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S 000	Initial Comments Investigation of Complaint #1972402/IL110978	S 000		
S9999	Final Observations Statement of Licensure Violations 330.710a) 330.710c)2030A)C)F) Section 330.4240a) Section 330.710 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part. c) The written policies shall include, but are not limited to, the following provisions: 2) Resident care services including physician services, emergency services, personal care services, activity services, dietary services and social services. 3) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following: A) Analysis of the risk of injury to residents and nurses and other health care workers, taking	S9999	**Attachment A** **Statement of Licensure Violations**	

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into account the resident handling needs of the resident populations served by the facility and the physical environment in which the resident handling and movement occurs.
C) Evaluation of alternative ways to reduce risks associated with resident handling, including evaluation of equipment and the environment.
F) Development of strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident.

Section 330.4240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Regulations were not met as evidenced by:

Based on observation, interview and record review, the facility failed to update and follow resident service plans to provide resident -specific services per resident plans and facility policy. The facility failed to have a written policy regarding the use of, and evaluation of, bed/chair alarms for residents at risk for falling.

Findings Include:

Facility Resident Service Plan / Sign-Off Pages, dated 1/2018, shows, "Purpose: 1. To ensure that Resident Assistants / Personal Care Assistants are carrying out the service plan. 2. To provide documentation that the resident's needs have been addressed each shift ....Procedure: 1. A Sign-Off page will be maintained for each resident as a record of

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services. 2. The assistance/service plan will be the basis for coordination of services. 3. The resident Services Sign-off page corresponds to the Resident Services Plan. 4. The Coordinator/Lead RA (Resident Assistant) / or other designee will fill out the resident name, date of last update, move-in date, room number and DNR (Do Not Resuscitate) status for each resident upon move-in and after the six-month service plan update. 5. The sign-off page holds up to six months of RSP (Resident Service Plan) initials for one resident. The month/year will be entered above each 30/31-day chart, and the resident assistant should initial the appropriate shift (AM, PM, MID) on the appropriate date. 6. Each RA/CAN who provides services to resident will sign and initial one time after the shift has ended. 7. The resident assistant for each shift each day will initial at the end of the shift to provide documentation that care was provided according to the Resident Service Plan ...."

On 4/17/19 at 9:32 AM, V1 stated the facility does not have any policies regarding bed/chair alarm use at the facility.

On 4/17/19 at 11:25 AM, V2 (Director of Nursing) stated she was working on updating the Resident Service Plans since the previous person left two months ago. V2 stated if there were changes with residents, she would update the resident plans. V2 stated she expected the RAs to speak to the nurses to determine if there were any changes to resident plans they needed to be aware of. V2 then stated, "The staff should be made aware of resident plans either thru the service plan or thru the communication."

On 4/17/19 at 11:43 AM with V10 (RA) and V4 (RN) in the C Unit, V10 took a binder with

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resident service plans and daily shift sign off sheets out of the locked closet. V10 showed the binder contained the service plans for only two of the thirteen residents residing on the C Unit. V10 stated the information in the binder had not had any updates in approximately a year. V10 stated a year ago, all residents had service plans in the binder and the plan information used to include if any of the residents were to be provided char/bed alarms. V10 stated, "Every shift we sign off on them." V10 stated, "They need to update this book! Because I have only two persons in there. It has been like that a year." V10 stated she worked at the facility many years and felt V10 knew what care the residents needed. V10 stated she was not sure how other RAs found out what type of services the residents needed. V10 stated she was never told if the service plans were located in resident hard charts and never looked in the hard charts.

1. R1's Incident / Accident Evaluation, dated 3/25/19, shows "Per RA (Resident Assistant), resident states, 'I am trying to get up.'" The evaluation shows, "Fall attributed to poor safety awareness, gait imbalance, and impaired memory." Fall/Incident Witness Statement, dated 3/25/19, shows "Heard him yelling for help when I was in the hallway .... By the time I arrived I saw R1 laying on the floor legs twisted yelling for help. I called for my co-worker and nurse ASAP ...."

R1's Nursing Home Billing and Notification Form Admission / Care Level Change form, dated 5/3/18, shows R1 was admitted to hospice on 5/3/18 with a diagnosis of Alzheimer's dementia.

R1's Resident Service Plan - General Information, dated 3/27/19, shows R1's

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diagnoses include Alzheimer's dementia, transient ischemic attack, cardiac pacemaker, osteoarthritis, generalized muscle weakness, gait abnormality, dysphagia, metabolic encephalopathy, peripheral neuropathy, pleural effusion, hypoxemia, diabetes and anemia.

R1's Resident Service Plans for Falls, dated 3/27/19, 11/2018, 5/2018, and 11/2017, all show, "R1 attempts to get up from his bed without assistance. R1 uses a bed alarm pad on his bed to notify staff when he is trying to get up. R1 attempts to get up from his wheelchair without assistance. R1 uses a chair alarm pad on his wheelchair to notify staff when he is trying to get up."

R1's Resident Services Sign-Off, dated March 2019, shows R1's Resident Service Plan was inconsistently signed off during the month of March.

On 4/17/19 at 10:14 AM, V5 (RA- Resident Assistant) stated on 3/27/19, V5 began her shift and did rounds at 2:00 PM. V10 stated R1 was up on the edge of the bed and wanted to get out of bed. V10 stated at dinner R1 became combative and V11 (RA) took R1 to bed. V5 stated she later heard R1 yelling for help and V5 ran to R1's room. V5 stated the bed alarm was not alarming and V1 was laying on the floor. V5 stated R1's bed alarm was very loud and she would have heard it first when R1 fell.

On 4/17/19 at 10:42 AM, V6 stated R1 was in bed sleeping at the beginning of his shift on 3/3/19 when R1 fell. V6 stated he heard R1 moaning from his room, found R1 on the floor, and no bed alarm was sounding. V6 stated he checked the bed alarm at the time of the fall and the alarm

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was not turned on. V6 stated at the time he never even knew R1 had a bed alarm in place. V6 stated when he changed R1 in bed during the night, no alarm ever sounded during care. V6 stated some of the resident bed/chair alarms have been malfunctioning at the facility. V6 stated no one ever informed V6 R1 had a bed alarm in the 1-2 months V6 worked at the facility. V6 (RA) stated he never knew R1 required a bed alarm. V6 stated he worked with R1 for one to two months, V6 stated he never heard a bed alarm go off as he changed R1 in bed or provided care throughout the night. V6 stated he only found out residents had alarms when they alarm sounded. V6 stated he initially only received four hours of training when he started working at the facility. V6 stated just recently he was introduced to the resident binders, including the service plan binder. V6 stated the resident service plan binder at the nursing station did not have half of the resident plans in the binders. V6 stated, "I don't know the point of it." V6 stated since R1's fall, he arrives at work early to check all of the alarms. V6 stated he finds resident alarms unplugged and needing battery changes.

On 4/17/19 at 3:45 PM, V5 stated at the time R1 fell, she checked the bed alarm device and the device switch was positioned in the "Low" setting, but the device was not alarming. V5 stated she could not understand why the device was turned on, but the alarm was not alarming. V5 stated she would have heard the alarm sounding even if the device was switched in the low position.

On 4/17/19 at 3:35 PM, V11 (RA) stated she placed R1 in his bed on 3/27/19 when he fell and broke his femur. V11 stated she put the bed alarm switch setting on low and left the room with R1 in bed. V11 stated when V5 yelled that R1

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was on the floor, V11 came directly to the room and there was no sound from the alarm. V11 stated both she and V5 checked the alarm and the alarm was on and the switch was set to low. V11 stated she could not understand why the alarm was not alarming if the switch was on.

Fall incident reports, dated 5/15/18, 10/5/18, 10/24/18, 3/3/19, and 3/25/19 all show R1 fell however the reports do not indicate that R1's bed or chair alarm were alarming at the time of his fall. Fall incident report, dated 3/25/19, shows R1 was observed lying on the floor at the bedside with legs twist and screaming, "Help me." The investigation shows the left femur bone appeared shifted and was painful to touch.

Chicago Portable X-ray, dated 3/26/19, shows R1 had an acute oblique 0.6 cm (centimeter) displaced angulated fracture through the mid to distal shaft of the femur. The bones are osteopenic. DJD (Degenerative Joint Disease) is present in the knee. There is an old proximal left femur ORIF (Open Reduction Internal Fixation) with intact hardware.

Hospital note dated 3/26/19, shows, "Given cardiac history and end stage dementia high risk for any surgical procedure."

Nursing notes, dated 3/27/19, show R1 was readmitted back to the facility. Nursing notes, dated 3/28/19, show R1 was refusing to open his mouth or eyes, was not eating, and was holding on to his covers. Nursing note, dated 3/31/19 at 1609, shows, " ....entered resident room to administer medications and deceased. TOD (Time of Death) 4:00 PM."

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On 4/9/19/at 10:19 AM, V9 (Coroner) stated, "This is an accidental death related to his fall."

2. POS, dated 4/1/19, shows R2 was admitted to the facility on 1/23/16 and diagnoses include dementia, macular degeneration and restless leg syndrome.

Incident / Accident Evaluation, dated 4/5/19, shows R2 "is a fall risk" and "attempts to stand up frequently." The evaluation shows R2 was "unaware of physical limitations due to cognitive impairments."

On 4/9/19 at 11:25 AM, V3 (LPN-Licensed Practical Nurse) identified R2 as high risk for falls and stated R2 slid to the floor over the weekend. V3 stated interventions for R2 to prevent falling included a chair alarm, bed alarm, low bed, and bilateral floor mats beside her bed.

On 4/9/19 at 11:33 AM in the dining room before lunch, R2 was sitting in her wheelchair at her lunch table. A chair alarm was attached to the back of R2's wheelchair. When prompted, V3 examined R2's chair alarm and determined it was not turned on. V3 stated the alarm should have been turned on, turned the alarm on and stated, "She probably just went to the bathroom."

R2's Resident Service Plan, dated 3/8/19 and provided by V1, shows, "Mobility/Transferring ... Use chair alarm as needed."

On 4/17/19 at 11:20 AM with V3 (LPN), R2's Resident Service Plan located in the RA binder containing resident service plans, showed "Review Date July 2017". The service plan failed to show R2 uses any bed or chair alarms. V3 stated R2 used a form of chair and bed alarm

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consistently since September 2018. V3 stated the use of the alarms should be written in the service plans because R2 required them at all times.

On 4/17/19 at 11:25 AM, V2 stated she just updated R2's care plan in March 2019 when admitted to hospice. V2 stated, "I think with R2 we put in that if she needs a chair alarm, she can use it depending on what her mood is ..." V2 stated the nurse was to determine each shift if R2 was to have a chair alarm on and the nurse should communicate the information to the RA. V2 stated, "If she is sitting in the wheelchair, I think they are using more frequently."

On 4/17/19 at 11:55 AM, V3 stated R2 must have a chair alarm on her chair at all times she is in a chair. V3 stated R2's alarm use is not determined on a shift-by-shift basis.

3. POS, dated 4/1/19, shows R3 was admitted to the facility on 11/3/18 and R3's diagnoses included dementia, fatigue, spinal stenosis, and cardiac pacemaker.

Memory Care Pre-Assessment Form, dated 11/5/18, shows R3 had a history of falls prior to admission to the facility.

Resident Service Plan Mobility/Transferring/Safety/Falling, updated March 2019, fail to show R3 required the use of a bed alarm when in bed.

Nursing notes, dated 4/6/19 8:10 PM, shows R3 was found on the floor by staff who heard R3's bed alarm sounding.

On 4/9/19 at 11:40 AM, V4 (Registered Nurse)

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identified R3 as a fall risk. V4 stated R3 fell over the past weekend and fall interventions included toileting R3 prior to going to bed, use of a bed alarm, and floor mats beside his bed. Nursing notes, dated 4/6/19 8:10 PM, show, "Bed alarm heard upon entering residents room found him near his bed laying on his right side ...." Incident Report, dated 4/7/19, shows, "Bed alarm heard coming from resident's room upon entering room found him near his bed laying on right side ...."

On 4/9/19 at 2:45 PM, V4 was assessing R3 as he was sitting in the parlor in his reclining chair. V4 stated "He just fell." V4 stated R3 was in his bed in his room, tried to get up out of bed by himself, and fell to the floor. V4 stated he heard R3 moaning and went to R3's room. V4 stated R3's bed alarm was not alarming when he arrived to find R3 on the floor. V4 stated R3 usually falls while trying to get out of bed. At 2:49 PM V4 went to R3's room to assess R3's bed alarm. The bed alarm was attached to bed and outlet. V4 stated, "Yeah, it's on." V4 pushed on the bed several times near middle of resident's bed trying to activate the alarm, but no alarm sounded. V4 pushed on the bed in several positions and then higher up on the bed, in the middle of first third of the bed from the top, and alarm finally sounded. V5 pulled pad out from under bed stated, "It's very narrow."

On 4/9/19 at 2:55 PM, V7 (RA) stated she and V4 were at the nursing station and heard R3 moaning. V7 stated R3 was on floor with his legs on the bedside mat and was laying on his side with head toward door. V7 stated R3's bed alarm was not alarming when entering the room. V7 stated staff must utilize a mechanical lift to transfer R3 to bed. V7 stated R3 was in bed about fifteen minutes after being transferred to

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S9999	Continued From page 10 bed when she heard R3 moaning. Nursing notes, dated 4/9/19 at 4:00 PM, show, "Res had fall at 2:35 PM. RN and RA heard res (resident) making a sound from his room and rushed to find him laying prone on the door side of the bed ....Bed alarm did not go off at the time of fall ...." Incident Report, dated 4/10/19, shows, "Res heard making a sound, RA and RN went to room and res was laying prone on ground ...." RA Fall / Incident Witness Statement, dated 4/9/19, shows "Ensure bed alarm is working properly prior to laying resident in bed." On 4/17/19 at 11:25 AM, V2 (Director of Nursing) stated she was working on updating R3's Resident Service Plan. V2 stated, "He is a fall risk when he goes to bed .... He started using the bed alarm recently. I have to update his service plan to include that. Going forward I will add it in the service plan when it is implemented." On 4/17/19 at 11:43 AM, V10 and V4 both stated R3 had been using a bed alarm consistently since January 2019. (B)	S9999		