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	IL6009500	A. BUILDING _____ B. WING _____	12/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 000	Initial Comments annual health	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)6) 300.3240a) 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: 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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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.

These Regulations were not met as evidenced by:

Based on observation, record review and interview, the facility failed to: identify fall hazards, analyze the cause of multiple falls, and failed to implement, monitor and modify interventions to prevent further falls and injury for 3 residents (R31, R25, R20) reviewed for falls. These failures led to multiple falls resulting in a right proximal humerus fracture with displacement, worsening of the fracture, pain and subsequent surgery for R31.

The findings include:

1. R31's computerized medical record documents; R31 is an 85 year old resident admitted on 6/28/17. R31's record indicates diagnosis of subdural hematoma with brain shift syncope, Rheumatoid Arthritis, Osteoarthritis, and Osteoporosis. R31's care plan for fall risk, initiated on 9/11/17, documents that R31 is a high risk for falls, due to gait/balance problems and a history of frequent falls. Prior to R31's frequent falls beginning on 8/12/17 a Nursing Progress note dated 8/ 5/17 at 9:33am documents R31 is continent of bowel and bladder, toilets self and ambulates about the facility with a rolling walker.

On 12/04/17 at 1:44 PM, R31 was in her room, seated in a wheelchair with her right arm in a

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sling. R31 indicated that she had a fall in the dining room several weeks ago that led to a fracture and surgical repair. Nursing progress notes from 11/18/17 at 4:58pm, document R31 falling in the dining room. Further notes from the 18th indicate that R31 had increased pain with right side drooping, was sent to the Emergency room and found to have a transverse fracture of the right proximal humerus with displacement. The notes from the 18th continue with R31 being referred to an Orthopedic clinic. The nursing progress notes describe further falls for R31 on 11/23/17 at 12:30pm and on 11/24/17 at 4:13pm. A progress not dated 11/28/17 at 1:50 PM, documents R31 has received new orders to have surgery on 12/1/17 to repair her right humerus fracture. A second progress note dated 11/28/17 at 12:32pm explained that R31 had returned from the orthopedic visit with new orders relating to R31's right humerus fracture becoming worse since the 11/18/17 fall. R31's new orders from the appointment on the 24th included: no motion of shoulder, keep shoulder in sling with no motion to the shoulder.

On 12/4/17 at 1:44pm, R31 and V11 (R31's family), said that R31 has had increased pain and some confusion due to the fracture and recent surgery. R31's nursing progress note dated 12/2/17 documents that R31 will be returning this afternoon related to repair of right humerus fracture. R31's nursing progress note of 12/3/17 at 12:53pm documents that R31's wound included 25 staples and bruising to the surgical site.

R31's nursing progress notes document 12 occasions when R31 complained of pain and received pain medication, on 11/18/17 through 11/27/17, prior to the surgical repair. The 11/19/17

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note at 8:10pm states that R31 is crying in pain. The 11/20/17 6:45am note states that R31 is crying and saying "hurry", due to pain.

Incident report records and care planning for R31's falls document that seven falls occurred from 8/12/17 through 11/24/17. The fall documents included:

8/12/17 - 11:55am, R31 was walking with a four wheeled walker and while attempting to sit down the walker moved. R31's care plan, initiated on 8/12/17, indicated the fall was related to poor balance and an unsteady gait. The intervention was: resident education, R31 was reminded to lock the walker prior to sitting down.

9/1/17 - 4:40pm, R31 was walking to a table in the main dining room, started to feel dizzy, lost balance and fell onto buttocks. The intervention documented was to monitor the resident for dizziness, and resident education to sit down if dizzy and ask for help. This fall was not care planned.

9/9/17 - 10:07am, R31 was found on the dining room floor, face down and slightly to the left. R31 was reported, in the care plan, to have bruising to the left face/eye and knee. The report states a Certified Nurse Aid (CNA) found the resident on the floor, face down. No interventions were added to the incident report, after this fall. The fall care plan was updated on 9/11/17 to include: to anticipate the residents needs, to keep the resident"s call light in reach, to encourage R31 to participate in activities, to wear proper footwear, and for physical therapy to evaluate and treat R31. There was no evaluation to determine the cause of the fall documented. Nursing progress notes dated 9/9/17 at 4:43pm read, R31

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remembers falling but is not sure why.

10/11/17 - 1:02pm, R31 was found in in her room on her back. R31 had attempted to sit on a rolling walker and missed. R31 was soiled with Bowel Movement at that time. The incident report does not denote any intervention for this fall. The care plan documents that physical therapy will consult for strength and mobility.

11/18/17 - 4:38pm, R31 was found on her back in the dining room. The incident report states that R31 lost her balance and fell onto the right side. There is no cause indicated for this fall and no interventions noted. The incident report further documents that R31 had increasing pain noted at 8:30pm with her right side drooping, and R31 was sent out for an X-ray that found a fracture of the right proximal humerus. R31 returned from the hospital that same evening, with a sling and a referral to an Orthopedic clinic. The care plan notes the fracture as a major injury, dated 11/20/17.

11/23/17 - 12:30pm, R31 fell while transferring off the toilet in her restroom. R31 indicated she lost her balance, but denied further injury to the broken right shoulder. No interventions or analysis of the fall were on the fall investigation report. The care plan for this unobserved fall did not include any interventions.

11/24/17 - 4:20pm, R31 was found on the floor of her room. No description of the unobserved fall was documented. The intervention added per the incident report and care plan included an under chair and bed alarm, due to R31's recent falls.

On 12/12/17 at 12:30pm, V10 (physical therapy, PT) stated they did not receive any referrals for

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the therapy department to evaluate R31. V10 stated that R31 was discussed at a weekly fall meeting and picked up for a PT evaluation. The PT progress notes document that R31 was evaluated on 10/21/17 for an initial assessment. R31's care plan intervention from the fall of 9/9/17 and 10/11/17 both document a referral to PT. There was no documentation of this referral located in R31's computerized medical record or the PT department records.

PT notations from 11/1/17 include: "Patient (R31) reports she gets a funny feeling in her chest prior to falling. She states "its like I can feel it coming on in my chest and I know I'm going to fall." PT notes from 11/14/17 state that R31's prognosis for further progress is poor, due to non-compliance. PT notes from 11/16/17 read, "pt continues to be at risk of falling due to decreased balance and decreased safety awareness. She insists on ambulating by herself regardless. V10 stated that R31 was discharged from therapy on 11/16/17. V10 said that R31 liked to be independent. However, V10 described that R31 transfers very poorly, walks with a shuffling gait and has very poor balance. V10 described that R31 should have had at a minimum, supervision while walking.

2. R25's computerized medical record documents R25 is 84 years old and was admitted to the facility on 10/28/14 with diagnosis including dementia and depression. R25's current fall care plan, dated 10/4/17, documents that R25 had falls on 10/4/17, 10/7/17, and 10/8/17.

The incident report form for the unwitnessed fall on 10/7/17 at 4:20am documents that R25 was found on the floor sitting with her back against the

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bed. A scratch from her side to the mid back was noted. There was no documentation on the report that the cause of the fall was investigated. No new interventions were documented to prevent further falls.

The fall investigation report form for the fall on 10/8/17 at 5:40am documents that R25 was found on the floor next to her bed by a CNA. The report documented that the fall was unwitnessed and that R25 complained of pain to the buttocks at that time. There was no notation that R25 was observed for potential head injury at that time. There was no documentation on the report that the cause of the fall was investigated. There was no documentation on the report that any new interventions were put in place at that time.

On 12/12/17 at 10:15am, V3 (Licensed Practical Nurse, LPN) stated that she began looking for a low bed for R25 on 10/8/17, when V3 arrived at work. V3 further stated that neurochecks should have been conducted for R25 since the 10/7/17 and 10/8/17 falls were unwitnessed.

3. The Electronic Medical Record states R20 was admitted to the facility on 6/29/17 after a fall at home resulting in a fracture of the Thoracic 11 and 12. The records state upon admission, R20 has increasing confusion, a history of falls, Major Depression, Dementia and Weakness. R20's 07/06/17 Minimum Data Set (MDS) documents R20 has a Brief Interview for Mental Status (BIMS) of 11 indicating she is cognitively intact, requires extensive assistance of two for bed mobility and transfer and is frequently incontinent of urine and occasionally incontinent of bowel. The Nurse's Notes from 08/24/17 to 12/04/17 document R20's declining condition with increased weakness, occasional

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S9999	Continued From page 7 confusion/forgetfulness and a decrease in her activities of daily living functioning. The incident report forms for R20's falls document: R20 fell on 09/05/17, 09/16/17, 09/27/17, 10/03/17, 10/20/17, 11/09/17, 11/17/17 and 12/03/17. There are no root cause analysis documents or records to indicate what interventions were put in place after each fall beginning on 09/05/17. R20's Fall Risk Assessment dated 08/22/17 documents R20 had a score of 60 (61 or above indicates a High Risk for falls.) This Assessment was repeated on 10/20/17 with a score of 60, on 11/08/17 with a score of 65 and again on 12/03/17 with a score of 70. On 12/12/17 at 4:25pm, V2 (Director of Nurses) stated since the facility went to the new computerized record system she is not aware of where the fall interventions are documented. (A)	S9999		