) documented R9 came down the hall with "blood on the back of his head. It was noted pt (patient) apparently got up and fell backwards hitting head on the footboard of the bed next to him. Pt had an appox (approximately) 1 - 1 1/2 in laceration on the posterior head." The note continues to document the physician was notified and R9 was sent to the hospital. V24 documented

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that R9 returned to the facility on 7/16/18 at 9:27pm with 7 staples in his head.

A Witness statement dated 7/16/18 documents R9 was last seen in bed prior to the fall.

The Incident report documents the same information on this fall on 7/16/18 but fails to document the root cause of the fall. The immediate post incident action was "added alarm while in bed, keep res in common areas as tolerated, check room arrangement."

The care plan interventions dated 7/16/18 reflects the same as the incident report but again fails to identify needed assistance with ambulation and/or increased supervision.

The next entry into the progress notes is on 7/17/18 at 6:44pm by V24 LPN who wrote "at approximately 1:30pm, pt was found lying on his floor by his bed. Pt was trying to get up. Pt was assessed, no injuries were noted. Pt immediately got up off the floor and began walking down hallway."

The Incident Report dated 7/17/18 fails to reflect a root cause analysis but documents the immediate post incident action as "pt will have a bed alarm place on his bed. More freq (frequent) checks will be done of pt."

On 8/9/18 at 2:40pm, V24 stated R9 was up walking in the hallways right before he fell, not in bed. There was no explanation as to why they added a bed alarm as an effective intervention if R9 was not in bed. There was also no witness statement in the report to determine where R9 was immediately prior to the fall and where staff was and no reference to added supervision

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S9999	Continued From page 6 and/or assistance. Progress Notes dated 7/19/18 at 9:45pm entered by V27 LPN documents R9's "gait unsteady at times, wandering aimlessly late this evening despite constant staff redirection." On 7/20/18 at 3:24pm, V24 document in the progress notes in EHR "resident lays in bed for short period and then removes alarms and gets out of bed." On 7/24/18 at 7:54pm, V27 entered into the progress notes in the EHR "res started on Seroquel due to increased agitation and combative behaviors. Since then res has had increased confusion and is off balance when he is walking. The physician was asked to decrease the Seroquel to 25mg from 50mg at hs if no improvement in res balance and confusion, nursing will ask MD to do GDR (gradual dose reduction) of Seroquel to 12.5mg. Team will review again in 1 week." On 7/25/18 at 7:54pm, V27 documented in the EHR progress notes "res is sleepy throughout day & is unsteady at times when walking." V27 documented a message was sent to the MD, V25. On 7/26/18 at 10:56pm, the EHR progress notes entered by V24 document "pt was walking down the hall, lost balance and fell backwards. Pt was assessed by nurse, pt then stood up could not hold balance and began to collapse x 3 with pupils fixed. Pt blood pressure was low and could not be confirmed, unable to hear, pulse rate 25-52 and SPO2 (oxygen) was 88 to 91, Dr V25 called, pt sent to ER via ambulance."	S9999		

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The Incident Report dated 7/26/18 fails to identify the root cause of the fall. Immediate actions documented as taken was "pt will be assist of one, cont with GDR of Seroquel."

The current care plan fails to include this fall and the added assistance needed.

Social Service note dated 7/26/18 at 6:36am entered by V28, Social Service Designee (SSD), documents "Resident is taking Trazodone 50mg (milligrams) at HS (bedtime) and Depakote 125mg 4 caps twice daily, and Zoloft 12.5mg daily and Seroquel 50 at HS was added on 7/8/18 but noticed that resident was off balance so on 7/14/18 Seroquel was (reduced) to 25mg at HS. Resident still has no improvement so asking that resident have gdr of 12.5 and team will review in one week."

The Falls prevention plan in the care plan fails to list the addition of Seroquel as a concern for increase fall risk. There is no new fall risk assessment completed.

On 8/9/18 at 2:30pm, V2 Director of Nurses (DON) stated R9 wanders constantly. V2 was asked why added supervision and/or assistance were not added sooner; V2 stated R9 was "independent in ambulation" but has since required more help. V2 was asked where R9's room was and stated it was at the end of the hallway. When asked why they would not have considered moving him closer to the nurses station instead of being the room the furthest away, V2 stated they didn't consider it but couldn't state why.

On 8/9/18 at 11:35am, the facility's policy/procedure for Falls Prevention was

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requested and V1, Administrator provided a policy entitled "Transfer Screen" dated 8/11 which documents the policy as such: To determine a safe and appropriate method of transferring a resident, nursing staff will perform a transfer screen on each resident. Complete upon admission, readmission and/or quarterly. The policy does not include any procedure to determine falls risk and putting an effective plan in place to address risk and prevention of falls.

B) On 8/8/18 at 7:50 AM R9 was sitting in a chair in the dining room. R9 did not have a personal body alarm present.

R9's Care Plan dated 5/18/18 documents R9 is at risk for falls related to diagnosis of Parkinson's Disease. R9's Care Plan documents intervention for R9 dated 8/3/18 that R9 is an assist of one and gait belt for transfers. Personal Body Alarm at all times.

On 8/9/18 at 11:36 AM V2 DON stated she would expect R9 to have a personal body alarm on at all times as identified as an intervention.

2. R7's MDS dated 7/19/17 documents R7 requires extensive assistance and one person physical assistance for bed mobility, transfers and ambulation. R7's MDS dated 7/22/18 documents that R7 requires extensive assistance and two plus physical assistance for bed mobility and transfer. R7 has a diagnosis of Alzheimer's Disease.

R7's Fall scale dated 7/19/18 documents a score of 95, with a score of 46 or above as high risk

R7's Care Plan dated 11/25/15, documents R7 is at risk for fall related to Alzheimer's Disease and

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history of falls. R7's Care Plan documents on 10/18/17, R7 was found on the floor with interventions listed: frequent visual checks and touch sensitive alarm in bed. R7's Care plan documents on 7/19/18 R7 slipped in puddle of fluid on bathroom floor and that R7 continues to be noncompliant with transfers. R7's careplan documents an intervention dated 8/1/18 Weight Bearing as tolerated to Right Lower extremity and transfer to wheelchair with two assist.

R7's x-ray report dated 7/19/18 documents a severely comminuted displaced fracture proximal right femur involving the intertrochanterric region. R7's hospital consultation note dated 7/19/18 that documents R7 had a closed reduction of right hip and intramedullar nailing.

On 8/9/18 at 2:15pm V2 DON stated that it was determined that R7 was trying to use the bathroom as the causative factor. V2, DON stated R7 had dismantled the touch sensitive alarm.

On 8/9/18 at 3:15 PM V26 CNA stated that she was on duty when R7 fell on 7/19/18. V26 stated that the alarm was not sounding as R7 had dismantled the alarm. V2 (Administrator) present at this time and stated that R7 dismantles the alarm all the time.

On 8/9/18 at 3:10 PM V25, R7's physician, stated that he had not been made aware that R7 dismantled his alarm.
V25 stated that if an intervention for falls is ineffective, something else should be implemented. When asked if R7's fall resulting in a fracture could have been prevented because of ineffective interventions, V25 stated "possibly."

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The current care plan fails to identify that R7 dismantles his alarm and no interventions are present to address this safety concern or that R7 gets up unassisted.

On 8/8/18 at 1:29 PM at 1:29 PM R7 was sitting in wheelchair and V20, V21 and V22 CNAs, and V23 LPN were in R7's room. R7 stated he needed to go to the bathroom prior to laying down. V20 and V22 transferred R7 from the wheelchair to the toilet with the use of a gait belt. During the transfer R7 did not assist with the transfer by bearing any weight. After toileting, V20 and V22 transferred R7 from the toilet back to the wheelchair with the use of a gait belt but no support to his lower extremities. R7 did not bear any type of weight and was holding on to the grab bar in the bathroom. V21 CNA slid the wheelchair under R7, as V20 and V22 were unable to complete the transfer. After R7 was seated in his wheelchair R7 was then pushed to the side of the bed facing the window. R7 was then transferred from his wheelchair to the bed using a gait belt by V20 and V22. At no time during the transfer did R7 bear any type of weight nor did staff encourage/direct him to put his feet on the floor and assist by standing up.

On 8/9/18 V1 Administrator stated a thorough investigation is done on all falls including witness statements if there are any witnesses.

On 8/8/18 at 4:15 PM V2, DON stated that staff are aware that if during a transfer if a resident needs additional assistance, they can provide that to ensure safety.

3. On 8/8/18 at 4:32 PM, R8 was physically picked up out of her bed by V12 Certifed Assistant (CNA) without the use of agait belt and

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S9999	Continued From page 11 sat in her wheelchair. There was no gait belt in R8's room as verified by V2, Director of Nursing (DON). R8's Care Plan dated 12/27/12 documents R8 is at risk for falls and requires extensive assist of two with a gait belt for all transfers. R8's Care Plan documents intervention of two person assist with gait belt for transfers. R8's Minimum Data Set (MDS) dated 5/20/18 documents R8 requires extensive assistance and two plus person physical assistance for transfers and bed mobility. On 8/8/18 4:34 PM V2, (DON) stated that she would expect staff to use a gait belt for transfers. The Facility Policy Transfer Belts/ Gait Belts, dated 4/14, documents a gait belt is used if indicated on the Care Plan. (A)	S9999		