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S 000	Initial Comments Complaint 1989514/IL00118747 F689 G cited.	S 000		
S9999	Final Observations Statement of Licensure Violations: 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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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:

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.

These Regulations were not met as evidenced by:

Based on observations, interviews and record reviews, the facility failed to develop effective interventions to prevent a resident from multiple falls in which two resulted in serious injuries. R3 was reviewed for falls with injuries.
R3 sustained an injury to left forehead requiring sutures and sustained a Left Rib fracture.

Findings include:

On 1/09/2020 at approximately 1:10pm, V32(Local Fire Department) reported, "When we arrived, the resident was lying on the floor in blood. They left him in the same spot where he fell. The staff didn't try to get him up. There was blood on his head and the floor. He was alert and denied pain. This guy was coherent. He knew

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what was going on around him. The nurse called 911 for us to pick him up. The engine company (It's called that not paramedic), picked patient up and placed him in a wheelchair. V32 stated that R3 told him that the nurse blocked him in his room by placing the medication cart in front of his door. V32 reported, "The patient told me he wanted to go to the hospital and not return." R3 was transferred to community hospital B.

On 1/9/2020 at 2:45pm, V24(RN) stated, "It's been a while since I worked on the evening shift. I worked on 12/25/2019. I took care of R3. The CNA informed me that R3 was on the floor in his room. I went to his room and resident was laying on the floor on his left side. I did an assessment: He stated his left rib area was hurting, took vital signs. They were stable. We put him in bed. Don't remember if I gave him pain medication or not. Received doctors order to send patient to hospital."

On 1/9/2020 at approximately 3:00pm, V23(RN) stated, "The fall incident with R3 happened in November, 2019. I did rounds on my shift. The CNA told me the resident was on floor. I first saw resident face down. I saw blood on the floor. I turned R3 to the side and saw laceration on R3's left eyebrow. Didn't know if resident had a spinal injury. I did not move resident. Resident was alert and oriented to name. R3 said he tripped. I asked the resident if he was in pain, he denied any pain, took vital signs and they were stable. I put pressure dressing on forehead. I called for another nurse. I left the room to call 911. When ambulance arrived, they placed resident on a stretcher from the floor. I notified the doctor."

Requested to interview CNA's(V27 and V28) who reported R3 falls on 11/24 and 12/25/2019. On

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1/09/2020 at 3:30p.m., V1(Administrator) stated that they no longer worked at the facility and attempted call both CNA's but they had not returned call.

On 1/09/2020 at 3:40pm, V25(Physician) stated, R3 had prior history of falls prior to admission to this facility. R3 was admitted from hospital for weakness. He had falls since he's been here. I'm aware of R3's head injury on 11/24/2019 and his left rib fracture happened on 12/25/2019. The first fall was not preventable because staff was not familiar with the resident. After the first fall, interventions were put in place such as bed alarm, R3 was moved closer to the nursing station and other interventions. Resident was ok to get up with staff assistance. The nurse told me, "R3 said he was going to fall on the floor and hurt himself." Despite interventions put in place, R3 continued to have falls. I ordered another psychiatric evaluation but resident was not here long enough to receive it. V25 responded to question about R3 left on floor until Emergency Medical Services arrived. He said, "It's not uncommon for a patient to be left on floor/ground depending on the situation. The nurse may have not moved resident to prevent further injury to head or spine, as long as staff is by his side for support.

On 1/10/2020 at 12:20pm, V30(Nurse Practitioner) stated, R3 had some falls while in the facility. R3 had diagnoses of Schizophrenia in his chart. He denied R3 was taking anti-psychotics. R3 denied hearing voices and he did not verbalize any delusions to me. He was somewhat withdrawn. He was continued on Ritalin because that's what he was taking in the hospital. Ritalin can be given for ADHD(Attention

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Deficit Hyperactivity) or ADD(Attention Deficit Disorder). Ritalin may also be prescribed for failure to thrive, low body weight. He was not eating well. Did the hospital figure out why he had so many falls?

MDS (Minimum Data Sheet) indicates R3 was admitted on 11/22/2019, with history of falls with minor injury, Medications received: 2 days admission: Anticoagulant (i.e., Warfarin, heparin). MDS section for balancing and transfer indicates: Surface to Surface transfer (transfer between bed and chair or wheelchair=2=Not steady, only able to stabilize with staff assistance. Moving from sitting to standing=8= activity did not occur, walking =8= activity did not occur, turning around=8=activity did not occur. Wheelchair indicated. Family or Significant other participated in assessment. MAR(Medication Administration Record) dated 11/25 and 1/26/2019 indicates R3 received Enoxaparin Sodium 40 MG/4.0ML subcutaneously in Right Upper Quadrant and Left Upper Quadrant of abdomen respectively: This medication is given to prevent clots.

On 1/9/2020 at 4:15pm, V26(LPN/ Fall Coordinator stated, "Anytime a resident has a fall, I will conduct a full investigation of the fall. I will do my own investigation to determine root cause. The Root Cause Analysis is done electronically. I will modify the nurse's care plan and put in new fall interventions or change interventions. R3's thought process was jumbled, confused. He started having some delusions. R3 seemed alert and oriented to name, place and time but the more you speak to him, he seemed more confused. The first fall was due to weakness. He tried to get up out of bed. He was seen by the psych nurse practitioner after the first fall. He stated someone was trying to get him. He was

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paranoid. R3 was to be seen by the psychiatric doctor for another evaluation. R3 was impulsive He fell on the floor a couple of times. We put him closer to the nursing station, placed bed alarm and explained safety awareness. He was not started on any medication. Explained to R3 to pull call light. He nodded his head as if he understood but he did not do it when he needed help.

V26 presented a chronological fall history for R3. R3 experienced eight falls between 11/24/2019 and 12/26/2019.

11/22/2019: R3 Admitted to facility
11/24/2019: R3 fell, laceration to forehead, sent to hospital ER. Intervention, R3 educated on using call lights and to ask staff for assistance. To be seen for Psych Evaluation.
12/3/2019: R3 fell from wheelchair- no injury. Mat placed in wheelchair to minimize sliding.
12/10/2019: R3 fell attempting to transfer self from wheelchair to bed without waiting for staff assistance. No injury revealed by in-house X-rays, PT/OT to evaluate strength and mobility. Educated to change positions slowly especially from sitting to standing and ask for staff for help.
12/25/2019, Resident fell from bed. R3 presented with delusions and was noted calling 911 stating that "Two guys are outside of the door trying to kill me." R3 sent to ER.

12/26/2019 at 4:05am, R3 returned from ER with diagnoses of Fracture above Eighth rib. A chair and bed alarm put in place for safety. Resident to be evaluated by in house Psychiatrist.

12/26/2019 at 8:31am, Resident observed laying on the floor next to his bed. R3 stated, "I'm trying to leave, I don't want to live in this place

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anymore." Resident sent to ER for Evaluation. 1:05pm: R3 returned from ER with no injury. Resident moved to room closer to nursing station for closer observation. Resident to be visually checked more frequently while in bed.

12/26/2019 at 6:40pm, Resident fell from bed stated he was attempting to reach his phone when he slipped out of bed. R3 sent to ER for evaluation. 10:56pm: Resident returned from ER with no injury. Resident to be provided with activities that can provide a distraction and minimize the potential for falls. Resident's bed should be in lowest position while in bed for safety. (Per Policy, all residents's on blood thinners that have unwitnessed fall must be sent to the ER for evaluation.)

Facility's Psych Provider (V30/Nurse Practitioner) Initial Evaluation Note documents: History and Physical dated 11/25/2019, indicates R3 diagnoses include: Cerebral Infarction, Dysphagia, Type II Diabetes Mellitus, Schizophrenia, Muscle Wasting, Lack of Coordination, Reduced Mobility, Encounter for Surgical Aftercare following Surgery on the Circulatory System, Fracture of one rib, Hypertension. Cognitive Impairment: Mild, Mood=anxious/depressed. Present History: Patient denies mental illness despite schizophrenia listed in records; patient denies current antipsychotic treatment. Medication: Ritalin 5mg BID.

Community Hospital A ER(Emergency Room) Physician's notes dated, 11/24/2019 documents, R3 was admitted to the ER at 9:48am and discharged back to nursing home at 4:51pm. Physician notes Indication: Trauma; head injury after mechanical fall. History of CVA with residual

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weakness. Noncontrast CT of brain was obtained. Impression: No intracranial hemorrhage(bleeding). Small left frontal scalp laceration/hematoma. Impression: In order to achieve hemostasis, patient forehead laceration repaired at bedside with 3 interrupted sutures. Approximately 2cc Lidocaine with epi injected around laceration site prior to repair. X-ray of pelvis Impression: No acute fracture.

According to Hospital B Emergency Room(ER) Intake Sheet dated 12/25/2019, R3 was admitted to the ER at approximately at 5:58pm and was discharged back to the facility on 12/26/2019 at 12:34am. ER Physician's History and Physical documents: 72 y/o male Previous Medical History of CVA(Stroke-October, 2019), MI, Hypertension and Type II Diabetes presents to ER via EMS from facility/nursing home with fall. Of note on 12/3/2019 had similar presentation with fall from wheelchair. Patient has residual Left sided weakness from CVA. Patient states he was trying to stand from his bed to get to his wheelchair and in the process slipped and lost balance, then fell on this left side and flank, also hit his head. Denies (LOC-loss of consciousness). Appearance: Left facial droop. Patient Physician Exam denotes reason: FALL. Exam: Left rib pain, 3 views. Clinical indication: 72 year old male with left rib pain. X-ray Findings: There is an acute appearing nondisplaced left eighth rib fracture near the constochondral junction. Impression: Acute appearing left eighth anterolateral nondisplaced rib fracture. Correlate with point tenderness. CT of Head: Impression: No acute intracranial hemorrhage or depressed skull fracture. There is a concern for stroke, further evaluation with MR. ER Nurse's note dated 12/25/2019 documents: Nurse from Warren Barr contacted. Nurse was notified that

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patient has a nondisplaced rib fracture and is going to be discharged.

According to Hospital B ER admitting intake sheet dated 12/26/2019, R3 was admitted to the ER at 7:46pm, for accidental fall at nursing home. R3 was discharged back to nursing home at 10:20pm. Physician note documents: Patient to ER for mechanical fall. Patient states he dropped his cell phone, bent over to pick it up and accidentally tripped over and struck left parietal (side) of head against the siderail. Denies LOC, history of CVA; left sided weak. Patient states he does not feel safe where he is staying. Patient requested social services for possible transfer.

Hospital B ER Physician's Notes dated 12/26/2019 remarks: Differential Diagnosis: Contusion, Head injury. Cardiac: Sinus Tachycardia. Notes. Patient just seen at community hospital ER for complaint of fall just yesterday. Patient with multiple falls sent from Warren Barr again today with complaint of fall.

Hospital B History of Present Illness documents: The patient is a 72 y/o male who presents with fall. The course of pain is decreasing. Location of pain: head. The degree of headache: negative. The other degree of pain is negative. The degree of bleeding is negative. Existing injuries prior to trauma were left 8th Rib Fracture.
Re-examination: Head CT: Negative for any acute process. Patient to go back to Warren Barr and continue usual medical regimen. Reviewed cautions for falling and patient awaiting transportation.

Hospital B ER intake document dated 12/26/2019 remarks; R3 arrived in ER at 10:00pm. R3 in ED(Emergency Department) at facility(Warren

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Barr South Loop Nursing Home) for mechanical fall today. Patient dropped his cell phone, bent over to pick it up, and slipped on his side. Patient states he hit the left side of his head against the siderail. Denies LOC. No noted injuries. Patient and per EMS(Emergency Medical Service Driver) states patient had a total of 3 fall episodes today, 2 of which he "slid down from his bed while sleeping and fell, the 3rd time was when he dropped his phone and tried to pick it up. Patient currently receiving physical therapy for CVA deficits which are left side residual weakness. Patient states normally ambulates on his own but with a limp. Per EMS, patient was seen yesterday here at "community hospital B" for same complaints of fall. Discharge note dated 12/26/2019 at 10:20pm documents: ambulance here to take patient back to Nursing Home.

On 1/3, 1/7, 1/8, 1/9 and 1/10/2020, R16, R17 and R19 are at risk for falls. Residents were interviewed and observed in their rooms. Residents denied any fall concerns.

Fall Occurrence Policy dated July 30, 2019 documents: It is the facility policy to ensure that residents are assessed for risk for falls and interventions are put in place to prevent them from falling. A Fall Risk Assessment form will be completed by the nurse or the Falls Coordinator upon admission, readmission, quarterly, significant change, and annually.

(B)