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	IL6005284	A. BUILDING: _____ B. WING _____	C 02/27/2020

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LEE MANOR	1301 LEE STREET DES PLAINES, IL 60018

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S 000	Initial Comments Complaint Investigations #2091286 / IL120253 #2090997 / IL119936	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210 b) 300.1210 d)6) 300.1220 b)3) 300.3240 a) 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. 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 and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee	S9999	**Attachment A** **Statement of Licensure Violations**	

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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.

These regulations are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to identify a resident's correct fall risk, failed to use a gait belt during transfer of a resident as per their care plan fall interventions, failed to adequately monitor a resident at risk for falls, and failed to revise and implement resident specific fall interventions for two (R1, R4) of three residents reviewed for accidents. This facility failure resulted in R1 sustaining a head laceration requiring sutures, a fractured left clavicle, and subarachnoid hemorrhage (bleeding in the brain) that necessitated hospitalization, and in R4 sustaining a right dorsal hand skin tear and a fractured left hip.

Findings include:

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1.) R1 is a 92 year old, verbal resident with diagnoses per POS (Physician Order Sheet) that include (but not limited to) History of Falls, Lack of Coordination, Abnormal Posture, Abnormalities of Gait and Mobility, Macular Degeneration and Alzheimer's Disease. R1 is alert and oriented, but forgetful.

On 2/18/20 at 11:22 AM, surveyor observed R1 seated in her wheelchair in the dining area. Surveyor asked R1 about her fall on 11/19/19; R1 said she only remembered being on the floor and saying, "get me up!" "They don't want me to go to the bathroom without someone with me. But I cannot go in my diaper, I need to use the toilet. If I use the buzzer, I can wait at least a half hour before someone comes to help. I have a really weak bladder." R1 asked V15 (Certified Nursing Assistant/CNA) to take her to the toilet. V15 assisted R1 to a standing position (no gait belt was applied) and seated her on the toilet. V15 told R1 she would come back and help her when she was done, and left R1 alone in the bathroom. V15 returned and assisted R1 off of the toilet and back into her wheelchair (no gait belt was applied).

On 2/18/20, surveyor reviewed R1's medical records:
R1 fell on 9/13/19 and on 10/15/19 in the bathroom after attempting to transfer self (no injuries were sustained), fell on 11/19/19 in her room sustaining a head laceration, fractured left clavicle and subarachnoid hemorrhage (was hospitalized four days), and fell on 2/3/20 in her room (no injury sustained). R1 was alone during all her falls, and all falls were unwitnessed.

9/13/19 Fall Risk assessment notes R1 at "11"

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(moderate risk - had fall on 9/13/19). On 10/15/19, R1 assessed at "9" (moderate risk - had fall on 10/15/19); On 11/19/19, R1 assessed at "10" (moderate risk - had fall on 11/19/19 with significant injuries); on 11/23/19 R1 assessed at "19" (high risk); on 2/3/20, R1 was assessed at "21" (high risk - had fall on 2/3/20).

7/1/19 MDS (Minimum Data Set) Section "G" (Mobility) indicates R1 needing extensive, one person physical assistance for bed mobility, transfers and toileting. (R1 fell on 9/13/19; MDS 9/23/19 remains at one person physical assistance). 11/26/19 MDS "G" (completed after 11/19/19 fall with significant injuries) indicates R1 needing extensive, two person physical assistance for bed mobility and transfers, and remaining with extensive, one person assistance for toileting. 12/18/19 MDS "G" indicates R1 needing decreased assistance, requiring extensive, one person physical assistance for bed mobility, transfers, and toileting (R1 fell on 2/3/20 in her room).

Care plan documents focus area "R1 is at risk for falls," with interventions including: "Be sure call light is within reach and encourage to use it for assistance as needed. Prompt response to all requests for assistance. Ensure wearing appropriate footwear when ambulating or mobilizing in wheelchair. PT evaluate and treat as ordered or PRN (as needed). Review information on past falls and attempt to determine cause of falls. Educate resident/family/caregiver/IDT (interdisciplinary team) as to causes." Focus area: "The resident has had an actual fall with no injury/minor injury related to poor balance, unsteady gait with interventions: Continue interventions on the at-risk plan (no information documented of what

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the actual interventions are on the "at-risk plan")." Focus area: "Restorative Ambulation Program: R1 has limited mobility ... due to bilateral lower extremity weakness ... poor standing balance ...and includes intervention. Use gait belt, obtain permission from the resident before applying."

During interview on 2/25/20 at 11:50 AM with V2 (Director of Nursing/DON), V3, and V4 (both MDS Coordinators), surveyor asked what does at-risk fall interventions mean on R1's care plan? V2 said the at-risk interventions are those that are named on the care plan's first page. Surveyor asked V2, V3 and V4 if it was an appropriate intervention for a resident with a diagnosis of dementia to remind to ask for assistance. All agreed it would be difficult to expect a resident with dementia and memory issues to remember to ask for assistance. Surveyor asked what was considered a prompt response time frame. V2 stated it means "Immediately. Anyone can answer a light. I would consider it a prompt response if a call light was answered within five to ten minutes." Surveyor informed V2, V3, and V4 R1 said it can take at least a half an hour for assistance. V2 stated we know R1 is a fall risk, and we should have prioritized her to have assistance more quickly. Surveyor reviewed with V2, V3, and V4, the multiple fall risk assessments, MDS Section "G" sections, and current care plan for R1. Surveyor asked V2, V3, and V4 if R1's current care plan was accurate and progressive in its fall interventions to prevent further falls, considering R1's fall risk assessments increased from "moderate" to "high" risk, yet her MDS Section "G" assessments decreased her from an extensive, two person physical assist for transfers to one person physical assistance, and R1 has since fallen on 2/3/20. All agreed that MDS information needs to

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be correct because it guides the resident's care plan, and agreed R1's current care plan did not reflect any intervention changes after R1's falls or with an increasing fall risk. V2 stated, "I admit, you're right - the interventions are not showing progression for fall prevention, even though R1's fall risk has increased. I do agree a care plan needs to be individualized to address the specific care needs, and R1's present care plan isn't individualized."

During interview on 2/27/20 at 2:20 PM, V14 (Medical Director) was informed of the multiple falls sustained by R1 with the fall on 11/19/19 resulting in multiple injuries, and surveyor asked "How important are the fall interventions in a resident's plan of care?" V14 said the interventions need to address the resident's safety concerns, and if a resident is having multiple falls the interventions need to address the increasing safety needs of that particular resident.

2.) R4 was a 91 year old, verbal resident with diagnoses per POS (Physician Order Sheet) that include (but not limited to) Abnormalities of Gait and Mobility, Alzheimer's Disease/Dementia, Glaucoma, Closed Fracture of Left Femur with Malunion, History of Transient Ischemic Attack ("mini stroke") and Cerebral Infarction, Atrial Fibrillation and Atherosclerotic Heart Disease of Coronary Artery with Aortocoronary Bypass Graft. R4 was admitted into hospice care on 1/20/20, and expired on 1/22/20.

Review of R4's closed medical record documents the following falls: 8/30/19: fell in room, no injuries; 10/5/19: fell in room, no injuries; 10/14/19: fell in room, no injuries; 1/11/20: fell in room, sustained a left subcapital hip fracture, and

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a skin tear to his dorsal right hand. R4 was alone during all falls, and falls were unwitnessed.

10/14/19 Fall Risk assessment notes R4 was assessed at "21" (high risk - had fall on 8/30/19). On 11/19/19, R4 was assessed at "15" (moderate risk - had fall on 10/14/19). On 1/11/20, R4 was assessed at "19" (high risk - had fall on 1/11/20 resulting in the left hip fracture and right dorsal hand skin tear).

9/4/19 Admission MDS (Minimum Data Set) Section "C" (Cognition) indicates a BIMS (Brief Interview Mental Status) of "6", indicating R4 had severe cognitive impairment. Section "G" (Mobility) indicates R4 needed extensive, two person physical assist for bed mobility and transferring. 11/25/19 MDS Section "C" indicates "00", Section "G" remained at an extensive, two person physical assist.

R4's care plan had the focus areas of, "R4 is at risk for falls related to cognitive decline from dementia, impaired vision, gait abnormality ..." with interventions "Anticipate and meet needs. Be sure call light is within reach and encourage to use it for assistance as needed. Prompt response to all requests for assistance. Ensure wearing appropriate footwear when ambulating or mobilizing in wheelchair. Follow facility fall protocol. PT evaluate and treat as ordered or PRN (as necessary). Review information on past falls and attempt to determine cause of falls. ... Educate resident/family/caregiver/IDT as to causes." Focus area "Has had a fall due to unsteady gait and weakness" with interventions to "Continue interventions on the at-risk plan" (no information documented of what the actual interventions are on the "at-risk plan). Focus area "Restorative Ambulation Program: R4 has

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limited ability or willingness to initiate or participate in mobility related task of ambulation due to cognitive deficit. Needs assist with ambulation. Poor safety judgement. Poor sitting and/or standing balance related to Alzheimer's disease, glaucoma, muscle weakness and others" with interventions including "Have resident in standing position for few seconds before taking steps for balance. Ensure that resident is wearing appropriate footwear. Use gait belt, obtain permission from the resident before applying."

During interview on 2/25/20 at 11:50 AM with V2 (Director of Nursing/DON), V3, and V4 (both MDS Coordinators), surveyor asked, "What does 'At-risk fall interventions' mean on R4's care plan? V2 said the "at-risk" interventions are those that are named on the care plan's first page. Asked V2, V3, and V4 if it was an appropriate intervention for a resident with a diagnosis of dementia to remind to ask for assistance. All agreed it would be difficult to expect a resident with dementia and memory issues to remember to ask for assistance. Surveyor asked what was considered a "prompt response" time frame. V2 stated, "It means immediately. Anyone can answer a light. I would consider it a prompt response if a call light was answered within five to ten minutes." Reviewed with V2, V3, and V4 the multiple fall risk assessments, the MDS Section "G" sections (consistently indicating R4 required extensive, two person physical assistance for mobility and transfer), and R4's care plan. Surveyor asked V2, V3, and V4 if R4's care plan was accurate and progressive in its fall interventions to have prevented further falls, considering R4's fall risk assessment initially was noted at a "high risk", then R4 had two separate falls and was assessed

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to be a "moderate risk" falls, and then R4 fell again and sustained a hip fracture and was reassessed on 1/11/19 again to be a "high risk" for falls? All agreed R4's fall risk assessments and most recent care plan did not reflect any intervention changes after R4's falls or note R4's increasing fall risk. V2 stated, "I admit, you're right. The interventions are not showing progression for fall prevention, and R4 was at a high fall risk. I do agree a care plan needs to be individualized to address the specific care needs, and R4's care plan wasn't individualized."

Review of facility policy "Fall Management" (reviewed 1/24/19) states "Definitions: Avoidable Accident: means that an accident occurred because the facility failed to ... Implement interventions, including adequate supervision and assistive devices, consistent with a resident's needs, goals, care plan ... in order to eliminate the risk, if possible, and, if not, reduce the risk of an accident, and/or monitor the effectiveness of the interventions and modify the care plan as necessary ..."

(B)