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	IL6016737	A. BUILDING: _____ B. WING _____	01/17/2020

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S9999	Final Observations	S9999		

Statement of Licensure Violation

300.610a)
300.1210b)5)
300.1210d)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 300.1210 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:

Attachment A
Statement of Licensure Violations

5) All nursing personnel shall assist and

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encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.
(A, B) (Section 2-107 of the Act)

These Requirements are not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff were aware of and implemented interventions from the resident's plan of care for resident (R17) assessed as high risk for falls. This failure resulted in R17 having a fall and being hospitalized for a left hip fracture. The facility also failed to follow their policy by not having resident specific interventions for resident (R12) who was not responding to fall interventions due to cognitive status of being forgetful and noncompliant, which resulted in R12 having multiple falls.

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Findings include:

1.) R17 is an 88-year-old female admitted to the facility on 11-1-2019 with medical diagnoses that include but are not limited to: history of falling, anemia, reduced mobility, difficulty in walking, lack of coordination, and generalized anxiety disorder.

R17's fall assessment dated 11-5-2019 documents R17 as a high risk for falls with a score of 80.

R17's Kardex (communication sheet used by nursing to document information related to resident care needs) dated 11-5-19 documents: LOCOMOTION: The resident requires (Stand by assistance) by (1) staff for locomotion using (walker); TRANSFER: The resident requires extensive assist of 1; Toileting: TOILET USE: The resident requires (extensive assistance) by (1) staff for toileting; NURSING REHAB/RESTORATIVE: ACTIVE ROM (range of motion) Program #1 AROM (active range of motion) to BUE (bilateral upper extremities) and BLE (bilateral lower extremities) 15 reps x's 2 6-7 days/week.

MDS (Minimum Data Set) assessment dated 11-18-2019 documents that R17 requires limited assistance of 1 staff when transferring to or from bed, chair, wheelchair, standing position and requires limited assistance of 1 staff with toilet use. MDS also documents that R17 is not steady, only able to stabilize with staff assistance while moving on and off toilet and with surface to surface transfers (transfer between bed and chair or wheelchair).

R17's care plan initiated on 11-18-2019 with a

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revision date of 11-25-2019 includes goal of improving current level of function in (ADLs) through review date. Currently requires extensive assist with ADL's. Interventions include: TOILET USE: the resident requires extensive assistance by (1) staff for toileting; TRANSFER: the resident requires extensive assistance of 1

1-14-2020 at 10:30 A.M. R17 observed in R17's room alert and oriented said, "I like to walk but I am not steady (walking) and I need to get stronger to go back to my apartment." The white board in R17's room lists (R17's) shower days, as well as the names of the nurse and certified nursing assistant; no care plan interventions noted on the white board.

1-14-2020 at 14:48, after lunch R17 was observed in the television room sitting on a chair. R17 stated she had just fallen while trying to transfer from walker into wheelchair and she fell in between chairs, she states no one saw her fall and she got up. Facility X-ray of the left hip shows that R17 had a left hip fracture and was transferred to a local hospital for evaluation and treatment. R17 was subsequently admitted to local hospital with chief complaints of pain, injury, and swelling and a diagnosis of acute left hip fracture.

R17 had a previous fall on 11-6-2019 at 14:34; R17 was observed on R17's bathroom floor.

1-15-2020 at 12:15P.M. V3 (Licensed Practical Nurse) said, "R17 called my attention and asked me if I could help her get the walker. The walker was next to R17's chair, when R17 stood up, she immediately complained of pain to left hip area. I called the medical doctor, ordered an emergent x-ray of the left hip, called the responsible party

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and the Director of Nursing. R17 is continent of bowel and bladder and goes to the bathroom independently. Frequently R17 does not use the call light and R17 assumes she is independent to do all the walking. The care plan is updated as needed and the interventions are documented on the white board by R17's bed side."

1-15-20 at 12:30P.M. V4 (Certified Nursing Assistant) said, "on 1-14-2020 I had R17, I do not do much for R17. R17 is very independent on all ADL's and is continent of bowel and bladder I just come to the room, set up the linen and R17's daily cloths. R17 has a walker that R17 uses occasionally; I did not see when R17 was having a fall."

1-15-20 at 1:05P.M. V5 (Registered Nurse - MDS/Restorative) said, "R17 ambulates with the rolling walker with stand by assistance. On multiple occasions R17 needs to be reminded to use the walker. I am responsible for updating the care plans for nursing. For falls we have an interdisciplinary meeting and the team will determine which intervention will be put in place next, the interventions need to be patient specific; once the care plan is in place we will update the white board in the residents' room for everyone to know the new interventions. R17 is currently in the restorative program and won't be able to be considered independent because she requires staff supervision."

01/15/20 at 02:00 PM V2 (Director of Nursing) said "R17 ambulates independently with the rolling walker with supervision or assistance as needed. R17 can stand independently, able to dress independently, and is continent of bowel and bladder. The care plan is updated by the MDs coordinator after the interdisciplinary team

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meets and discuss the new patient specific interventions, the new interventions will be put in the Kardex (communication sheet used by nursing to document information related to resident care needs) for the staff to see and on the white board in resident' room."

2). R12 is an 87-year-old female admitted on 10-8-18 with medical diagnoses that include but are not limited to: epilepsy, repeated falls, displaced fracture of olecranon process without intraarticular extension of right ulna, transient ischemic attacks, difficulty in walking and unsteady on her feet. R12 is alert and oriented but forgetful.

MDS (Minimum Data Set) dated 8-23-2019 documents that R12 requires one-person physical assist with toileting and dressing. MDS dated 12-13-2019 documents that R12 needs limited assistance of 1 person for bed mobility, transfers, walking in room and corridor, locomotion in unit, toileting and personal hygiene. Needs extensive assistance of one person for locomotion off unit and dressing.

Fall evaluation dated 10-8-2018 (R12) scores 50, high risk for falls.

R12's care plan initiated on 10-11-2018 with focus of high risk for falls related to confusion and unaware of safety needs/seizure disorder includes intervention: be sure call light is within reach and encourage resident to use it for assistance as needed. Resident needs prompt response to all requests for assistance.
Interventions added include:
1-21-2019 educate R12 to use the walker when ambulating;
2-11-2019 remind R12 that R12's balance

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requires R12 to use the walker while in room when ambulating;
3-4-2019 anticipate R12's needs;
9-14-2019 educate R12 to use the call light and ask for assistance especially at night time;
10-18-2019 educate R12 to use the call light and walker when R12 needs assistance to use the bathroom for safety, requires assistance;
11-17-2019 educate R12 to use call light when toileting as R12 needs the assistance as R12 balance is unsteady.

Per fall reports, R12 had falls as follows:

1-21-2019 at 15:57 unwitnessed fall in R12's room kneeling, R12 stated, I was trying to use my walker and I stumbled.

2-10-2019 at 10:24 am unwitnessed fall in R12's room, R12 was observed sitting on the floor in the bathroom.

3-4-2019 at 7:30 am unwitnessed fall in R12's room, R12 stated while in bed I reached out for my walker and fell out of the bed. Per nurses notes, R12 had bruising and hematoma to the forehead. V3 (Licensed Practical Nurse) asked R12 what had happened and she reported that 2 days ago she fell from bed.

9-14-2019 at 22:09 unwitnessed fall in R12's room, R12 stated, I fell last night when I was changing my shirt, I did not report it to the nurse, R12 complained of pain to the back and flank area, X-ray done, negative for fracture.

11-17-2019 at 6:28 am unwitnessed fall in R12's bathroom, staff assisted R12 to the bathroom, 5 minutes later staff went to check on R12, was observed sitting on the floor by her bed and

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stated, I tried to get back in bed by myself and I had a fall.

On 1-14-2020 around 10:30 A.M. R12 was observed in bed, alert and oriented to self, place and date. White board in R12's room lists the name of the nurse and certified nursing assistant the date and shower days; no mention of any fall interventions observed.

01/17/2020 at 11:20 AM V3(Licensed Practical Nurse) said, R12 needs assistance of one person for ambulation, transfers and toileting. R12 uses the call light occasionally but R12 is alert and forgetful. R12 had a few falls that R12 reported after they happened, not when the actual fall happens.

01/17/2020 11:30 AM V4 (Certified Nursing Assistant) said, R12 uses the rolling walker or the wheelchair but staff needs to make sure R12 is monitored when walking with the rolling walker or the wheelchair. R12 is continent of bowel and bladder. R12 needs to be taken to the toilet and wait until finished because R12 is forgetful to use the call light and has unsteady gait. R12 does not follow the instructions of calling for help when getting out of the bed.

01/17/2020 12:04 PM V2 (Director of Nursing) said, R12 is alert and forgetful; the staff needs to be with R12 when she is in the bathroom. R12 is not compliant with the use of the call light. When asked if interventions have been updated or revised because resident is not responding to education or to meet resident needs (since resident is known to be forgetful and does not usually use call light or ask for help), V2 stated that R12's care plan interventions need to be patient specific and evaluated for effectiveness.

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S9999	Continued From page 8 The interdisciplinary team needs to meet and update the interventions as per MDS schedule or as needed. "Fall Prevention and Fall Occurrence Policy" dated May 2008 includes: All Elder/residents identified, as a "high risk" by the Fall Risk Assessment and/or clinical assessment will have an individualized care plan developed. The Kardex will reflect these interventions ...Nursing has the overall responsibility to assure that care is coordinated among all disciplines and to achieve established goals ...At the care conferences the care plans will be reviewed with the team and the resident/responsible party ...Each care plan will be revised and updated with appropriate revisions and dates as applicable. (B)	S9999		