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	IL6007181	A. BUILDING: _____ B. WING _____	C 12/10/2021

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S 000	Initial Comments Complaint Investigation: 2148963/IL140909	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210a) 300.1210b)5) 300.1210d)6) 300.1220b)3) 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. 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. 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: 5) All nursing personnel shall assist and	S9999		

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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:

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.

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.

These Requirements are not met as evidenced by:

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S9999	Continued From page 3 Based on observation, interview and record review the facility failed to assess for fall risks, provide supervision and implement progressive interventions to prevent falls for 3 of 3 residents (R1, R2, R3) reviewed for falls in the sample of 11. This failure resulted in R1 falling and sustaining a Femur (long leg) fracture requiring surgical repair, R2 sustaining a laceration to the head requiring 4 staples to close, and R3 sustaining a 1.5-centimeter laceration to head requiring 3 staples. Findings includes: 1. R1's Hospital History and Physical (H&P) report, dated 6/25/21 prior to facility admission, documented, R1 presented to Emergency Department for change in mental status, excessive falls at R1's residency which resulted in a fractured collarbone. The Hospital H&P documented R1 was unsteady on feet and confused, hallucinating and wandering, to include, a Modified Rankin Scale, documented moderately severe disability, unable to attend to own bodily needs without assistance and unable to walk unassisted. The H&P documented per R1's family, R1 was falling a lot at home, was unsteady on her feet, confused and hallucinating regarding her deceased husband and son. R1's Facility's Admission Record, printed 12/7/21, documented R1 was admitted to the facility on 7/1/21 to South hall, with the following diagnoses: left clavicle fracture from home, admitted for Skilled Therapy, Parkinson's Disease, altered mental status, fracture of unspecified part of Left Clavicle, hallucinations, wandering, and repeated falls. The facility had no Fall Risk Assessment in R1's	S9999		

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S9999	Continued From page 4 medical record at R1's which was completed at the time of R1's admission to the facility on 7/1/21. On 12/9/21 at 9:57 AM, V1, Administrator, stated there was not a Fall Risk Assessment completed for R1's admission of 7/1/21. V1 stated that due to the facility being bought and under new ownership, she was unable to find fall assessments and (Minimum Data Set) MDS prior to 11/1/21 when the new ownership took over. R1's Care Plan, initiated on 7/14/21, documents R1 had impaired cognitive function related to impaired thought processes and Neurological symptoms secondary to Parkinson's Disease. The Care Plan documented R1 was at risk for falls related to confusion, deconditioning, gait/balance problems and incontinence. The Care Plan Interventions to address falls were as follows: assess clothing for proper fit; assess for UTI (Urinary Tract Infection) using McGeer's criteria; assistive devices will be within reach of (R1) while in recliner /lift chair; Bathe prior to sleep; Be sure (R1's) call light is within reach and encourage her to use it for assistance as needed; and check labs. The Care Plan did not address if R1 required increased supervision due to her history of falls. R1's, "TUT-Fall Risk Data Collection" form, dated 9/15/21, documented R1 had a witnessed fall. The form documented it was a witnessed fall. The form did not document the time R1's fall occurred or where it occurred. The form documented R1 had no history of falls and was oriented to person, place, time and situation. This form did not document if R1 sustained any injury. This form did not document any interventions that were to be put into place to prevent future falls.	S9999		

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S9999	Continued From page 5 R1's Hospital Record, dated 9/15/21, documents R1 was present to Emergency Department due to a fall at the facility on 9/15/21 at 10:49 AM, with an impacted, partially displaced Femoral Neck Fracture of the Right Hip, an immediate surgical candidate for surgery. The hospital record documented "She has a history of Parkinson's disease and repeated falls." The Hospital Record documented R1 had a Right Hip Hemiarthroplasty to repair the fracture. R1's Care Plan Intervention, dated 9/15/21, documented "Educate (R1) to ensure her feet are not tangled in her call light cord prior to getting up and ambulating." R1's Care Plan Focus, initiated 9/24/21, documented "The resident has limited physical mobility." The Care Plan Interventions, initiated on 9/24/21, documents "(R1) is totally dependent upon staff for ambulation/locomotion." The Care Plan did not address R1's increased need for supervision due to her high risk for fall, cognitive impairment, and recent hip fracture. R1's Minimum Data Set (MDS), dated 11/18/21, documented, moderate impaired cognition, extensive assistance of two staff for transfers, bed mobility and toilet use. This was the only MDS in R1's medical record for review. R1's, Incident Audit Report, documented R1 fell on 11/20/21 at 8:32 AM. The Report documented R1 had an unwitnessed fall and was found on the floor at the end of her bed sitting on her buttock by a commode. The Report documented R1 was ambulatory with assistance, and she was "confused today." The Report documented R1 had no injury, but an order was obtained to send out to local hospital for evaluation and treatment due to a recent Right Hip Surgery.	S9999		

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2. R2's Admission Record, documented R2 was admitted on 7/23/21, with the following diagnoses: Huntington's Disease, lack of coordination, abnormal posture and seizures.

R2's Fall Risk Data Collection, completed while the facility was under different ownership, dated 7/23/21, documented that R2 was at high risk for falls due to inability to stand without assistance, loss of balance and jerky movements while standing.

R2's Care Plan, initiated on 7/23/21, documents "(R2) is at risk for falls." The Care Plan documented the following interventions implemented on 7/27/21: Anti-tippers on back of wheelchair; Be sure (R2's) call light is within reach and encourage (R2) to use it for assistance as needed.

R2's Progress Notes, documented R2 fell on 8/5/21, 8/12/21, 9/3/21, 9/4/21, 9/17/21, 9/25/21, 10/2/21, 10/8/21, 10/21/21. The Notes documented all of these falls were unwitnessed and were due to R2 sliding out of her recliner.

R2's Care Plan Interventions related to falls, initiated on 8/4/21, were as follows: Educate (R2) to call for assistance with transfers; and ensure personal items are within reach.

There is no documentation on R2's Care Plan or in R2's Medical record that the facility implemented interventions after R2's falls on 8/5, 8/12, 9/3, 9/4, 9/17 and 9/25/21.

R2's Progress Note, dated 10/2/21 documents "Call into resident's room by staff CNA (Certified Nurse's Aide) states that when walking past

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resident's room, they saw resident adjusting herself in her recliner and then slid out of her recliner." The Note documents "Will attempt to find a piece of (non-slip pad) to put into recliner to prevent sliding out of chair again."

There was no documentation in R2's medical record that a piece of (non-slip pad) was placed in R2's recliner to prevent her from sliding out of her recliner.

R2's Progress Note dated 10/8/21 documents "Resident was lowered from recliner footrest to floor due to not following instructions to stand on 2 feet, was holding 1 leg out straight."

R2's Care Plan Intervention, dated 10/8/21 documents "Gripper strips on floor in front of recliner to reduce sliding. "The Care Plan did not address R2's inability to follow instructions from staff during transfers.

R2's Progress Note, dated 10/21/21, at 10:35 AM documents "resident was observed by CNA (name of CNA), on duty, sliding out of Recliner and landing on buttocks on floor." The Note documented "resident did not hit her head per CNA who witnessed resident slide out of recliner." The Note documented that staff would continue to monitor.

There is no documentation that the facility implemented any progressive intervention to address R2 from sliding out of her recliner after this fall occurred.

R2's Progress Note, dated 11/5/21 documented as a "late entry" that R2's Physician and family were notified that R2 fell and had injuries/4 staples to head. The Note did not document at

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S9999	Continued From page 8 what time R2 fell or the circumstances regarding how R2 fell. R2's Hospital Discharge Summary, dated 11/5/21, documented treatment of 4 staples to a laceration to forehead. R2's Care Plan Interventions, initiated 11/5/21, documented "ensure (R2) has appropriate fitting grip socks when up in wheelchair and recliner." R2's Progress Notes, dated 11/15/21, documented she was in her room sitting on her buttocks in front of her recliner and stated she slid out of her recliner. R2's Progress Note, dated 11/21/21 stated she slid out of her recliner and was found on the floor. R2's Progress Note, date 11/24/21 documented "Family to bring in new recliner." R2's Progress Notes dated 12/1/21 and 12/2/21 all noted she fell. R2's Care Plan Intervention, dated 12/1/21 documented "Therapy to evaluate for position in new recliner." R2's Care plan Intervention, dated 12/2/21 documented "Place (non-slip pad) in recliner for position aid." This Intervention was implemented almost four months after R2 had an initial fall due to slipping out of her recliner. R2's Interdisciplinary Care Conference, last documentation dated 7/25/21. R2's, "Fall Risk Assessment, (New facility ownership), dated 11/5/21, documented R2, "At	S9999		

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Risk for Falls," was developed for a fall that occurred 11/5/21, with transport from Emergency Medical System for a laceration to the forehead. A Fall Risk Assessment, dated 12/1/21, completed for fall 12/1/21, documented "At Risk for Falls."

3. R3's Admission Record documented R3 was admitted on 7/22/21. R3's Admission Record documented the following diagnoses: Zygomatic fracture of left side (cheek bone), multiple fractures of ribs on right side, fracture of shaft of right tibia and right fibula, (whole leg), Dementia, Aphasia (loss of ability to understand or express speech), abnormal posture, lack of coordination.

R3's Care Plan focus, initiated, 9/18/21, documents "(R3) is a risk for fall r/t (related to) in the community with fracture, hx (history) of fall, cognitive decline, unable to bear weight." R3's Care Plan intervention, initiated 7/22/21, documents "Be sure (R3's) call light is within reach and encourage the resident to use it for assistance as needed. If note to be wandering with facial grimacing, lay down elevate, ensuring bed is low and fall mat is in place." R3's Care Plan Intervention, dated 7/23/21, documents "Call Don't Fall" sign.

R3's Incident Audit Reports, completed at the time of R3's fall occurrence, documented the following R3 fell on the following dates: 11/12/21, 11/13/21, 11/17/21, 11/18/21, 11/23/21, 11/30/21. The facility failed to present Incident Reports for dates of 11/13/21 and 11/23/21. These fall occurrences are un-witnessed with a main location of incident occurring in her room.

R3's Incident Audit Report, dated 11/12/21 documented at 8:35 AM, R3 was found lying on

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S9999	Continued From page 10 her left side. The Report documented she was found in front of her wheelchair which was in front of her bed and R3 was off the fall mat. R3's Fall Assessment, dated 11/12/21 documents she has 3 or more falls in the past three months, The Assessment documented that she has balance problems while standing and walking and decreased muscular coordination. The facility failed to implement new interventions to address R3's fall on 11/12/21 to prevent her future falls. R3's Care Plan was not revised after this fall with new interventions. R3's Minimum Data Set, (MDS) dated 11/15/21, documented, severely impaired cognition, extensive assistance of two staff, for transfers and toilet use for continuous incontinence of bowel and bladder. R3's Incident Audit Report, dated 11/17/21, documents on 11/17/21 at 2:00 PM, R3 was observed by staff attempting to self-transfer from her wheelchair and fell and hit her head on the nightstand in her room. The Report documented R3 sustained a laceration to the back of her head and was transferred by local Emergency Medical System (EMS) to local hospital. R3's Emergency Room report, dated 11/17/21 at 5:44PM, documented, R3 was transferred for evaluation and treatment due to a fall with a laceration to the head. R3's laceration was 1.5 centimeters in length requiring 3 staples to the occipital area (scalp). R3's assessment upon entry to emergency room documented a witnessed fall at facility and assisted to floor by staff.	S9999		

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S9999	Continued From page 11 R3's Incident Audit Report, dated 11/18/21, documented an un-witnessed fall on the floor in front of her bed without injuries. There was no documentation in R3's medical record that the facility implemented progressive interventions after R3 fell on 11/8/21. R3's Incident Audit Report, dated 11/30/21, documented, an observed fall in the facility hallway, R3 fell on her left side of face, left shoulder and left hip and hitting her head hard. R3 was transferred by local emergency medical system to hospital for evaluation and treatment with results of a contusion (bump) on left side of head. On 12/7/21 at 8:00 AM and through 4:00 PM, R3 was observed in her tilt back wheelchair, constantly self-propelling herself throughout the three hallways and foyer areas. R3 was observed to not be in her bed asleep at any time throughout this 12/7/21 and 12/8/21 investigation. On 12/18/21, at 4:30 AM, R3 was propelling self by front entrance door without staff identified to be in their viewing. On 12/8/21, V1, stated she understands that a Fall Risk Assessment needs to be completed with each fall incident and for each fall, new interventions documented on the Care Plan. V1 stated, she would expect her staff to monitor resident more frequently that are a high risk for falls and requiring assistance from staff. The facility's policy and procedure, entitled, "Fall Prevention Program," dated 11/21/17, documented, "To assure the safety of all residents in the facility, including measures which	S9999		

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S9999	Continued From page 12 determine the individual needs of each resident by assessing the risk of a fall and implementation of appropriate interventions to provide necessary supervision. To include methods to identify risk factors and Care Plan to addresses each fall and interventions with each fall." (A)	S9999		