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S 000	Initial Comments Facility Reported Incident Investigation of 4/12/22/IL146049	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 manifest decubitus ulcers or a weight loss or gain 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. 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)	S9999		

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These Regulations were not met as evidenced by:

Based on observation, interview, and record review, the facility failed to immediately assess a resident for injury following a fall including neurological checks, implement fall interventions, and supervise a resident while they are showering for two of three residents (R1, R2) reviewed for falls. These failures resulted in R1's injury not being identified and treated immediately. R1 sustained a closed fracture of right radius and ulna (right wrist) as a result of her fall. R2 received a 1/2 inch abrasion to his right lower leg as a result of his fall.

Findings include:

The facility's Fall policy, no date available, documents, "Policy: To provide for the investigation of all falls. To provide a safe environment for resident. Procedure: When a resident falls the nurse on duty will assess the resident for injury."

1. On 4/26/22 at 12:30 p.m. R1 alert sitting up in wheelchair. R1 had a hard cast on R1's right arm from right upper arm down to R1's hand. R1's fingers were swollen and light purple/green in color. R1 was pleasantly confused with garbled word salad. States, "I fell" pointing to her cast

R1's Incident Investigation, dated 4/12/22 at 3:30 p.m., documents, "I walked around to elevator and saw (V5 CNA) with R1 on the floor. She was sitting/leaning up against the wall reaching for the linen cart. The investigation also documents, "Resident's verbal report of the fall and circumstances: (R1) unable to communicate

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S9999	Continued From page 3	S9999		

verbally. (R1) was agitated at the time of fall." The report also documents, "List the interventions you immediately put in place to provide resident safety and prevent another fall: Assisted (R1) in to chair to prevent (R1) from attempting to get up on her own."

R1's Neurological Flow Sheet, dated 12/13/22, documents that R1 had neurological checks completed on 4/12/22 at 3:30 p.m., 3:45 p.m., 4:05 p.m., 4:20 p.m., and 4:40 p.m. signed by (V4 Licensed Practical Nurse). The entries also have a mark thru them and "Hospital" is written. The flow sheet documents that neurological checks were restarted when R1 returned from the hospital with the following checks: 10:40 p.m., 11:40 p.m., (4/13/22) 12:40 a.m., 1:40 a.m., 2:40 a.m., 3:40 a.m., 4:40 a.m., 5:40 a.m., 8:30 a.m., 2:30 p.m., and 6:30 p.m.

On 4/27/22 at 2:40 p.m., V4 stated, "I started doing neurological checks on (R1) when I saw her at 6:40 p.m. and that's when I did my first full assessment of her. I attempted to do her vital signs four different times at that time as well, but she was refusing. I did not do neurological checks at 3:30 p.m., 3:45 p.m., 4:05 p.m., 4:20 p.m., or 4:40 p.m. because I wasn't aware of the fall until 6:40 p.m. That is my signature on (R1's) form though. I think I messed up when I wrote 16:40 (4:30 pm) thinking it was 6:40 p.m."

Facility Staff Statement, dated 4/12/22, documents, "(V3 Assistant Director of Nursing) walked around to elevator and saw (V5 Certified Nursing Assistant-CNA) with (R1) leaning up against wall attempting to reach for a linen cart. (R1) was agitated at the time so I assisted (V5) in standing (R1) up to place her in a chair to be evaluated by floor nurse."

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S9999	Continued From page 4 Facility Staff Statement, dated 4/12/22, documents, "(V3) and I (V5) picked (R1) up off the floor in the hallway. I asked (R1) if she was okay and she said yes." R1's Nurse's Note, dated 4/12/2022 at 6:40 p.m., documents, "R1 complained of pain, held up her right arm. R1 sent to ER (Emergency Room)." R1's progress/nurses' notes have one entry prior to this dated 3/17/22. There is no other documentation regarding R1's actual fall. R1's 72 hour occurrence report, dated 4/12/22, documents, "R1 was observed on the floor by the elevator. Staff assessed resident. ROM (Range of Motion) within normal limits. Neurological intact. R1 sitting by nurses' station. R1 didn't complain of any pain/discomfort. See neurological sheet for orders noted." On 4/27/22 at 2:40 p.m., V4 stated, "I thought (V3) had done (R1's) initial fall assessment and neurological checks since she was with (V5) when (R1) was found on the floor. The entry I made on the 72 hour occurrence charting (dated 4/12/22) was information that I received from (V5). What I charted was not my assessment. I didn't assess her for ROM, and that entry was not put in until after (R1) went to the hospital." R1's Hospital X-ray results, dated 4/12/22, document, "Impression: Displaced and angulated distal radial and ulnar fractures." R1's Hospital Progress note, dated 4/12/22, documents: Assessment & Plan: R1's wrist reduced and placed in short arm splint." R1's Emergency Department After Visit	S9999		

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S9999	Continued From page 5 Summary, dated 4/12/22, documents, "Reason for visit: wrist injury. Diagnosis: Closed fracture of right radius and ulna." The facility's 5 day report to the State Agency, dated 4/15/22, documents, "R1 was observed on the floor in the the hallway on 4/12/22. R1 did experience swelling to her right wrist area. She was sent to the emergency room and returned the same date with a sling in place for a right radial and ulna fracture." R1's Fall care plan, dated 12/20/21, documents, "I have risk factors that require monitoring and interventions to reduce risk for falls. History of falls. I can be noted to be impulsive with no regards to safety." The care plan also documents that on 4/13/22 it was revised with the new intervention was a therapy screen. This same care plan documents R1 requires 1:1 or 2:1 extensive assist with most ADL's (Activities of Daily Living) and mobility. On 4/26/22 at 12:34 p.m. V5 (CNA, Certified Nursing Assistant) stated, "(R1) was wound up that day (4/12/22) trying to leave the floor. She was agitated. I was the one who found her on floor by the elevator. Myself and (V3 Assistant Director of Nursing, ADON) helped her up from the floor. I don't think (V3) did anything with her. (R1) was combative and fighting us. I walked her to a chair at the nurses' station, and (V3) left. When I took (R1) to the nurses' station, I reported to (V4 LPN-Licensed Practical Nurse) that (R1) had fallen, but she didn't do anything. (V4) didn't assess her or anything. At approximately 6:45 p.m. that night, (R1) was walking in the hallway complaining of her wrist and that's when (V4) sent her to the emergency room."	S9999		

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S9999	Continued From page 6 On 4/26/22 at 1:35 p.m., V4 (LPN) stated, "(R1) fell by the elevators (V3, ADON) and (V5, CNA) picked her up. (V3) didn't tell me anything before she left. I wasn't aware of the fall until the assessment I did. I assessed her around 6:40 p.m., and her wrist was blue and swollen. When I saw her wrist I sent her to the emergency room." On 4/27/22 at 11:35 a.m., V3, (ADON) stated, "I was leaving work that day when I walked around the corner and saw (R1) on the floor. (V5) was already there with (R1). (R1) was agitated and grabbing onto the laundry cart trying to stand herself up. I looked over (R1) really quick to make sure she didn't have any obvious injuries. I didn't notice anything, but I didn't do a full head to toe assessment because that's the floor nurse's job. I didn't see any bruising or swelling on (R1's) arm, but she was swinging and agitated with us. I also feel like her adrenaline was pumping so much I don't know if she would have noticed the pain. She isn't really verbal enough to verbalize her pain consistently. The agitation could have been a nonverbal sign of pain. (V5) and I lifted (R1) into a chair at the nurses' desk, (V5) told me she would report it to the floor nurse. So, I left and went home. (V1 (Administrator) called me later that night telling me I need to do (R1's) report. I wasn't even there to get all of the details for the fall report. It should have been the floor nurses that completed this. I helped (V5) with (R1) that was it. This is why I left the facility. Had I felt it was my responsibility, I would have never left but there was two floor nurses present so this was the floor nurse's responsibility. The following morning, they threatened me into doing the fall report. (V5) gave me a written statement that she had reported the incident to (V4), but (V4) wasn't going to do anything with it. Once (V5) got (R1) to the nurses' station they should have done a set of	S9999		

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vitals, and started neurological checks. We do neurological checks if it was unwitnessed, and unable to tell us what happened."

On 4/27/22 at 3:10 p.m., V2 (Director of Nursing) stated, "When (V3) found (R1) on the floor with (V5) she should have immediately assessed (R1) and do the fall paperwork or tell the floor nurse so the floor nurse could have taken over. (V3) did not do a full assessment of (R1) or start neurological checks." V2 confirmed that a full head to assessment nor neurological checks were done immediately after (R1) fell. V2 also stated, "No one noticed any pain or swelling until (V4) sent (R1) out to emergency room. If (R1's) ROM (Range of Motion) was assessed the nurses may have noticed (R1's) injury sooner. Our facility neurological check policy is to start neurological checks when fall happens and the resident has hit their head or they don't know if they've hit their head. The checks are to be started immediately, and the frequency is what is documented on our neurological check form of every 15 minutes for one hour, every 30 minutes for one hour, every hour for four hours, and then every four hours for 24 hours. After (R1's) fall we put an intervention in for therapy to evaluate (R1). However, because of (R1's) insurance we didn't get a therapy evaluation. So, there was no intervention put into place in order to prevent (R1) from falling again."

2. R2's Care plan, dated 12/29/20, documents, "I am at risk for falls related to history of prior to admission, ataxic, and gait/balance problems."

R2's Cognition care plan, dated 12/29/20, documents, "I have impaired cognitive function/dementia or impaired thought processes related to Dementia."

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S9999	Continued From page 8 R2's ADL (Activities of Daily Living) care plan, dated 6/28/21, documents, "(R2) presents functional deficits in self care. (R2) requires limited-moderate assist with most ADL's and mobility. (R2) demonstrates impaired decision making skills, short attention span, generalized weakness, functional ROM limitations in left upper extremity." R2's Fall Risk Evaluation, dated 4/22/22, documents a score of 13 putting R2 at risk for falls. The evaluation also documents the following risks that contribute to R2's risk for falls: Intermittent confusion; Chair bound; Balance problem while standing; Decreased muscular coordination; Requires use of assistive devices." R2's Incident Investigation Quality Improvement Process, dated 4/22/22, documents, "Observed sitting on the floor in the shower room trying to transfer himself from shower chair to his wheelchair." R2's Quality Assurance Fall Report, dated 4/22/22, documents, "Resident's verbal reports of the fall and circumstances: trying to transfer from shower chair to his wheelchair. Environmental status at time of fall: Floor wet. Immediate cause of fall: fall due to environmental. Injury as a result of fall: Minor-1/2 inch long on right lower leg. List the interventions you immediately put in place to provide resident safety and prevent another fall: All residents need supervision/assistance in the shower room, can not be left unattended." On 4/26/22 at 1:15 p.m., R2 was sitting up in a wheelchair in his room. R2 stated, "I was in the shower on my own, like usual, when I fell. I was sitting in the shower chair on the shower side.	S9999		

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When I was done, I needed to get to the other side of the shower room to get into my wheelchair and dry off. My feet don't touch the ground while I'm in the shower chair, so in order to move around in the chair I rock my body to scootch (move) the chair to where I want to go. There is an incline between the two areas of the shower room. So I have to go up and over that incline. When I tried to go up the incline the shower chair tipped over on me. I cut up my leg pretty good." R2 raised his pant leg where multiple scabbed over abrasions were scattered over the majority of R2's right lower leg.

On 4/26/22 at 1:25 p.m., the facility shower room was a small area separated into two areas that was completely tiled. There is a separation between shower and entrance area, that is a raised incline. In order to get over the incline from either side of the shower you must go up and then down it.

V9's (Certified Nursing Assistant) Facility Corrective Action Notification, dated 4/22/22, documents, "On 4/22/22 you were giving (R2) a shower and you left the shower room and floor. Even though you reported to the nurse you were doing so, it is not acceptable to ever leave a resident unattended in the shower room. If the resident is independent and requests privacy you must stay in the shower area. This behavior is completely unacceptable as a caregiver. This also creates a hardship for the rest of your team in providing caring, quality care for our residents."

On 4/26/22 at 2:35 p.m., V1 (Administrator) stated, "The staff education that was provided in response to (R2's) fall was to remind them that no resident is to be left alone in the shower. We have one resident that is able to independently

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S9999	Continued From page 10 shower, and that is not (R2). (R2) shouldn't have been left alone." On 4/27/22 at 3:10 p.m., V2 (Director of Nursing) stated, "(V8) took (R2) to shower in the shower room. (V8) left (R2) to shower on his own and left. (R2) fell while in the shower room alone. (R2) should not have been in shower alone." (B)	S9999		