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S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)3)6) 300.3240a) Section 300.610 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 by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five	S9999	Attachment A Statement of Licensure Violations	

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percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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:
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.
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 300.3240 Abuse and Neglect

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

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resident. (Section 2-107 of the Act)

These Requirements were not met evidencded by:

Based on interview, and record review, the facility failed to implement their post fall protocol which includes immediate assessment, physician notification, communication with direct care staff members, and documentation requirements for 1 of 3 residents (R6) reviewed for falls in the sample of 13. This failure resulted in R6 not receiving care for 14 days after falling from her wheelchair and sustaining a right femoral fracture, requiring hospitalization with surgical repair. Also, the facility failed to identify and treat pain for R6, this unidentified and delayed or pain care for 14 days after R6 sustaining a fall with an undiagnosed femoral fracture.

Findings Include:

A "Fall with Fracture Final Investigation Report" dated 2/19/20 documents R6 sustained a witnessed fall in the dining room on 1/29/20 at 7:25 AM. The report documents R6 was seen by Nurse Practitioners from "Tapestry Telehealth" (which is a teleconference system where nurse practitioners/MDs can evaluate the residents' via video) on 2/4/20, 2/5/20 and 2/11/20. This report does not document they were notified of R6's fall that had occurred on 1/29/20.
The report documents V29 (Physician) was notified of the 1/29/20 fall on 2/12/20 at 4:54 PM with new orders for x-rays. X-rays were obtained at the local hospital with the diagnosis of a "Displaced sub capital fracture of the right femur and equivocal basicervical fracture of the left femur." V29 was notified of the x-ray results with orders to send R6 to the local ER for evaluation.

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The same report goes on to document after being seen in the ER, R6 was transferred to an area hospital for orthopedic care. R6 returned to the facility on 2/16/20 after surgical right femur repair. The facility documents their investigation concluded R6's right femur fracture is "Possibly related to the fall and/or occurred during routine ADL (Activities of Daily Living) care / transfers and comorbidities of Osteoporosis and contractures to both lower extremities. The facility documents staff were "In-serviced on the Incident / Accident Reporting Policy to include that all change of planes is considered falls and all falls are to be documented per facility protocol with DON (Director of Nursing) notification." The report also goes on to state that "(name) V28 (Licensed Practical Nurse/LPN) was in-serviced regarding the occurrence and requirement of timely documentation and physician notification."

"Progress Notes" for R6 document on 2/4/20 at 4:04 PM, V36 (Nurse Practitioner) was notified via "Tapestry" telehealth services for a chief complaint of nausea and vomiting. V36 documents, "This is a 75 y/o (year old) female with dementia with behaviors. Noted to have increased agitation 2 days ago, curled up into the fetal position today. Emesis times 1 at 10 AM. Usually cries out with care, now is crying out constantly." Review of Systems includes the "Psychiatric" review of "Displays Mood Changes," and "Constitutional" review of "Displays fatigue. Displays poor appetite." "Physical Exam" documented as, "The patient is awake, well developed but appears ill. Laying in fetal position." "Extremities" documented as having "1 plus pitting edema." The same document goes on to state R6 is oriented to person only. "Care Plan / Assessment" is documented for R6 as "Nausea with vomiting, unspecified. (brand name)

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Ondansetron 4 milligrams (mg) ODT (orally disintegrating tablets) Q (every) 6 hours prn (as needed). Unspecified abdominal pain. Cath (catheter) UA (urinalysis), CBC (complete blood count), CMP (complete metabolic profile), vitals Q shift. Unspecified dementia with behavioral disturbance, other mixed anxiety disorders. Risperidone, (brand name) Valproic Acid, (brand name) Alprazolam. Return Appointment: Tomorrow."

Review of R6's Plan of Care lists a focus area of R6 requires the use of a physical restraint. Interventions listed include an initiation date of 8/2/19 documenting the use of a "self- releasing lap belt." The same plan of care also documents a focus area for R6 of, "I am at risk for fall R/T (related to): depression, poor balance, poor safety awareness, non-ambulatory" with a date initiated as 2/8/19. Interventions listed for this focus area include: "Assist resident as needed with ADLS (activities of daily living)" and "Notify physician as needed of any changes."

R6's "Restraint / Evaluation Review" last completed 2/11/20 regarding the use of the self-releasing seatbelt documents the "Reason for use of physical restraint" as, "frequent falls" and "Sliding out of chair / wheelchair." The same document lists the benefits of use of the self -releasing seatbelt as, "Prevents injury to self."
R6's "Fall Risk Assessment 1" completed 12/1/19 documents a score of 12, indicating R6 is "At risk for falls."
R6's MDS (Minimum Data Set) dated 12/2/19 documents R6 is not cognitively intact. R6's functional status for transfer is documented as "3, 3" indicating R6 requires extensive assistance of two plus physical assist when R6 is transferred between surfaces (bed, chair, wheelchair).

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A Facility Policy titled "Fall Prevention Program" with a revision date of 11-21-17 documents, "To assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary." The same policy goes on to state the fall prevention program includes the following components: ...Use and implementation of professional standards of practice .... Notification of physician, family / legal representative .... communication with direct care staff members .... documentation requirements."

An undated Facility Policy titled "Incident / Accident Reports" defines an incident as, "Any happening, not consistent with the routine operation of the facility, that does not result in bodily or property damage." An accident is defined as, "Any happening, not consistent with the routine operation of the facility that results in bodily injury other than abuse. An incident / accident report will be completed for: 1. All serious accidents or incidents of residents ....3. Any unusual occurrences ....6. All unexpected events that occur that cause actual or potential harm to a resident or employee ....9. Any condition resulting from an accident requiring first aid, physician visit, or transfer to another health care facility." The same policy documents, "An incident / accident report is to be completed by a RN (Registered Nurse) or LPN (Licensed Practical Nurse) and is to include a. Date and time of an incident / accident. b. Full written statement and possible cause of incident, physical assessment, injuries noted, vital signs,

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treatment rendered, and notification of appropriate parties."

On 2/18/20 at 1:15 PM, V15 (RN) stated R6 is not cognitively intact and cannot make her needs known. V15 stated R6 does have behaviors of grabbing, hollering, and crying at times, which she described as being easily re-directed. V15 stated although she cannot recall the specific date, she was working one of the days prior to R6 being diagnosed with the femur fracture when the aides notified her R6 was crying uncontrollably and could not be consoled. V15 stated she contacted "Tapestry." V15 stated "Tapestry" was not notified of a previous fall because she was not aware R6 had a fall that she needed to report. V15 states the normal procedure after a resident experience a fall would be to notify the nurse, the nurse evaluates, notify the physician and resident representative of the fall and take any new orders received and complete the risk management evaluation report of fall.

On 2/19/20 at 11:15 AM, V16 (Certified Nurse Assistant, CNA) stated he was aware of a fall R6 had around the end of January in which R6 fell forward out of her chair. V16 stated he did in fact witness the fall which occurred in the Garden hall living/dining room. V16 confirmed R6's seatbelt was not on at the time of the fall. V16 stated V31 (CNA) was also working during that time. V16 stated R6 was placed back in her chair and he reported the fall to V28 who was the nurse. V16 stated he wasn't sure what V28 did with that information. V16 confirmed a TV had also fallen off a table as she pulled the tablecloth during the fall.

On 2/19/20 at 2:20 PM, V31 stated she was working with V16 and V28 on or around 1/29/20

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when R6 experienced a fall. V31 described being in the hallway getting ready to pass breakfast trays when she heard a thud, followed by V16 hollering for her from the living/dining room. V31 confirms R6 was on the floor and she helped V16 lift R6 back into her wheelchair and went back to passing hall trays. V31 states she did not observe V28 evaluate R6 post fall.

On 2/19/20 at 12:57 PM, V29 (Physician) stated the facility did not notify him of a fall sustained by R6. V29 stated he could not recall the name, but facility staff had notified him of an incident on the day R6 went to the ER when it was reported to him that a TV had reportedly fallen on her on an earlier date. V29 states he was not notified of any incident involving a TV falling on R6 at the time it occurred. V29 stated he finds the care and timeliness of care provided to R6 as unacceptable. V29 stated had he been notified of a fall or incident involving R6 which may have resulted in injury immediately, it would have changed the plan of care for R6. V29 stated R6 had a history of babbling, with occasional crying but stated R6 had demonstrated new onset inconsolable crying which had been presented to him as possible advancing dementia / behaviors. V29 stated with the inconsolable and increased crying, resident character changes, etc. (etcetera) he would have ordered further medical evaluation and attributed the crying more to the possibility of discomfort. V29 stated a femoral fracture would cause significant pain, and even further pain with R6 being moved and manipulated without the fracture being stabilized. V29 once again confirms the lack of prompt physician notification regarding a fall and/or incident which may cause injury, along with the questionable accuracy of the events resulted in R6 receiving inaccurate, insufficient, and untimely care.

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On 2/20/20 at 8:45 AM, V1 (Administrator) stated during the AM (morning) meeting on 2/12/20, the team was discussing R6 due to her new onset abnormal postural changes in her wheelchair. V1 stated V34 (Medical Records / Restorative Aide) mentioned she thought she heard V16 saying R6 had a recent fall. V1 stated he was not aware of a fall that had recently occurred with R6. V1 stated he asked V16, who was working at that time around the fall, in which he confirmed what had happened. V1 stated V11 (Registered Nurse/RN) notified V29 (Physician) who gave orders for an x-ray, which revealed a fracture. V1 stated the occurrence of the fall R6 sustained had not been communicated to "Tapestry" due to V28's lack of documenting and reporting the fall. V1 stated the facility does have surveillance cameras which were reviewed, showing the fall. V1 described the video as showing R6 in the dining room next to a smaller "coffee table like table" which had a tablecloth and TV sitting on top of it. V1 described the video as showing R6 leaning forward in her wheelchair, pulling the tablecloth, and falling forward out of her chair onto her right side, and causing the tablecloth and TV to fall off the table and onto R6's left side. V1 stated he does not recall seeing R6 undo her seatbelt prior to falling out of her chair and isn't sure why her seatbelt wasn't on. V1 stated V16 and V31 (CNA's) were seen getting R6 back into her chair on the video and stated V28 was not visualized. V1 described R6's normal status as being alert to person only, anxious, and unable to communicate. V1 acknowledged if accurate information such as the occurrence of the fall followed by a change in condition had been communicated to "Tapestry" (which is a teleconference system where nurse practitioners/MD's can evaluate the residents' via video) he expects it would have changed their

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course of treatment. V1 acknowledged V28's failure in not reporting the fall to the physician, resident representative, or completing any necessary documentation post fall.

On 2/20/20 at 8:45 AM, V28 stated the normal facility practice for when a resident sustains a fall or incident which may cause injury would be for the nurse to immediately assess, notify the physician & resident representative regardless of if there is an injury, and fill out the incident / risk management report. V28 stated he does remember a fall involving R6 occurring on 1/29/20, which he recalls being around a mealtime. V28 stated V16 reported to him R6 fell in the dining room and said he was given the impression it was a "simple fall." V28 stated he just visually glanced at R6 to be sure she wasn't bleeding and was her normal self. V28 stated R6 was already back up in her wheelchair when he went to look at her. V28 said he resumed passing medications. V28 stated once R6 was laid down in bed within approximately an hour of the fall, he looked at her and saw no concerns. V28 stated R6 was vocal and babbling / resistive to care which he describes as being her normal status at times. V28 stated when V16 reported the fall to him, there was no mention of a TV involvement. V28 stated he did not contact the physician, resident representative, or complete any documentation regarding the fall occurrence. V28 said some days are just busier than others. V28 stated the fall occurrence was not passed on to the next shift and acknowledged because of that, no follow up evaluation or care was completed. V28 stated he did work with R6 some days post fall when he described R6 as being "inconsolable." V28 described R6's "inconsolable" status to include being "very loud / vocal,

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babbling, resisting care, behaviors escalating when staff would try to comfort, redirect, or reposition her." V28 described R6 as not being cognitively intact and unable to make her needs known. When asked if he ever considered her increased behaviors and inconsolable status as an effect from the fall, V28 stated "no." V28 acknowledged those factors should have been considered and acknowledged his failure to not complete the appropriate post fall forms, physician, and resident representative notification.

On 2/20/20 at 11:10 AM, V36 (Nurse Practitioner) stated she recalls being contacted regarding R6. V36 stated residents are seen by video teleconference. V36 stated she was never told R6 had sustained a fall. V36 stated she suspected R6 was experiencing possible gastric discomfort due to the report of an emesis and R6's abnormal posturing. V36 stated had she been notified of a fall, it would have changed her treatment plan and included ruling out injury. V36 acknowledged that the facility's failure to provide accurate occurrences created a hindrance in R6's plan of care.

On 2/20/20 at 11:26 AM, V37 (Nurse Practitioner) stated she recalls seeing R6 via video teleconference. V37 stated this was her 1st time seeing R6, so she asked many questions to try and establish her baseline. V37 stated it was never communicated to her that R6 had sustained a fall. V37 stated she was contacted due to R6 having abnormal positioning in her wheelchair which included constant leaning forward. V37 stated V15 (who was the nurse present during the conference) did state it was questionable if R6 was experiencing pain in her left lower extremity when in her wheelchair. V37

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stated V15 demonstrated range of motion (ROM) to R6's left lower extremity during this time but noted R6 was in bed rather than her wheelchair. R6 displayed no sign of discomfort with the ROM being performed to that extremity. V37 states R6 was also contracted and thought based on this assessment, wheelchair comfort may be a factor in the postural changes related to her demented status or possible cerebrovascular accident. V37 stated a tilt wheelchair was recommended to try. V37 stated had she been notified R6 had sustained a fall, it would have changed her course of treatment to include ruling out injury with diagnostic testing. V37 verifies a femoral fracture would cause significant pain.

On 2/20/20 at 11:54 AM, V11 (RN) stated she was the nurse who was on duty that contacted V29 and received orders for x-ray that ended up diagnosing the fracture. V11 stated V41 (CNA) reported to V11 that R6 just wasn't acting right. V11 stated, "it was very evident she (R6) was in pain." V11 described R6 as being "loud" and "seems to be in pain." V11 stated that no matter what they did to try and redirect / reposition R6 they could not calm her. V11 stated V41 mentioned hearing R6 had possibly had a recent fall. V11 stated she checked R6's record and did not see any fall documentation, nor had it been passed on in shift report of any falls.

On 2/20/20 at 2:10 PM, video surveillance was observed which captured R6's fall in the living area of the Garden unit. Observation of video surveillance was timestamped as starting on 1/29/20 @ 7:42 AM. Video shows R6 sitting in her wheelchair with seatbelt unfastened and hanging to the side of wheelchair. R6 was observed leaning forward in her wheelchair, pulling at a

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tablecloth located in front of her. R6 was observed falling forward landing on right hip / right side of body. The tablecloth is pulled off the table with TV that was sitting on the table falling on top of R6's left hip / upper leg area. V16 (Certified Nurse Aide/CNA) is observed immediately responding and lifting the tv off R6, along with making a "come here" motion. V31 (CNA) was shown entering the video footage where she and V16 lifted R6 back into her wheelchair and V16 fastened R6's seatbelt. V31 and V16 then fixed the tablecloth, sat the tv back on the table, and exited the video surveillance area. At no time was V28 (LPN) observed evaluating R6. R6 exited the video surveillance area per staff transfer at the video time stamp of 8:05 AM.

On 2/20/20 at 12:57 PM, V2 (DON) acknowledged V28 failed to notify the physician and complete the required paperwork documenting R6's fall on 1/29/20. V2 stated V28's failure to report R6's fall to the MD (Medical Doctor) resulted in R6 receiving delayed treatment and lack of care. V2 would expect staff to notify the MD of a fall regardless of injury status and acknowledged that a femoral fracture would be painful. V2 stated she would expect if someone was displaying signs or symptoms of pain to be evaluated and administered pain medication as needed, along with reporting to the MD if no pain resolution. V2 stated staff should notify the MD of any falls regardless of injury status.

"Progress Notes" for R6 dated 2/12/20 at 7:30 PM by V10 (Licensed Practical Nurse) documents ER called and stated R6 was being sent to area hospital for orthopedic services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009815	A. BUILDING: _____ B. WING _____	C 02/27/2020

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APERION CARE FAIRFIELD	305 N.W. 11TH STREET FAIRFIELD, IL 62837

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Review of R6's Clinical Record from 1/29/20 - 2/16/20 includes no documentation indicating a fall occurred or that any physician had been notified of a fall. The first entry documenting a fall is noted on 2/17/20 at 10:28 AM, which was made by V3 (Regional Nurse Consultant) with the type of note listed as "Fall IDT (Interdisciplinary Team) Note" This note documents: "Summary of the fall: resident was in her chair and bent over to grab something and fell. Root cause of the fall: Confusion, leaning over. Intervention and care plan updated: leave resident in bed until therapy can eval for safety needs while up in w/c."

The local hospital "Radiology Report" dated 2/12/20 documents the "Reason for Study" as "Increased pain and contracted today Nursing home patient." "Findings" are documented as a "Displaced sub capital fracture of the right femur." The report goes on the state that the "Bone is displaced anteriorly at least 1.8 cm (centimeters). There is also lateral and superior displacement of around 2.2 cm."

The area hospital R6 was transferred to for orthopedic care documents on the "Orthopedic Operative Note" with admission date of 2/12/20 a Preoperative and Postoperative Diagnosis of "Right Femoral Neck Fracture." The same report documents the Procedure performed as a "Right Hip Girdlestone Procedure." The report documents R6 had been transferred to the emergency room "with concern for a fracture of undetermined timeframe."
A policy titled "Pain Management Program" with a revision date of 7/6/18 documents the purpose of this program is "To establish a program which can effectively manage pain in order to remove adverse physiologic and physiological effects of unrelieved pain and to develop an optimal pain

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management plan to enhance healing and promote physiological and psychological wellness." This same policy goes on to state "When a resident is unable to describe pain, physical signs such as grimacing, body posturing/protecting, vital sign changes, and changes in behavior and mood will be used to determine the presence of pain."

R6's Plan of Care with an initiation date of 2/8/19 and revision date of 2/18/20 documents a "Focus" area of, "I have a potential for pain r/t depression, osteoarthritis, immobility Fx. femur." "Interventions" included for this focus area include: "Administer analgesia per orders" with an initiated date of 3/21/19. "Monitor/record/report to Nurse any s/sx (sign / symptoms) of non-verbal pain: Changes in breathing (noisy, deep/shallow, labored, fast/slow); Vocalizations (grunting, moans, yelling out, silence); Mood/Behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); Eyes (wide, open/narrow slits/shut, glazed, tearing, no focus); Face (sad, crying, worried, scared, clenched teeth, grimacing), Body (tense, rigid, rocking, curled up, thrashing). Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment. Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents experience of pain."

Review of R6's Medication Administration Record (MAR) for 1/29/20 - 1/31/20 document Pain Assessments of "0" complete every shift with no additional as needed pain medications being administered for discomfort.

Review of R6's Medication Administration Record for 2/1/20 - 2/29/20 documents Pain Assessment

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scores of "0" complete every shift, except for a score documented of "3" on 2/2/20. Despite R6's current medication regimen including scheduled pain medication, progress notes and interviews in which it was conveyed R6 was experiencing many nonverbal signs and symptoms of pain, no pain acknowledgement or as needed pain medication is documented as being administered until 2/12/20 at the time the femur fracture was diagnosed. The MAR documents on 2/12/20 at 3:11 PM, R6 was given Acetaminophen 650 milligrams.

R6's physician orders document an order for "(name brand) Acetaminophen Give 2 tablet by mouth every 6 hours as needed for mild pain" with a start date of 2/8/19." It is noted R6 also receives "Fentanyl Patch 72hour 12 MCG (microgram) / HR (hour). Apply 1 patch trans dermally every 72 hours for pain and remove per schedule" with a start date of 2/13/19.

On 2/18/20 at 12:36 PM, R6 was observed lying in her bed. R6 is observed as being not alert to person, place, or time during this encounter. R6 was observed as having a surgical dressing present to her right hip area.

(A)