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	IL6005946	A. BUILDING: _____ B. WING _____	C 09/01/2020

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S 000	Initial Comments Complaint Investigation: 2066520/IL125910	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b) 300.1210d)6) 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 300.1210 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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 and assistance to prevent accidents.

Based on record review and interview the facility failed to develop and implement interventions to prevent an injury for one of three residents (R1) reviewed for falls with injuries and failed to complete quarterly and as needed fall assessments for two of three residents (R1, R2) reviewed for falls in the sample list of 12. This failure resulted in R1 rising from R1's wheelchair unassisted and falling to the floor which resulted in a left hip fracture requiring surgical repair.

Findings include:

The facility's Fall Prevention policy with a revised date of 2/28/19 documents, "A fall will be defined as unintentionally coming to rest on the ground, floor or other lower level, not intentionally from an overwhelming external force or other purposeful action." "Residents will be assessed for their fall risk: The facility nurse will be responsible for completing the Fall Risk Assessment on admission. The MDS (Minimum Data Set) Coordinator or designee will update following any significant change of status and as needed. On regular intervals which includes quarterly/annually MDS 3.0 Assessments. At any time necessary as

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assessed by the nursing administration." "The Nurse Managers are responsible for: completing the fall-risk assessment at the appropriate intervals, Updating resident care plans appropriately and to ensure proper interventions are in place." "Nursing staff including RNs (Registered Nurses), LPNs (Licensed Practical Nurses), and CNAs (Certified Nursing Assistants) are responsible for: Helping Nursing Administration with input to complete fall risk assessments upon admission and following a fall or change in condition of a low risk resident. To ensure procedures for high risk fall patients are in use."

1.) R1's Face Sheet dated 7/21/20 documents diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Chronic Kidney Disease (CKD), Congestive Heart Failure (CHF), Dementia without Behaviors, Unsteady on Feet, Muscle Weakness and History of Falling.

R1's Minimum Data Set (MDS) dated 6/11/20 documents R1 has moderately impaired cognition. This MDS documents R1 required limited assistance of one person for transfers and for walking. R1 required extensive assistance of one person for toileting. This MDS documents R1 was not steady moving from a seating to a standing position and required staff assistance to stabilize self. This MDS also documented R1's Range of Motion was impaired on both lower extremities.

R1's medical record documents fall events on 3/22/20, 5/22/20 and 7/17/20.

R1's medical record documents an annual Fall Risk Assessment dated 12/19/19 which documents a moderate fall risk. The next fall risk

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assessment in R1's medical records is a Quarterly assessment dated 6/11/20, almost six months later, and documents R1 is a high risk for falls with "altered awareness of immediate physical environment". R1's medical record does not document fall risk assessments following the 3/22/20 fall or the 5/22/20 fall and R1's medical record does not document a quarterly fall risk assessment between the 12/19/19 assessment and the 6/11/20 assessment.

R1's Restorative Note dated 3/5/20 completed by V26 Registered Nurse (RN), documents R1 requires one person assist for a stand pivot transfer. R1's Restorative Note dated 6/9/20 completed by V27 RN documents the same requirement for R1 to have one person assistance for a stand pivot transfer.

R1's Care Plan with a start date of 12/25/17 and updated 7/23/20 documents R1 is at risk for falls with interventions dated 5/28/20 to keep gait belt in reach, 3/23/20 to remind resident to use the call light for assistance when wanting to get up, 5/3/18 resident reoriented and re-educated to use call light and encourage to use it, 12/25/17 fall risk assessments quarterly and prn (as needed).

On 8/31/20 at 2:43 PM, V2 confirmed that there were no quarterly fall assessments completed nor were there fall assessments completed with the falls for R1.

On 8/31/20 at 4:00 PM, V2 Director of Nursing provided a portion of R1's Care Plan that was not available in the electronic record which documents a problem date of 3/8/20 and documents R1 has the inability to ambulate independently due to unsteady gait and general weakness.

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R1's Nurses Progress notes dated 7/17/20 at 7:51 PM, by V13, RN documents staff heard resident yelling "Hey, hey" and as they started walking towards the yelling, the resident was yelling "help, help, I've fallen". Staff ran to find resident (R1) laying on R1's left side next to R1's wheelchair, R1 stated that R1 was standing up, lost R1's balance and fell. Upon attempting assessment R1 verbalized severe pain to the left hip and lower back. Left lower extremity was noted to be abnormally rotated outward. R1 was unable to wiggle toes or move. R1 stated that R1's back hurt. Staff was instructed to not move resident and writer (V13) called 911. Ambulance arrived and R1 was taken to the hospital. SBAR (Situation, Background, Assessment and Recommendation) and bed hold were faxed to the hospital and POA (Power of Attorney) and PCP (Primary Care Physician) were notified.

R1's Fall Investigation dated 7/17/20 documents R1 was last seen at 6:45 PM, however none of the witness statements document visualizing R1 at 6:45 PM. V28 Certified Nursing Assistant's (CNA) witness statement documents that V28 saw R1 last at 5:00 PM when V28 took R1 to the toilet before supper. On 9/1/120 at 8:34 AM, V28 confirmed that was the last time V28 saw R1 before R1 had fallen. V29's witness statement documents that V29 did not start V29's shift until after R1 had already fallen.

On 9/1/20 at 9:00 AM, V13 Registered Nurse (RN) stated V13 was the one that saw R1 at 6:45 PM on 7/17/20. V13 stated R1 was in R1's room in R1's wheelchair at the end of R1's roommates bed reading a newspaper at 6:45 PM. V13 stated a little after 7:00 PM V13 heard a resident yelling for help so V13 went running and found R1 on the

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floor in R1's room. V13 stated R1 was non complaint with waiting for assistance to stand and transfer. V13 stated often times they would find R1 already on the toilet in the bathroom because R1 had taken R1's self to the toilet or they would find R1 in the doorway of R1's room with the depends at R1's knees because R1 took R1's self to the bathroom but could not pull up the depends afterwards.

R1's hospital emergency room History and Physical dated 7/17/20 documents the chief complaint as "fall from bed at nursing home". Hospital's assessment and plan document, R1 was unable to move R1's leg. Hospital Assessment/Plan documents a 93 year old female with known history of Dementia was sent to the hospital with noted unwitnessed fall, patient (R1) has been unable to move (R1's) left leg and is unable to give any history. Upon presentation to ED (Emergency Department) noted to a have left hip fracture. Will admit for possible operation tomorrow morning.

R1's Radiology Report dated 7/17/20 at 9:03 PM, documents acute comminuted and displaced intertrochanter femoral fracture. R1's Surgical Case Record dated 7/18/20 documents actual procedure as "left long intramedullary nail".

R1's Nurses Progress Note dated 7/21/20 at 5:17 PM, documents R1 returned to the facility by ambulance. R1 was slightly confused. R1 had two incisions on left hip from the hospital stay. There were 16 staples in the top incision and six staples in the bottom incision. On 7/21/20 at 6:49 PM, R1's Nurse's note documents R1 was unable to take R1's medications whole as R1 did previously. This Nurse's note documents the medication had to be crushed and administered

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S9999	Continued From page 6 to R1. On 8/31/20 at 2:43 PM, V2 confirmed that the facility was aware that R1 frequently stood up without assistance and there is not anything documented prior to the 7/17/20 fall that the facility was doing to prevent the fall with injury. V2 stated that they could have done 15 minute checks, rounding every hour or kept R1 in a more supervised area. On 9/1/20 at 8:34 AM, V28 Certified Nursing Assistant (CNA) confirmed V28 last saw R1 at 5:00 PM on 7/17/20 when V28 took R1 to the toilet and V28 left the facility at 6:00 PM. V28 also stated that R1 stood up a lot without assistance. 2.) R2's face sheet printed 9/1/20 documents diagnoses including Alzheimer's Disease, Chronic Pain, Retention of Urine, Repeated Falls and Insomnia. R2's medical record documents R2 had falls on 8/01/2020 at 4:25 PM, 7/30/20 at 2:27 AM, 7/26/2020 at 9:44 AM, 7/23/2020 at 12:44 AM, 7/22/2020 at 9:13 PM, 6/26/2020 at 8:21 PM, 6/18/2020 at 4:30 PM, and 5/03/2020 at 11:29 PM. R2's Care Plan dated 3/03/2020 documents R2 is at risk for falls related to Confusion, Forgetfulness, Poor Sleeping Habits, Lack of Personal Safety Awareness, Intermittent Impaired Balance and the use of medication known to increase the risk of falling. This Care Plan documents interventions for falls as placing safety mats next to the bed, medication review, make sure R2 has warm clothing on and Fall Assessments to be completed quarterly and prn (as needed),	S9999		

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S9999	Continued From page 7 R2's Transfer Assessment dated 2/26/20 documents R2 transfers independently. R2's Fall Risk Assessment dated 2/27/20 documents R2 transfers independently. R1's next fall assessment is dated 6/4/20 which documents R2 is now a high risk for falls. R2's medical record does not document fall risk assessments being completed with each fall. R2's medical record documents the quarterly fall assessment completed on 6/4/20 was due in May, 2020. On 8/31/20 at 2:43 PM, V2 confirmed that fall assessments were not completed with the falls for R2 and quarterly assessments were not completed on time. V2 stated that R2 had a significant decline from March to June when R2's family could no longer visit on a daily basis due to COVID-19 like they had previously. (A)	S9999		