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	IL6010367	A. BUILDING: _____ B. WING _____	C 10/18/2017

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S9999	Final Observations Statement of Licensure Violation: 1 of 1 Violation 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.	S9999		

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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 record review and interview, the facility failed to developed effective fall interventions and failed to supervise and monitor a resident displaying unsafe behaviors who is also identified as a high risk for fall. This failure resulted in the resident (R10) falling and sustaining additional injury in the spinal cord.

This applies to 1 of 3 residents (R10) reviewed for falls with injury in the sample of 12 residents.

The findings include:

R10's fall assessment dated July 18, 2017 showed R10 is a 72 year old who was admitted to the facility on July 12, 2017. R10 has multiple medical diagnoses to include generalized muscle weakness, dementia, seizure disorder and cervical (spinal) fracture of the C3 and C4. R10 is identified as a high risk for fall. R10's Minimum Data Set (MDS) dated July 24, 2017 showed R10 is cognitively impaired, requires extensive

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assistance with bed mobility and is totally dependent with locomotion on unit.

Z5's (Nurse Practitioner/NP) Progress Notes dated July 14, 2017 showed: R10 was admitted from the hospital where he was brought in after a fall incident in which R10 sustained fracture of the C3 and C4, fracture of the right, 5th and 6th ribs and right apical pneumothorax. Computerized Tomography (CT) of the head showed possible old bilateral subdural hematoma in the frontal area of the brain, enlarged socci. Primary history fall, seizure disorder, dementia. Other assessment showed generalized muscle weakness and recurrent falls. Plan: Fall precautions, close monitoring.

Review of R10's notes from admission on July 12, 2017 through transfer in the hospital on August 21, 2017 showed that R10 had multiple fall incidents (7/18, 7/27, 8/17, 8/18) in the facility to which all were unwitnessed and progress notes also indicate multiple behaviors.

1) July 18 at 6:25 AM- R10 was found on the floor at bedside on top of his floor mat, there was no injury noted upon assessment.

2) July 27- R10 was found on the floor in the hallway by the nurses' station. R10 sustained superficial abrasion and laceration to right forehead, superficial abrasion to right cheekbone, skin tear above right eyebrow. R10 was sent to the hospital for further evaluation (R10 was sent to the hospital for this fall and had to undergo spinal surgery).

R10 was readmitted to the facility on August 8, 2017 after undergoing spinal surgery and placed under hospice.

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3) August 17- Fell off from bed sustained 2 skin tears to right arm one measured 5.0 centimeter (cm) long and the other one in the antecubital area was 1.0 cm long.

4) August 18- R10 was found in the dining room floor after he was fed dinner. This incident was written by E15 (Nurse). (There was no detailed information as to what really happened to R10 after he was fed dinner and when he was found on the floor).

Z5 (NP) notes dated August 21, 2017 showed: Z2 saw R10 as requested by staff. R10 has been having intermittent seizures since the 18th of August. R10 also has a reported fall on August 18 after dinner with no signs and symptoms of injury reported.

On October 16, 2017 at 3:16 PM E10 (Certified Nursing Assistant/CNA) stated Z7 (Agency CNA) had taken care of R10. After Z7 fed R10 she (Z7) went out of the dining room and fed another resident in the bedroom. E10 was not sure if Z7 endorsed R10 to anyone. E10 was assisting other residents out of the dining room. While coming back E10 was called by a visitor and told E10 that R10 was under the table on the floor. E10 was with an activity staff there already with R10, but the activity staff did not witness the fall. E10 was unable to recall who the activity staff was. E10 asked someone to call E15 (Nurse) to check R10.

On October 17, 2017 between 4:15 PM to 4:51 PM E16 and E17 (Both Activity Staff) who worked on August 18, 2017 both stated they don't remember seeing R10 on the floor or having a fall incident at that time.

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On October 18, 2017 at 11:41 AM Z7 stated, she (Z7) remembered that R10 was her resident that day (August 18). After feeding R10, Z7 went to another resident's room to feed a resident. Z7 added she did not tell anyone that she's going to another resident because one staff was still inside the dining room, E18 (CNA) who was feeding one of the residents.

On October 18, 2017 at 12:15 PM E15 (Nurse) stated he couldn't remember the incident. E15 was passing medications and was not in the dining room at that time. E15 was extremely busy when R10 fell from his chair. E15 did not witness the fall and could not recall the total incident.

5) Multiple entries from the progress notes (July 12-August 21, 2017) also showed that R10 tends to lean forward in his chair, needs to be repositioned to lean back in the chair, restless, continues to slide down his chair and trying to get out of bed and chair. Other entries showed R10 was not eating well prior to going to the hospital on July 27 and then showed R10 eating after coming back from the hospital. Z1 (R10's wife) requested to send R10 to the hospital on August 21, 2017 for further evaluation due to seizure activities.

Hospital Note dated July 29, 2017 showed R10 was found with cervical fractures and a Magnetic Resonance Imaging (MRI) was obtained showing a spinal cord injury at the level of C3, C4 and C5 with the unstable fractures of both the anterior and posterior columns. Z6 (Neurosurgeon) offered a surgery to decompress the spinal cord and stabilize the bone so to not have unstable fracture.

Hospital Note dated July 31, 2017 showed: CT of

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the cervical spine revealed vertebral body and laminar fractures of C3, C4, and laminar fracture at C5 with fracture of facets (different sides) on C4-C5. MRI showed T2 (Thoracic 2) signal change consistent with spinal cord injury and bone marrow edema. Neurosurgery was consulted and Z6 performed C2 (Cervical 2) to T1 (Thoracic 1) posterior decompression and fusion.

On October 12, 2017 at 2:30 PM E12 (Nurse) stated, R10 is a high risk for fall. R10 was always leaning forward. Staff constantly had to reposition him (R10) back to the chair. Staff usually had his chair tilted backwards at 45 degree angle to keep him in position.

On October 16, 2017 at 10:32 AM E6 (Restorative Nurse) stated, R10 was a high risk for fall. R10 was kept in the common area to be monitored closely and to be in line of sight at all times. R10's wheelchair has been tilted backward due to impulsive behavior. E6 added, Z1 (wife) informed staff that R10 is an early riser, so R10 was placed in the morning get up list at 6:30 AM.

On October 16, 2017 at 1:50 PM E2 (Director of Nursing/DON) stated there was no one with R10 when he had fallen on July 27 in the hallway. The staff were all attending to other residents. The fall on August 18 was related to seizure disorder, the staff were coming in and out of the dining room to transport other residents. When R10 fell that time no one was directly looking at him.

On October 17, 2017 at 9:07 AM Z6 (Neurosurgeon) gave the following statement: R10 has history of multiple falls and sustained fractures in to C3 and C4 in one of his falls. When R10 came in to the hospital on July 27 after a fall incident R10's test showed acute trauma in the

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spinal cord. R10's injury exacerbated and he sustained additional injuries. R10 already had the old fracture in the C3 and C4 but he sustained additional injury in the C5 and C6 when R10 had that fall incident. R10 hurt his spinal cord more by falling. When R10 came into the hospital he had swelling in the muscle of his neck, spinal cord and bones, those were not old injuries. R10 should have been in the hospital to treat the fracture. R10 should have been sent right away for further evaluation and treatment from the first fall that happened to him in the facility. R10's motor skills were highly affected. Although R10 has multiple medical concerns which could affect his motor skills, the spinal injuries are the ones that really affected him the most which include his eating process (having difficulty to open his mouth). R10 has dementia and is unable to verbalize his needs and what he feels. R10's restlessness and anxiety could have been contributed by the pain related to his spinal injury. Z10 recommended and did the surgery to stabilize R10's spine.

On October 17, 2017 at 10:53 AM E11 (Nurse) gave the following statement: R10 is always restless, anxious and agitated these were his daily behaviors. R10 is supposed to be in line of sight at all times because R10 tends to lean forward and has the ability to get out of chair. Staff usually placed R10's wheelchair in a leaned back position to lessen R10's leaning forward behavior but it was not effective. When R10 is being fed he usually tried to hit people and refused to open his mouth to eat.

R10's fall care plan did not address the need for staff to stay with R10 and close monitoring when exhibiting unsafe behaviors and did not update R10's frequent behaviors of leaning forward as

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S9999	Continued From page 8 R10 fell twice from the wheelchair unwitnessed in the common area and twice from the bed which were also unwitnessed. Facility's Falls-Clinical Protocol (Revised August 2008) showed: Assessment and Recognition: The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happened, any observation of the events, etc. Monitoring and Follow-Up: - The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequence of falling. - If the individual continues to fall, the staff and physician will re-evaluate the situation and consider other possible reasons for the resident's falling (besides those that have been already identified) and will re-evaluate the continued relevance of current interventions. (A)	S9999		