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	IL6003578	A. BUILDING: _____ B. WING _____	C 07/02/2019

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S 000	Initial Comments Complaint# 1964623/IL113391	S 000		
S9999	Final Observations Licensure Violations 300.610a) 300.1210b05) 300.1210d)2)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. 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:	S9999	**Attachment A** **Statement of Licensure Violations**	

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5) All nursing personnel shall assist and 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:

2) All treatments and procedures shall be administered as ordered by the physician.

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 resident.

These regulations were not met as evidenced by:

Based on observation, interview, and record

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review the facility failed to provide supervision as outlined in R1's plan of care and failed to initiate targeted resident centered interventions to prevent falls for one resident (R1) of three residents reviewed for falls in a sample list of three residents. This failure resulted in R1 sustaining a dislocated right shoulder and a fractured right humeral head.

Findings include:

R1's Physician's Orders Sheet (POS) for June 2019 include the following diagnoses: Colostomy, Abnormalities of Gait and Mobility, Adult Failure to Thrive, Dysphagia, Acute Embolism and Thrombosis of Deep Veins of Right Upper Extremity, Scoliosis, Weakness, Unspecified Mental Disorder, Psychosis, Major Depressive Disorder, Anxiety disorder, Severe Intellectual Disabilities, Autistic Disorder, Other Conduct Disorders, and Epilepsy.

R1's Minimum Data Set (MDS) dated 6/11/19 documents R1 is severely cognitively impaired and not able to communicate verbally.

R1's most recent Fall Risk Assessment dated 6-22-19 documents that R1 is at high risk for falls due to history of one or more previous falls, takes high fall risk drugs, has an unsteady gait, and lack of understanding of R1's own physical and cognitive limitations.

R1's 4-20-19 Care Plan lists a problem statement related to potential for falls and injuries related to disease process of Bipolar, weakness, incontinence, unsteady gait/balance, and medication use. One intervention listed includes to "keep resident in supervised area while awake."

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R1's Care Plan entry dated 4/20/19 documents "(R1) has limitation in transfer ability related to weakness, unsteady balance and severe Intellectual Delay. (R1) has been noted transferring himself to/from bed, wheelchair and recliner without assist from staff. (R1) has impaired safety awareness and not easily redirected."

A progress note for R1 dated 5-29-19 3:30 p.m. documents R1 is unsteady and leans forward when walking, that R1 is constantly walking and wandering on the unit, and that R1 does not follow directions.

A progress note for R1 dated 5-29-19 11:40 p.m. states that R1 needs 1:1 (one to one) supervision, that R1 wanders about the facility ad lib into inappropriate areas, and that R1 needs close supervision.

R1's Medication Administration Record (MAR) for June 22, 2019 documents R1 received a PRN (as needed) dose of Ativan (Antianxiety) 1 Milligram at 1:41AM administered by V6, Licensed Practical Nurse (LPN) for "behavior".

On 7/2/19 at 3:00PM V2, Director of Nurses verbalized "Any resident who is given a PRN Ativan should be monitored for side effects." V2 stated that a side effect associated with Ativan is increased risk of falls. The manufacurers package insert for Ativan states "The most common side effects of Ativan include: sedation, dizziness, weakness, unsteadiness."

R1's progress note by V6, Licensed Practical Nurse (LPN) dated 06/22/2019 at 02:05 AM Documents "(V6) walked behind the resident (R1)

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on South East hallway when (R1) fell. (R1) was out of reach to prevent this fall." The progress note goes on to document that following the fall R1 was placed in the recliner chair in the East hall living room, with no other interventions documented.

R1's next progress note by V6, Licensed Practical Nurse (LPN) dated 06/22/2019 at 02:09 AM (4 minutes following R1's fall) documents "(R4) called for help, went to the room and observed (R1) sitting on floor by the (R4's) recliner."

R1's progress note by V7, Licensed Practical Nurse (LPN) dated 06/23/2019 at 09:18 PM documents "During HS (evening) care, CNA alerted (V7) to a bruise to the anterior right shoulder. (R1) assessed; dark red, with light purple bruising noted to anterior and posterior right shoulder. (R1) had decreased ROM to right shoulder and appeared to be guarding right arm. Increased swelling also noted to right arm. (V8, Medical Doctor) paged. Upon return call (V8) gave orders for (R1) to be sent to ED (Emergency Department) for evaluation and treatment."

R1's progress note by V9, Licensed Practical Nurse (LPN) dated 06/24/2019 at 01:43 AM documents (R1) "returned to facility via ambulance transport from (Local hospital) . Returned with Diagnosis of Dislocation of right shoulder joint. Returned with orders to call (V10) Medical Doctor in 2 days for Orthopedic follow up. Currently resident is alert, non-verbal, but if shoulder is touched resident will lean more to that side. ER (Emergency Room) nurse also endorsed that resident is sedated from medication given at ER. (R1) also is wearing a shoulder immobilizer."

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On 7/2/19 V9 Licensed Practical Nurse stated "I do remember readmitting (R1) after (R1's) right shoulder dislocation. (R1) had an immobilizer on. (R1) kept pulling at it, so we left it off. I'm not sure where the brace went. I haven't seen it since that day."

R1's Care Plan entry dated 06/24/2019 documents "(R1) required to wear a sling on his right arm r/t (related to) a recent shoulder dislocation."

R1's progress note by V11, Registered Nurse (RN) dated 06/25/2019 at 02:45 PM states "(R1) right arm continues to have hard non-pitting edema, with warmth, and resident has become guarded with extremity. NP (Nurse Practitioner) here to evaluate and ordered resident be sent back to (local hospital) ED (Emergency Department) for further evaluate to rule out compartment syndrome."

R1's progress note by V11, Registered Nurse (RN) dated 06/25/2019 at 07:36 PM documents "(R1) admitted to (local hospital) due to blood clot to the right arm."

On 7/1/19 at 9:30AM and 2:45PM and on 7/2/19 at 9:00AM, 1:40PM, and 3:00PM R1 was in the common area sitting in recliner. Other residents were present in the common area, but staff were not in visual control of R1. R1 did not have an immobilizer present to right shoulder as ordered.

R1's hospital history and physical dated 6/25/19 by V12, Nurse Practitioner documents "(R1) suffered a right anterior shoulder dislocation on 6/23/19 and was subsequently brought to the Emergency Department. The dislocation was reduced and repeat imaging indicated a proximal

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humeral head fracture. Patient was discharged back to the nursing home with a shoulder immobilizer. Patient has not been wearing shoulder immobilizer at the nursing home and was brought in for swelling of the right upper extremity. Subsequent exam and ultrasound revealed and confirmed the deep venous thrombus of the right brachial vein."

On 7/2/19 at 1:40PM V12, Nurse Practitioner stated "(R1's) right shoulder dislocation and humeral head fracture is consistent with the two falls 6/22/19 at the facility. It is highly likely the Deep Venous Thrombus (DVT) to (R1's) right brachial vein was also a consequence of the right shoulder injury. The DVT required inpatient hospitalization to treat. The lack of immobilization as ordered in the Emergency Department but not followed by the nursing home would have caused increased pain and increased likelihood of complications such as the DVT."

On 7/2/19 at 3:00PM V2, Director of Nurses stated "(R1) came back to the facility with an immobilizer in place 6/23/19. I think (R1) kept taking it off. The transfer sheet from the hospital stated (R1) had an immobilizer. Maybe since it was documented in the discharge sheet from the hospital we didn't realize it was a physician's order. In looking back I guess we should have documented (R1) taking off the brace and what we did to address it."

The facility's policy "Falls and Fall Risk Managing" revised 12/07 states "If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant."

(B)

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