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| S 000 | Initial Comments<br><br>Complaint Investigation: 2290018/IL142064 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations<br><br>300.1210b)5<br>300.1210c)<br>300.1210d)6)<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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.<br><br>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.<br><br>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.<br><br>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: | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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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.

These Requirements were not met as evidenced by:

Based on observation, interviews and record reviews, the facility failed to ensure that supervision and limited assistance during dressing and personal hygiene were implemented in preventing fall for one resident (R2) of three residents reviewed for accidents and supervision. This deficiency resulted in R2 complaining of left leg pain requiring subsequent emergent transfer to the emergency room; sustained a left intertrochanteric hip fracture and underwent a closed reduction with nailing of left femur.

Findings include:

R2 is a 101 year old, female admitted in the facility on 11/01/17 with diagnoses of Displaced Intertrochanteric Fracture of Left Femur, Subsequent Encounter for Closed Fracture with Routine Healing; Unsteadiness on Feet and Other abnormalities of Gait and Mobility.

According to progress notes dated 01/01/22, V19 (Registered Nurse, RN) documented that R2 was observed up in wheelchair getting ready for the day applying makeup and rollers. Approximately 10 minutes later, R2 was heard calling for assistance and observed sitting on the floor directly in front of her wheelchair with her pants around her ankles. Noted cup of water knocked

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| S9999 | Continued From page 2<br>on the floor. Assessment immediately initiated with no complaints of pain, redness, swelling or bruising visibly noted. No leg shortening observed or leg deformity noted. R2 verbalized that she was putting on her pants when she slid out of her chair and unto the floor landing on her bottom. Approximately at around 5:00 PM, R2 complained of pain to buttock area, PRN (when necessary) pain medication administered with effectiveness.<br><br>On 01/11/22 at 1:00 PM, V19 was asked regarding R2's fall incident on 01/01/22. V19 said, She was in the room, in her chair doing her hair and does not need any assistance. Then, all of a sudden she called out for help. I went into the room, she was sitting on the floor in front of the chair with her pants above to her knees. She was trying to pull up her pants. When she was on the floor, the pants were on her knees. It happened in the morning after morning medication pass. She was trying to dress up, put on pants and that's what she verbalized when she had the fall. She was pretty independent on dressing as far as I saw her that morning. I was there five minutes before, her call light was within reach. She was trying to dress herself up when it happened. At that time, she was doing her hair and applying makeup and I asked if she needs anything and said she was okay. Head to toe assessment was done. Range of motion are within normal limits, no complaints of pain. She was transferred back to her wheelchair. At the time, I was busy. I did not notify V24 (Physician) and V17 (Family Member) regarding incident. I did write it on the paper but I did not endorse the incident to the next shift.<br><br>R2's MDS (Minimum Data Set) dated 11/10/21 documented:<br>Section G - G. Dressing which includes putting on | S9999 | | |

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| S9999 | Continued From page 3<br>and changing pajamas and housedresses: needs supervision from one person physical assist Section G - J. Personal Hygiene which includes combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excludes baths and showers): needs limited assistance from one person physical assist.<br><br>During interview with V25 (Occupational Therapist) on 01/11/22 at 9:40 AM, she stated R2 needs supervision from one staff during dressing. V25 continued, Before the fall, she needs supervision from one person assist. She does not need any help performing upper body dressing but needs supervision from one person for lower body dressing.<br><br>Progress notes dated 01/02/22 time stamped 12:40 PM recorded: V23 (Licensed Practical Nurse, LPN) was informed that R2 was going to be transferred to hospital emergency room for further evaluation of left leg pain.<br><br>V23 (Licensed Practical Nurse, LPN) was interviewed on 01/11/22 at 1:14 PM regarding R2 complaining of left leg pain on 01/02/22. V23 said, She was fine in the morning, no complaints of pain. Around 11 AM to 12 PM, one of the nurses (V7, Licensed Practical Nurse, LPN) came to me, called me that she (R2) complained of pain and needs to be transferred to the hospital. They were saying she had a fall the previous day. There was no endorsement from the previous nurse that she had a fall. I learned it from V17 (Family Member).<br><br>On 01/11/2022 at 1:48 PM, V7 was asked regarding R2's fall incident. V7 mentioned: That Sunday (01/02/22) when I worked, V18 (Certified Nurse Assistant, CNA) told me that she (R2) said | S9999 | | |

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her (R2) side was hurting. She (V18) just happened to be walking past when she (R2) called her and told her that her side hurts. I told V23 that she (R2) had pain on her side.

An attempt was made to contact V18 for questions and clarifications but she was not available.

V9 (Assistant Director of Nursing, ADON) stated in an interview on 01/12/22 at 12:36 PM, One of the nurses (V23) notified me on a Sunday (01/02/22) when she (R2) was already in pain. I didn't know about the actual fall incident. I was the one who called V14 (Nurse Practitioner, NP) that time. Usually, she (R2) does not need someone to supervise or provide assistance when she dress up her upper and lower body. She puts her own makeup, does her hair, put on earrings, all by herself without staff present. She is alert, oriented to time, place and person. That time when she had the fall, she said she stood up from the wheelchair and was pulling her pants up and accidentally trip over her pants.

Progress notes dated 01/02/22 time stamped 10:40 PM documented: R2 was admitted in the hospital for left broken hip.

Progress notes dated 01/05/22 time stamped 8:31 PM documented: R2 returned from hospital post procedure closed reduction and nailing of the left femur.

On 01/10/22 at 11:35 AM, R2 was observed in her room, sitting in her wheelchair with V17 (Family Member). R2 is alert but forgetful. She is verbal but hard of hearing. She appeared fully made up and hair was curled and combed. R2 was asked regarding her fall incident last

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01/01/22, said, I fell backwards. I was sitting in wheelchair. I don't even know how I fell. I called out for help, they picked me up and put me back to bed." R2 was asked if there was a staff present each time she dresses up herself, stated, "I dressed up myself with no staff around me." V17 was also asked regarding her (R2) fall incident. V17 said, They didn't inform me that day when she fell. V18 called me that Sunday and told me to come here that she (R2) had fallen. She (V18) went to see her (R2) to wish her happy new year and she (R2) told her (V18) that she fell.

V2 was asked on 01/12/22 at 12:16 PM regarding R2 and recent fall incident. V2 replied, "I was the one who did the investigation. She has a tendency to get up at times, to get up without assistance, we educate and remind her. We've always make sure that she calls for assistance and good shoes to fit on. She had a fall last 01/01/22, she was trying to do her morning routine - dressing herself up, putting on her make up and do her hair. She does it by herself, likes to do that by herself. Probably someone, a staff needs to provide very limited assistance. She does not need any staff supervising her when she does her morning routine, not at all times. At times, she does need supervision and very limited assistance during dressing and performing her morning routine. She fell because she did not call for assistance. And she is able to. V2 was also asked regarding her expectations on staff in preventing falls. She (V2) said, staff has to follow the fall protocol.

V9 was also asked regarding her expectations on staff in preventing falls. V9 verbalized, "We have a system here that we follow for one or two person transfers. We make sure that bed is locked, wheelchair is locked. Staff are trained

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how to use the mechanical lift transfer. For agency staff nurses and CNAs who are new to the facility, we have to inservice them to the floor and know the residents. The first 30 minutes prior to their work schedules are intended for orientation. As far as CNA doing patient care, we encourage the nurses to walk with the CNAs and let them see the resident. We have a 24 hour report which tells the nurses the care to be rendered to a specific resident. MDS documentation are the basis of care plans for each residents. Whatever documentation in the MDS, it should be reflected in the care plan. R2 is independent, able to do everything for herself. She will ask for assistance if she needs it, she goes to the BR by herself, dresses herself up, applies make up on. Staff has to follow fall protocol and part of it is to notify the doctor, family and Supervisors regarding fall incidents."

On 01/12/22 at 2:30 PM, V14 (Nurse Practitioner) was interviewed regarding R2. V14 said, She is alert, oriented to person and place. She does a lot of her tasks by herself but she needs limited assistance from staff during dressing. She does her own hair and makeup. But when she dress up her upper body and lower body, she needs limited assistance from staff. Staff needs to be with her for safety measures. I was notified, she was sent out. I received the phone call from V9 that she (R2) was having some pain from her leg and difficult to move so she was sent out. I was notified only that time that she had a fall and was having pain. She lost her balance that is why she had the fall. Staff should be there to provide supervision and assistance during dressing. There was some weakness for sure, when she (R2) bended that low and pressure shifts happened which led to lose her balance. Staff needs to be present with her during bathroom

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| S9999 | Continued From page 7<br>use/shower and dressing so staff could step in if she struggles. If she was struggling on putting her pants on, staff can assist and intervene. She should be rounded on every two hours even during the course of the night to ensure safety. I need to be notified when incident occurred right away so X-rays can be ordered. This fall could have been prevented to happen.<br><br>R2's Care plan regarding Falls start date 11/02/17 documented: Approach start date 12/11/17 - increased staff supervision with intensity based on resident need.<br><br>There were no documentation in R2's progress notes dated 01/01/22 indicating that V14, V17 and V24 were notified at the time fall occurred. There were no documentation that endorsements were communicated to V23 and or to supervisors regarding fall incident and for post fall monitoring.<br><br>Facility's policy titled "Fall Reduction Program" revised date 04/19 stated in part but not limited to the following:<br>Objective:<br>1. It is the policy of this facility to have a Fall Reduction Program that promotes the safety of residents in the facility. The program intent is to assist clinical staff in determining the needs of each resident through the use of standard assessments, the identification of each resident's individual risks, and the implementation of approach interventions, supervision, and/or assistive devices deemed appropriate. Quality Assurance Program will monitor the program to assure ongoing effectiveness.<br>Program Contents:<br>The Fall Reduction Program includes the following components:<br>3. Use and implementation of profession | S9999 | | |

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| S9999 | Continued From page 8<br>standards of practice.<br>5. Notification of physician, family, or legal representative<br>6. Communication with direct care staff members<br>Standards:<br>3. Safety interventions will be determined and implemented based on the assessed, individualized risks and in accordance with standards of care, interventions to be documented within the resident's care plan.<br>6. In the event fall incident occurs, nursing staff will complete an assessment of resident and obtain the facts surrounding the fall, and report findings to the resident's physician and responsible party (if applicable) and document findings and notification within the resident's clinical record.<br>7. Post fall monitoring shall be completed by the nursing staff every shift for 72 hours and findings documented<br>within the clinical record.<br><br>(A) | S9999 | | |