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	IL6010086	A. BUILDING: _____ B. WING _____	C 04/19/2022

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S 000	Initial Comments Complaint Investigations 2292587/IL143347 Investigation of Facility Reported Incident of March 14, 2022/IL145089 Investigation of Facility Reported Incident of January 21, 2022/IL143701	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2): 300.610a) 300.690c) 300.1210d)6) 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. Section 300.690 Incidents and Accidents c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. Section 300.1210 General Requirements for Nursing and Personal Care 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. These requirements were not met as evidenced by: (1) Based on interviews and records reviewed the facility failed to provide interventions to prevent or reduce the risk of falling for a resident known to be a fall risk with confusion. The facility also failed to ensure a resident was positioned in the center of the bed after providing direct care. These failures affected 2 of 3 residents (R2, R9) both reviewed for safety and falls. This failure resulted in R2 having a fall incident resulting in a	S9999		

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S9999	Continued From page 2 right hip fracture, and R9 falling from bed sustaining a laceration to left forehead area requiring 3 sutures. Findings include: a. R2 face sheet documents R2 is an 89-year-old admitted to the facility on 1/10/2022. R2's admission fall risk assessment dated 1/10/2022 documents R2's fall risk score of 13.0 which designates R2 as a high risk for falls. R2 progress note date 1/21/2022 at 4:23 AM by V9 (RN) documents R2 started to doze and slid out of wheelchair onto the floor. The facility Reported incident (FRI) dated 1/21/2022 documents resident alert and oriented x2 with periods of confusion and diagnoses including: encephalopathy, dysphagia, non-traumatic intracranial hemorrhage, cerebral aneurysm, TIA, and Cerebral infarct. The FRI final report dated 1/21/22 at 6:18 AM documents resident noted sliding from wheelchair to the floor. During physical therapy later in the resident complained of pain. MD notified and x-ray Completed. Results of x-ray showed a right femur fracture. V9's (Nurse) hand written account of the fall documents the following: Upon making rounds at approximately 3:30 AM, author noted patient trying to get out of the bed and walk. She was alert but confused to place and time. Knowing patient's medical history author was concerned for her safety. Author assisted Patient to wheelchair and placed her at the nursing station with wheelchair in locked position. At approximately 4:00 am author and Certified Nursing Assistant (CNA) had backs turned.	S9999		

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S9999	Continued From page 3 Patient started to slide and fall out of the wheelchair as author turned head and noted patient falling to the floor and landing on her right side. On 4/12/2022 at 8:03 AM V9 states R2 was one assist to wheelchair and incontinent. V9 states she had cared for R2 a couple of times before. V9 states R2 was confused and a fall risk. V9 states, R2 had "very unsteady gait. V9 states, "At around 3:00 am R2 was in her room sitting at the edge of the bed. She kept trying to get up by herself." V9 states after she made sure R2 did not have to go to the restroom or anything else, she saw that R2 kept trying to get up. V9 states she then helped R2 into the wheelchair and wheeled her to the nurse's station where she and a CNA were sitting. V9 states, "I turned my back to get charting done and heard her [R2] trying to move. I saw movement out of the corner of my eye. By the time I could get up, she was already falling." "It was a witnessed fall. She fell on her right side. Surveyor asked why V9 didn't have R2 in her field of vision at all times. V9 states, "I didn't think she would try to get up." X-ray results dated 1/21/2022 documents the following findings: Right hip: Examination reveals an impacted Basi cervical fracture of the right femoral neck with varus deformity and no significant displacement. On 4/7/2022 at 1:45 PM V2 (Director of Nursing, DON) states staff should make sure residents that are high fall risks are monitored more frequently and are safe, not slipping and falling to the floor or trying to stand up without assistance. V2 states, the staff should be within reach to intervene if resident tries to get up.	S9999		

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S9999	Continued From page 4	S9999		

b. R9 is 78-year-old with diagnosis including but not limited to Adult Failure to Thrive, Pressure Ulcers, Pain in Arms, Dysphagia, Lack of Coordination, Repeated Falls, Anemia in Chronic Kidney Disease, Hypertensive Chronic Kidney, Cachexia, Bipolar Disorder, Depression, and Unilateral Primary Osteoarthritis.

On 4/6/22 at 11:33AM the surveyor observed R9 in the dining room in a wheeled reclining chair. The surveyor noted a pink scar above and along R9's left eyebrow. R9 did not respond verbally when surveyor spoke to her.

On 4/6/22 at 1:46PM V38, Certified Nursing Assistant (CNA), said on 3/14/22 she was in the dining room when she was notified that R9 was on the floor.

On 4/6/22 at 3:00PM R9 observed sitting in the reclining chair in the dining room with V24, R9's family. V24 said we (the family) were notified R9 fell but we don't know how she fell. V24 said she visits 3 or 4 times a week. V24 said R9 does not move, I have never seen her moving around, only her hands.

On 4/7/22 at 1:35PM V2, Director of Nursing, said R9 should be placed in the center of the bed. V2 said the air mattress and the sheet would cause her to slide in the bed. V2 said it is not likely that R9 slid from the center of the bed when she fell. V2 said she was not sure who was the last person to provide care to R9 before she fell on 3/14/22. V2 said the intervention after the fall for R9 was education of the staff on proper placement of a resident while in the bed.

On 4/7/22 at 2:20PM V25, Wound Nurse, said R9

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S9999	Continued From page 5	S9999		

usually remains in the same position. V25 said pillows and wedges are used to position her and minimize positioning on her back.

On 4/12/22 at 9:53AM via phone interview V35, CNA, said R9 must have slid out of the bed. V35 said someone must have removed R9's floor mat and that is why she got hurt. V35 said she did not realize the floor mats were not in place when she saw R9 earlier. V35 said R9 was able to sit up and move around before she fell on 3/14/22.

On 4/12/22 at 11:15AM V2 said new interventions after R9 fell on 3/14/22 were to get her up at breakfast and place floor mats to prevent injury. V2 said residents determined to be a high fall risk will get floor mats as an intervention. V2 said high fall risk residents are those with previous falls and fall risk as determined on the fall risk assessment. V2 said a score 10 or more on the assessment indicates the resident is a fall risk. V2 said a score of 14 is a high risk for falls. V2 said psychotropic medications can make a resident groggy contributing to their fall risk. V2 said R9 should have had floor mats in place before her fall on 3/14/22.

On 4/12/22 at 11:20AM V34, Restorative Nurse, said R9 had interventions for floor mats since before her fall on 3/14/22. V34 said R9 was not able to stand before 3/14/22.

On 4/12/22 at 11:45AM V33, Licensed Practical Nurse, said she was notified that R9 was on the floor on 3/14/22. V33 said she saw R9 on her side on the floor next to her bed. V33 said R9 had a laceration over her left eyebrow. V33 said she sent R9 to the hospital for further evaluation.

On 4/12/22 at 12:57PM V16, Physical Therapy,

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S9999	Continued From page 6 said R9 was treated by physical therapy from 3/1/22-3/4/22. V16 said we did not see progress and therapy services were discontinued. V16 said R9 was not able to turn or sit herself up while she was on therapy caseload. R9's Cognitive Pattern Assessment dated 3/5/22 notes a score of 10, moderately impaired cognition. R9's Functional Status Assessment dated 3/5/22 notes R9 required extensive assistance for bed mobility, transfer, toilet use, and personal hygiene. Balance test note R9 was not steady. R9's Fall Risk Evaluation effective date 2/15/22 notes a score of 14. A document titled Fall date 3/14/22 notes R9 was on the floor. R9 has ½ cm laceration to left eyebrow. Review of R9's progress notes dated 3/14/22 at 2:00PM indicates R9 returned to the facility from the hospital. R9 received 3 sutures to left brow. R9's care plan initiated on 12/13/21 notes R9 is at risk for falls due to diagnosis and history of unilateral primary Osteoarthritis, Bipolar Disorder, Hypertension, Acute Kidney Failure. Resident has medication ordered that may alter gait and balance. Interventions include anticipates and meet resident's care and safety needs. The facility policy for Fall Prevention and Management Review date 10/2021 notes: The facility will identify and evaluate those	S9999		

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S9999	Continued From page 7 residents at risk for falls, place for preventive strategies, and facilitate as safe an environment as possible. A score of 10 or greater indicated the resident is as "high risk" for falls. The facility's Fall Prevention and Management Guideline dated 10/2021 documents the following: This facility is committed to maximizing each resident's physical, mental and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. (2) Based on interviews and records reviewed the facility failed to report serious resident injury to IDPH within 24 hours of resident (R9) falling resulting in a laceration requiring sutures. This failure effected 1 (R9) of 3 residents reviewed for reporting. Findings include: Review of R9's Fall Report dated 3/14/22 at 8:00AM notes R9 was on the floor with a laceration to the left eyebrow and orders to send R9 to the hospital for evaluation. Review of R9's progress notes dated 3/14/22 at 2:00PM indicates R9 returned to the facility from the hospital. R9 received 3 sutures to left brow. On 4/12/22 at 11:45PM V33, Licensed Practical Nurse, said she assessed R9 on 3/14/22 and noticed a laceration over her left eyebrow so I sent her out for further evaluation.	S9999		

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S9999	Continued From page 8 On 4/12/22 at 2:00PM V2, Director of Nursing (DON), said after R9 fell she was sent to the hospital and returned to the facility on the same say and same shift of the fall on 3/14/22. V2 said they (staff) are supposed to notify me when a resident has an injury. V2 said I did not know of R9's injury until 3/15/22 when I came into work. V2 said I have to report an injury within 24 hours. The initial report to IDPH was sent 3/15/22 at 5:25PM to notify of R9's fall with laceration resulting in sutures, greater than 24 hours from R9's hospital return. The facility policy for Reporting of Unusual Occurrences review date 9/2021 notes if the incident report is serious, by which there is serious harm of injury to the resident it be reported to IDPH within 24 hours and a final summary completed in 7 days (A) Statement of Licensure Violations (2 of 2): 300.698b)3) 300.698j) Section 300.698 COVID-19 Vaccination of Facility Staff b) Each facility shall require all staff to be up to date on COVID-19 vaccinations or be tested in a manner consistent with the requirements of subsection (c) until they are up to date on COVID-19 vaccinations. 3) Each facility shall exempt individual staff members from the COVID-19 vaccination requirements if:	S9999		

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S9999	Continued From page 9 A) Vaccination is medically contraindicated, including any individual staff member who is entitled to an accommodation under the Americans with Disabilities Act or any other law appliable to a disability-related reasonable accommodation; or B) Vaccination would require the individual staff member to violate or forgo a sincerely held religious belief, practice, or observance. j) Failure to comply with any of the requirements set forth in this Section creates a substantial probability of risk of death or serious mental or physical harm and shall result in a Type "A" violation as defined in Section 300.274(b)(2). Violations of the requirements of this Section shall have the status of "high risk designation." Findings include: Based on interviews and records reviewed the facility failed to follow their policy for all employees to be vaccinated or have documented exemptions in place. This failure resulted in the facility currently listing 4 positive Covid residents R18, R24, R30 and R31. On 4/6/22 at 1:57PM The surveyor reviewed the COVID 19 vaccination declination forms provided. On 4/7/22 at 10:39AM V24, Human Resources, said if a staff member wants to decline the COIVD-19 vaccination then we have a declination form for them to complete. V24 said staff who decline require either a doctor's note for a	S9999		

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S9999	Continued From page 10 medical exemption or documentation for religious exemption. V24 said V49's (Nurse) declination statement shows V49 declined to be vaccinated because she does not want it. [No reason for declination is indicated on the form.] V24 said this is not following policy for declination. After reviewing V50 and V51, (both CNAs) declination statements V24 said, I will double check for additional documentation related to their reasons for declination. On 4/7/22 V2, Director of Nursing, reviewed COVID-19 positive resident list with the surveyor. The 30-day COVID 19 list includes R18, R24, and R31. V2 said R30 should be included on the list. On 4/13/22 at 4:49PM additional documentation was provided related to V51's declination. V51's declination states she declines due to religious reasons. A religious Accommodation Request form was provided to the surveyor. The Date of Request and R51's signature is not dated. Page 2 of the form is not completed. [This was requested by the surveyor at the end of V24's interview on 4/7/22.] V50's, CNA, declination form stated medical exemption on 12/17/21. The facility provided a vaccination card for R50 dated 4/8/22. [The day after V24 was interviewed.] No additional information was provided for V49's declination. The facility COVID 19 Vaccination for Staff Member policy revised on 1/19/22 notes the facility mandates that all employees participate in the COVID 19 vaccination program or complete a statement of declination. All staff are required to receive the 1st dose of vaccination unless they complete a declination with medical contraindication or because of religious beliefs. (A)	S9999		

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