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	IL6013120	A. BUILDING _____ B. WING _____	C 06/11/2019

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MEADOWBROOK MANOR	431 WEST REMINGTON BOULEVARD BOLINGBROOK, IL 60440

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S 000	Initial Comments Complaint Investigations #1974025/IL112746	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210 b) 300.1210 c) 300.1210 d) 6) 300.3240 a) 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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 review, the facility failed to ensure safe practices for turning a resident in bed, and failed to ensure a resident with a fall risk was monitored.

This failure resulted in a resident falling out of bed during care and sustaining an acute significant temporal lobe brain hematoma, a subdural hematoma, maxillary sinus fracture, and a facial laceration requiring 10 stitches.

This applies to 2 of three residents (R1 and R4) reviewed for falls.

The findings include:

1. According to the Electronic Health Record (EHR), R1 had diagnoses including: hemiplegia and hemiparesis of left side, atrial fibrillation, heart failure, vascular dementia with behavior, dysphagia following cerebral infarction, gastrostomy, obesity, neuromuscular dysfunction of bladder, unsteadiness on feet, anxiety disorder, functional quadriplegia, polyneuropathy, left artificial hip joint, venous thrombosis and embolism, and rheumatoid arthritis.

The admission Minimum Data Set (MDS) dated 03/11/2019, showed R1 needed extensive assistance of two people for bed mobility which includes how a resident moves to and from a lying position, turns side to side, and positions body while in bed; transfers; bathing; and toilet use. R1 needed extensive assistance of one

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person for dressing and personal hygiene. The MDS showed R1 had impairment on one side of the body of both the upper and lower extremities. R1 used a wheelchair for mobility and had an indwelling urinary catheter. The MDS showed R1 weighed 282 pounds and was five feet eight inches tall. R1 had a Brief Interview for Mental Status (BIMS) of 15 /15 possible points, indicating (R1's) cognition was intact. The MDS showed R1 had an indwelling urinary catheter and was always incontinent of bowel.

A care plan showed R1 was at risk for falls related to heart failure, hemiplegia, vascular dementia, and rheumatoid arthritis. R1 had a care plan created on 03/18/2019, and cancelled on 05/29/2019, showing R1 needed extensive assistance of two people for toileting, transfers, and bed mobility due to weakness, limited mobility, decrease strength and endurance, poor safety judgment related to hemiplegia and hemiparesis following cerebral infarction, and obesity.

On 06/05/2019, between 2:08 PM and 2:36 PM, V6, Certified Nursing Assistant (CNA), said as per R1's usual routine, every morning around 11:00 AM, V6 was getting everything to get R1 ready to get up for the day. V6 was standing on R1's right side and turned R1 onto R1's left side to clean off R1's back. V6 said V6 wasn't giving R1 a complete bath, but R1 liked having R1's back cleaned off in the morning. V6 said R1's left side was R1's weak side, and V6 would only roll R1 to the left side, or R1 wouldn't be able to grab onto the bed rail with R1's left arm if R1 was turned onto the right side. V6 said if V6 needed to remove R1's incontinence brief, V6 would pull it out from behind and underneath R1. V6 stated when V6 turned R1, R1's left leg went off the bed,

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and the weight of R1's leg going over carried R1 the rest of the way over the bed. V6 said R1 was a big guy, probably weighing over 300 pounds. V6 said R1 was close to the left side of the regular size (not a bariatric or wide bed) air mattress bed when R1 was turned. V6 said R1 had partial side rails near the head of the bed used for positioning. According to V6, it happened suddenly, and V6 couldn't recall if R1 had grabbed onto the side rail with R1's right hand. V6 said R1 was alert and oriented 60 to 70 percent of the time, with mild confusion,was pleasant, and R1 could use the call light when R1 needed assistance, which R1 always used. V6 said R1 needed two-people for transfers using the sit to stand mechanical lift, and also needed two people for toilet use when getting R1's incontinence brief changed while lying in bed. V6 thought R1 was just a one person assist for bed mobility because R1 could grab the side rails to assist. V6 stated, however, R1 needed assistance with turning in bed because R1 was unable to turn on R1's own, and was unable to grasp anything with R1's left arm. V6 said when R1 fell, R1 landed on R1's face and that R1's whole body landed on the floor, hitting the floor at the same time. V6 said R1 must have hit the base of a gastrostomy tube feeding pole when R1 fell also. V6 called the nurse (V7, Licensed Practical Nurse, LPN) from the doorway and when V7 came in, V6 and V7 saw bleeding from R1's face. V7 called the supervisor. V6, V7, and the supervisor turned R1 to R1's back; the nurses did first aid to stop the bleeding, then V6 and V7 transferred R1 to bed using the total body mechanical lift. When the wound nurse left the room, V6 stayed in the room until the ambulance arrived, but V6 was unsure how long it took for the ambulance. V6 said R1 seemed disoriented and didn't really know what happened, although

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R1 did recognize who V6 was. R1 would say some things that made sense, and some things didn't make sense, which was not normal for R1, which the nurses were aware of.

On 06/05/2019 at 3:34 PM, V7, LPN, said according to the CNA (V6), V6 was trying to clean R1 up. R1 was on R1's weaker side, and then R1 fell out of the bed. When V7 entered the room, R1 was lying on the left side of the bed on the floor; R1 was lying on R1's left side, not completely face down. R1 was bleeding from R1's head, and there was a laceration on the left side of the forehead above the eyebrow area. V7 said V7 did not know how big it was, it wasn't measured as they were focused on cleaning up the wound and controlling the bleeding. R1 fell sometime before lunch, and was unsure who rolled R1 to R1's back and got R1 to bed. V7 said R1 needed to be sent to the hospital because of the laceration and the bleeding. V7 said a private ambulance company was called instead of 911 because R1 was alert and oriented, talking, the bleeding had stopped, and since it wasn't life threatening, no respiratory issues, and (R1's) vital signs were stable. V7 could not recall how long it took before the ambulance arrived.

On 06/10/2019 at 4:50 PM V9, Medical Doctor (MD), Hospital Emergency physician, said (R1) was seen in the emergency room, then transferred to another hospital for the neurosurgery consult. V9 said R1 had an acute significant traumatic brain hematoma which was caused from the fall at the nursing home. He stated, "All of our head bleeds with a potential to become severe and possibly need surgery we have to send out to be monitored closely as only time will tell if the hematoma will worsen. We never know if it is going to get bigger, so R1 was

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transferred to an Intensive Care Unit setting." V9 said since R1 was on Apixaban (a blood thinner), they would have had to hold giving it to R1 to not be the cause of worsening the brain bleed. V9 said of course holding the blood thinner would put him at a higher risk for developing blood clots, stroke, and embolism. "All of the things it was given to prevent in his diagnoses", but since R1 did have a brain bleed, they wouldn't have wanted the brain bleed to get worse.

The hospital records, Radiology studies, Computed Tomography (CT) scan, dated 05/14/19 at 3:05 PM, showed R1 had an acute 1.6 centimeter (cm) by 1.0 cm left temporal lobe hematoma with surrounding edema, a 0.5 cm thickness subdural hematoma along the left aspect of the falx, nondisplaced fractures of the anterior and posterolateral walls of the left maxillary sinus with hemorrhagic fluid level, left periorbital and premalar soft tissue hematoma with swelling, and a small amount of right mastoid fluid present.

The Emergency Room record dated 05/14/19, showed R1 had a five centimeter laceration to the left upper eyelid which was closed with 10 sutures, as well as a 0.5 cm skin tear to the left nasal bridge, and a quarter size abrasion to the left anterior leg. R1 had left infraorbital edema and ecchymosis with mild tenderness, and mild left temporomandibular joint (TMJ) tenderness.

The second hospital record, a CT scan, dated 05/14/19 at 10:58 PM, showed R1 had a partial increase in the parenchymal hemorrhage within the anterior left temporal lobe measuring approximately 2.3 by 1.5 cm. A third CT scan dated 05/15/19 at 3:23 PM, showed the anterior left temporal lobe hemorrhage measured 2.4 by

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1.6 cm, and the anterior subdural hematoma measured six to seven millimeters (mm). The hospital records showed R1 was in the hospital for one week. The discharge summary showed R1's Apixaban (blood thinner) was recommended to be held for one month, after which a repeat CT scan and follow-up with neurosurgery should be done to determine restarting the blood thinner.

On 06/10/2019 at 1:13 PM, V8, Physical Therapist, Acting Therapy Manager, stated R1's most recent Physical Therapy evaluation dated 05/01/19, bed mobility assessment, showed during therapy R1 needed maximum assistance of one person for rolling side to side. V8 said, we enter a residents transfer code status in the EHR, and whatever was entered for the person we expect them to follow that. V8 said R1's transfer assistance was entered as a two person assist. V8 said we don't put in for bed mobility because if the resident needed two person assistance for transfers from the nursing staff, then the resident would probably need two person assistance for bed mobility as well, for safety reasons. V8 said, "The correct procedure for rolling a person from side to side in bed, as an example, if we are rolling them to their left side, have the resident bend the right leg so they can push against the mattress to facilitate turning to the left and use their right hand to reach to the left handrail. If they still need assistance we would give them some assistance toward the hip or trunk." V8 said, "Maximum assistance would mean (V8) had to do maximal assistance for (R1) including helping (R1) to bend the knee, assist by bringing (R1's) right arm to reach the left side bedrail, and assisting by placing (V8's) hands on (R1's) trunk and hip. The person should be standing on the side that the person was turning toward to prevent them from turning too far and potentially

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falling off the bed." V8 said the bedrail was mostly used for support for the resident to grab, not to stop them from falling.

The Physical Therapy Plan of Care dated 05/01/2019, showed R1 needed maximum assistance (76 to 99 percent) for rolling side to side.

The Occupational Therapy Plan of Care dated 05/01/2019, showed R1's left upper extremity gross motor and fine motor skills were severely impaired. R1 required dependent 100 percent assistance for be to wheelchair transfers.

On 06/06/2019 at 3:40 PM, V3, Director of Nursing (DON), stated R1 was extensive assistance of one person for hygiene and the CNA wasn't giving R1 a bath; "(V6) was just giving (R1) some hygiene on his back." V3 said yes, the CNA did have to turn R1 to the side to clean R1's back. V3 said R1 needed two people for bed mobility and R1 was on a low air loss mattress.

The MDS shows personal hygiene includes: combing hair, brushing teeth, shaving, washing and drying of the face and hands, and it excludes baths and showers. The MDS for Bed mobility was how a resident moves to and from lying position, turns side to side, and positions their body while in bed.

The American Congress of Rehabilitation Medicine Caregiver Guide and Instructions for Safe Bed Mobility dated 2017, included bed mobility refers to activities such as scooting in bed, rolling (turning from lying on one's back to side-lying), side-lying to sitting, and sitting to lying down. It also includes scooting to sit on the edge

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of the bed when preparing to stand or transfer. The instructions include to decide which side of the bed the patient should get out from based on their strength, and position yourself to that side of the bed. The patient should always roll toward you not away from you. Patient safety included to assist the patient on their weaker side and if you are ever unsure, get needed help.

2. According to the Electronic Health Record (EHR), R4 had diagnoses including: fracture of superior rim of right pubis, dementia without behavior, psychosis, generalized anxiety disorder, severe protein malnutrition, muscle weakness, restlessness and agitation, need for assistance with personal care, hypothyroidism, idiopathic neuropathy, and cardiac pacemaker.

The quarterly Minimum Data Set (MDS) dated 04/04/2019, showed R4 needed extensive assistance of one person for bed mobility, transfers, dressing, and toilet use. The MDS showed R4 was not steady, and only able to stabilize with staff assistance for moving from seated to standing position, walking, and turning. R4 had a Brief Interview for Mental Status (BIMS) of 0 out of 15 possible points, indicating (R4's) cognition was severely impaired.

A care plan dated 05/24/19, showed R4 was at high risk for falls related to a right pelvic fracture, impaired mobility, impaired balance, poor safety awareness, and impulsive behavior. Interventions dated 05/23/19, included to continue with chair and bed pad alarm to alert staff that resident is transferring self without assistance, closely monitor resident due to recent fall related injury, be sure call light is within reach, continue to attempt to encourage resident to stay in common area, continue to do frequent alternating rounds

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between CNA and nurse every two hours and as needed. Continue to do frequent alternating rounds when resident is in bed, keep bed in low position at night.

A Fall Risk Assessment dated 05/01/19, showed R4 was at a high fall risk with multiple falls in the last six months.

The facility's Accident and Incident Log showed R4 had a recent fall on 05/21/19.

On 06/04/2019 at 4:29 PM, R4's bedroom door was completely closed. Upon entering the room R4 was awake, non-verbal, lying in bed, with the top cover bed sheets on the floor on the right side of the bed. The bed was elevated with the top of the mattress approximately 28 inches from the floor. R4 was leaning to right side, with R4's head off the right side of the mattress. R4 was alternating between attempting to remove R4's soiled incontinence brief, which was unsecured by pulling up on the front of the brief, and reaching toward the floor for the bed sheets with R4's left hand. A bed alarm pad was noted at left edge of the mattress with the cord laying on floor not connected to the alarm box hanging on the side rail. The call light cord was on the floor. The Director of Nursing (V3) was notified, and when we went back to room less than 90 seconds later, R4 had the bedsheet from the floor in R4's hand and draped over the right side rail. V5, LPN, showed R4's bed alarm pad was bunched up to the left side of the mattress, behind R4's back. R4 was not laying on the bed pad alarm. V3, DON, said R4's bed was in the lowest locked position, however V3 was able to lower the bed approximately 3 more inches before the bed frame was resting on garbage disposal can at head of bed.

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On 06/04/2019 at 5:00 PM, V5 said V5 had last checked on R4 around 2:30 PM (two hours prior to the observation at 4:29 PM). V10, CNA, said V10 last checked on R4 at 2:00 PM (two and a half hours prior to the observation at 4:29 PM) because R4's alarm was sounding. V10 said V10 had to reposition R4 in bed because the bed alarm pad was bunched up to R4's side. V11, CNA, and V10 were using a total body mechanical lift to get R4 from the bed to a wheelchair. The lower extremity right side of lift sling was hooked on the purple colored loop by V11. The lower extremity left side of the lift sling was hooked on the pink colored loop by V10. After prompting by this writer, V10 said the sling loops should be on the same colored loop.

On 06/05/2019 at 4:28 PM, V12, LPN, said R4's fall prevention interventions for close supervision was when R4 was up in the wheelchair. V12 said when R4 was in bed, R4 needed an every two hour check and change, and R4's room was close to the nurse's station. V12 said the every two hour check and change was for all the residents. V12 said R4 didn't need more frequent checks than everyone else.

On 06/06/2019 at 2:57 PM, V13, LPN, said when there was an intervention to closely monitor a resident it would be to check the resident more frequently than regular protocol. V13 was the facility's regular protocol for regular monitoring was every two hours, alternating between the CNA and the Nurses, so that each resident would be checked every hour to know where they were and what they were doing. V13 said V13 was unsure how R4's fall care plan intervention of frequent alternating rounds every 2 hours would be any different than monitoring for any other

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S9999	Continued From page 11 resident. On 06/06/2019 at 3:40 PM, V3, DON, said "Closely monitor resident on the care plan means the same intervention for every resident. The residents should be checked on every hour; the CNA checks on the residents every two hours, and the nurse does a check on the residents every two hours on the alternating hours." At 4:45 PM, V3 said if a resident should be closely monitored for falls, they should not have their bedroom door closed all the way. The facility's Fall Policy dated 11/10/2012, shows, "It is the facility's policy to act in a proactive manner to identify and assess those residents at risk for falls, plan for preventive strategies, and facilities as safe environment as possible." (A)	S9999		