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	IL6001804	A. BUILDING: _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK-LINDSEY VILLAGE	101 WEST WINDSOR ROAD URBANA, IL 61801

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S 000	Initial Comments Investigation of Facility Reported Incident of November 2, 2022/IL153602.	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b)5) 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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. 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. 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. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview the facility failed to implement fall intervention of assistive devices for R1 and R2.	S9999		

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S9999	Continued From page 2 The facility also failed to adequately supervise (R1 and R2) cognitively impaired residents with known history of falls and repeated falls, resulting in R1 and R2 sustaining falls with injuries. R1's unwitnessed fall resulted in R1 sustaining multiple fractures requiring hospitalization. R2's unwitnessed fall resulted in R2 sustaining a laceration above the right eye requiring emergency medical services of sutures and hospital admission for observation. These failures affected two (R1 and R2) of three residents reviewed for falls on the sample list of three. Findings include: 1.) R1's "Morse Fall Scale" Risk Assessment dated 10/26/22 documents R1's admission date as the same 10/26/22. R1 fall risk assessment score as 75 indicates R1 score equals high risk for falling, has a history of falls and uses crutches, cane or a walker. R1's Minimum Data Set (MDS) dated 11/01/22 documents R1's Brief Interview of Mental Status score of 14 out of a possible 15 indicating no cognitive impairment (on admission, prior to urinary tract infection, later identified confusion). The same MDS documents R1 requires extensive assistance of one person for transfers, toileting, bed mobility, uses a wheelchair and walker for mobility, is not able to stabilize balance without staff assistance during walking, surface to surface transfers, or seated to standing positioning. The same MDS documents R1 has impairment of one lower extremity. The same MDS documents R1 had a fall with fracture prior to admission to the facility 10/26/22. The facility fall log "Incident by Incident" documents R1 fell five times since admission to	S9999		

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S9999	Continued From page 3 the facility 10/26/22. R1's Care Plan dated 10/26/22 and revised 11/2/22, 11/8/22 and 12/02/22 documents the following: Acute Pain, Date Initiated: 11/08/2022 Resident Will Be Free of Pain /Discomfort. Date Initiated: 11/08/2022 Administer ice packs as ordered. Administer pain medications per order, if non-medication interventions are Encourage non-medication suggestion for pain relief. (R1) is risk for falls r/t recent falls with injury, multiple hospitalizations & comorbidities, deconditioned, impaired balance. Date Initiated: 11/08/2022 frequent checks, non-skid footwear at all times, place walker within reach of resident when leaving. Fall 11/02/2022 R1's first "Unwitnessed" Fall "Incident Description" and investigation note signed by V3, Licensed Practical Nurse (LPN), dated 11/2/22 at 1:56 pm, documents the following: "Resident (R1) was noted by staff to be sitting upright on the floor with her back leaned against the wall with AC (air conditioner) unit. The room was in order, nothing, tipped over or out of place. wheelchair was three feet from resident towards the bathroom. At the time of the incident resident was continent, in a nightgown, with bare feet, call light was within reach when in bed but not activated. On nurse assessment no obvious injuries, (vital signs) and neuros (neurological assessment) WNL (within normal limits). Resident complained of pain rated 3/10 (three out of a possible 10, 10 being the worst pain level) to the left hip where she had recently (10/20/22) had hip surgery. Provider (unidentified) notified and an order (for) X-ray of (R1's) leg and hip. Resident diagnosed	S9999		

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S9999	Continued From page 4 with UTI (Urinary Tract Infection) late 11/1/22, provider waiting to start antibiotic treatment until culture and sensitivity results. Resident last visualized by staff 1 (one hour) before falling asleep in bed. Staff reported overnight resident was more confused than baseline. When resident asked about fall (R1) reported (R1) was trying to go to the bathroom and thought her walker was nearby, she couldn't stand the pain anymore and fell down. Walker was on the opposite side of the room. Root cause: UTI, bare feet, poor lighting, no light (call light) activated, walker out of reach. Intervention - frequent checks, non-skid footwear at all times, place walker within reach of resident when leaving (room)." On 12/7/22 at 3:56 pm V3 (Licensed Practical Nurse/LPN) confirmed her documentation of the above fall and stated the fall occurred around 7:15 am day shift 11/2/22 and was documented late as 11/2/22 at 1:56 pm. V3 confirmed the events as documented above, up without assistance, last visualized one hour prior, confusion, walker out of resident reach, and bare feet. On 12/9/22 at 7:40 am R1 was lying in a low bed, floor mat in place and call light cord attached to R1's blanket. R1 was holding the call light activator button handle and stated "I don't know how to get this slot machine to work. Is it a quarter to play?" R1 stated she could use some help. R1's wheelchair was positioned eight feet away from the right side of R1's bed. R1's walker was positioned ten feet away from the foot of R1's bed. R1's walker was folded and leaning behind R1's recliner. R1 feet were bare. On 12/9/22 at 7:45 am V12 (Registered Nurse/RN) entered R1's room and confirmed	S9999		

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S9999	Continued From page 5 R1's wheelchair and walker placement, bare feet and confusion with the call light. V12 verified the interventions on the care plan and stated the night shift may have thought the fall interventions were supposed to be implemented on days and should be implemented on days and night shifts. R1's second "Unwitnessed" Fall "Incident Description" and investigation note signed by V10 (RN) dated 11/02/22 at 3:28 pm, is the second fall of this day and documents the following: "Nursing Description: ST (V13 Speech Therapist) came and found this nurse (V10 RN) to report pt (patient-R1) was on the floor. This nurse (V10 RN) went to assess resident (R1). She (R1) was face down on the floor between window and bed. Complaining of pain in R (right) shoulder. Pt (R1) was last seen 2 (two) minutes prior in wheelchair. This nurse (V10 RN) stepped out to get antibiotic to treat UTI. Before this nurse left (V10 RN), she (V10 RN) reminded pt (R1) to not get out of her (R1's) chair on her (R1's) own and to use the call light. Pt was wearing non-skid socks and was not incontinent. Immediate Action Taken: Description: Assessed resident. She (R1) is yelling and complaining of severe R (right) shoulder pain. Rolled resident onto her back to be able to put (mechanical lift) sling under her and got her up with 2 (two) assist and (mechanical lift). Put pt (R1) in bed. Notified Nurse Practitioner (V11 NP). Who gave orders to send (R1) to (the) hospital. Notified (V8 Family Member). Resident Taken to Hospital: Yes." The same report documents the following: "Notes: Pt (R1) is normally fully alert and oriented. UTI was found this am (morning before first fall 11/2/22, noted above). Since then, pt has only been alert and oriented to self and has become confused and agitated." On 12/7/22 at 3:20 pm V10 (RN) stated "On	S9999		

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S9999	Continued From page 6 11/2/22 in the afternoon, I had just left (R1) in her wheelchair and reminded her (R1) not to get up. I was going to get medicine for her UTI (Urinary Tract Infection). (R1) was really confused and had fallen just before I came in that same morning (11/2/22). I think I came that day at 7:30 am. (V2 Director of Nursing) and (V14 Social Service Director) had also been going into talk resident (R1) into having an X-ray from (R1's) fall that morning. That fall happened just before my shift. (R1) was very confused, had just been diagnosed with a UTI. We called (V11) Nurse Practitioner and got an order (physician/provider) for Rocephin (Intramuscularly antibiotic). When I (V10 RN) left her room, I was only gone a couple minutes to draw up (fill a needled syringe) the Rocephin. I (V10 RN) asked her (R1) not to get up. I (V10 RN) told her I would be right back. Since, I (V10 RN) knew she (R1) had had the increase confusion, I (V10 RN) probably should not have left her (R1) alone. I just thought once she (R1) had the antibiotic (Rocephin), she may be less confused and willing to get the X-ray." R1's "(Private Hospital) Surgical Discharge Summary" dated 11/5/22 documents R1 was admitted to the hospital post-unwitnessed fall at this skilled nursing facility on 11/02/22. "(Private Hospital) Surgical Discharge Summary" documents R1's hospital admission diagnoses list included: Trauma Fall Encounter, Closed Fracture of Proximal End of Right Humerus Unspecified Fracture Morphology Initial Encounter, Closed Interochanteric Fracture Left Hip, Initial Encounter, Pubic Ramus Fracture, and Acute Cystitis Without Hematuria. R1's same " (Private Hospital) Surgical Discharge Summary" documents R1 had surgical repair of left hip two weeks prior to this hospital admission. This hospitalization 11/2/22 "Patient (R1) was	S9999		

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S9999	Continued From page 7 found to have a proximal Humerus fracture and new interval increase displacement of lesser trochanter fragment, both injuries did not require surgical intervention." The same report documents "Patient (R1) initially had reasonable pain during the initial stages of her admission. Her (R1) pain was eventually controlled with PO (by mouth) medications. During her stay she was treated for suspected UTI (Urinary Tract Infection) with IV (Intravenous) Ceftriaxone (antibiotic) and eventually switched to Bactrim (unidentified route)." The same report documents R1 was discharged from the hospital back to this same skilled nursing facility on 11/05/22. On 12/07/22 at 1:21 pm V11 (Nurse Practitioner/NP) confirmed R1's fractures were caused by R1's fall 11/2/22. V11 stated V11 had evaluated R1 after the first fall 11/2/22 and R1 was complaining left leg pain. V11 stated V11 evaluated R1 after her first fall 11/2/22 (R1) did not complain of arm pain at that time V11, stated it is hard to know if (R1's) arm fractures were from the first fall on 11/2/22 or the second fall that day. Her fractures were confirmed when she was sent out to the hospital post the second fall. I ordered an x-ray of (R1's) hips when I evaluated (R1) after the first fall. (R1) did have a complaint of leg pain. (R1) did not complain of arm pain, to my knowledge until after the second fall. It was likely the second fall caused the arm fracture, but it is hard to really tell. V11, NP also stated "We knew (R1) had a UTI. (R1) had some delirium. I am always concerned with possibility of c-diff and hold off prescribing antibiotics until we have the culture back. I don't think R1 should have been educated to stay in (R1's) wheelchair. Someone needed to keep a close eye on (R1). (R1) was very confused when I saw (R1) that morning." V11 also stated the care planned interventions	S9999		

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should be consistently implemented. R1's care plan interventions for non-skid socks, and to keep (R1's) walker and wheelchair within reach staff are aware of what they should be doing this.

R1's third "Unwitnessed" Fall "Incident Description" and investigation note signed by V5 (RN) dated 11/20/22 at 8:15 am, documents R1 was found on the floor, incontinent and with bare feet, on floor mat next to R1's bed. V5 also documents R1 had not been visualized since between 7:00 am and 7:15 am by V5. V5 also documents on the same fall report, V5 did not know the last time an unidentified Certified Nursing observed R1. V5 also documents the following: "Night shift (unidentified staff member) gave report to day shift (V5) that res (R1, resident) had been dangling (R1's) feet out of bed several times throughout the night and needed to be put back to bed." The same investigation note documents the root cause of this fall as: weakness, incontinence and confusion. Intervention: Video monitoring during night, frequent checks, leave door open for increased supervision."

On 12/7/22 at 12:10 pm V5 stated "I worked on 11/20/22 and responded to a CNA (unidentified) who found (R1) on the floor mat next to her bed. (R1's) call light was not turned on but was within (R1's) reach while in bed. The call light was clipped to (R1's) bedsheet. I had seen (R1) about 45 minutes before (R1) fell. (R1) was asleep. (R1) told me when I evaluated her on the floor, (R1) had to go to the bathroom and got up by (R1's) self. (R1) did not have non-skid sock on, I documented that in my note. I was told in report that (R1) had been dangling (R1's) feet off the bed overnight shift and staff had to assist (R1) in putting (R1's) feet back in bed. I guess (R1) was

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kind of restless for them (night shift). (R1) was asleep when I saw (R1) about 7:15 am. I documented that as well. (R1's) room has been changed to here (points to the room closest to the nurse's station), closer to the nurses station. (R1) is so sweet and said (R1) doesn't like to bother staff. I reminded (R1) that is what we are here for, to help (R1) and the other residents. Video monitor placed in (R1's) room to keep (R1) safe after that fall as well as the closer room. (R1) had no injury and I called (V9, Physician) and (R1's family member) to report."

R1's fourth "Unwitnessed" Fall "Incident Description" and investigation note signed by V12 (RN) dated 11/21/22 at 7:30 am, documents R1's family member (V8) found R1 on the floor. R1 had been having an increase in confusion and was unable to communicate what R1 was trying to do. No injury identified except complaint of ongoing pain of right arm and left leg. Root cause: UTI, incontinence, weakness, and confusion. Intervention identified for signage to be placed in R1's room to put on call light for help and wait before getting up."

On 12/9/22 at 7:45 am V12 (RN) confirmed R1's fall as written 11/21/22 and stated V12 was new and working with another nurse (unidentified) that day. V12 also stated V12 believed V12 documented the fall details correctly as they occurred.

R1's fifth "Unwitnessed" Fall "Incident Description" and investigation note signed by V3 (LPN) dated 11/26/22 at 9:30 am documents R1 was found on the right side of R1's bed, had no clothes on, was covered in feces from torso to bilateral legs and arms." The same "Incident Description" investigation note documents the last

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time R1 was visualized was at 7:30 am (two hours prior to fall) and was sleeping at that time. The same report documents the (unidentified CNA) had been told in report from night shift R1 was last changed at 5:00 am. The same report documents "neither wheelchair or roller walker were nearby". The same report documents "Resident description as follows: "Resident (R1) said (R1) was going to crawl to the bathroom. When asked why (R1) didn't use (R1's) call light, the resident (R1) said '(R1) didn't think anyone was here.' Resident (R1) denies any new pain."

On 12/7/22 at 3:56 pm V3 (LPN) confirmed R1's fall 11/26/22 fall is accurately documented. V3 stated R1 was not changed after 5:00 am, was sleeping, and neither R1's wheelchair or walker were nearby R1.

2.) R2's "Morse Fall Scale" Risk Assessment dated 10/16/22 documents R2's fall risk assessment score as 90 equals high risk for falling, has a history of falls and uses crutches, cane, or a walker.

R2's Minimum Data Set (MDS) dated 1019/22 documents R2 was admitted to the facility on 10/16/22. The same MDS documents R2 has severe cognitive impairment, ambulates with limited staff assistance of one person and requires extensive assistance of one staff with transfers, bed mobility and toileting needs, is unsteady with all transitions and only able to stabilize with staff assistance. The same MDS documents R2 had one fall prior to admission (10/16/22), uses a walker and a wheelchair for mobility.

R2's "Unwitnessed" Fall "Incident Description" and investigation note signed by V5 (RN) dated

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S9999	Continued From page 11 10/23/22 at 11:01 am, documents the following: "Res (R2) was fof (found on floor) at the nurse's station, lying on (R2's) back in between the desk and the sitting chairs. Res (R2) was found at 11:01 am. Res (R2) was last seen sitting in the chair with the walker beside (R2) at 10:58 am. Res (R2) had been fed breakfast, toileted and taken outside in (R2's) wheelchair for a stroll. (R2) was then placed at the nurse's station in the chair. Resident (R2) was unable to tell staff what had happened or what lead to the fall due to res (R2's) hx (history) of Dementia and non-sensical communication pattern. Resident description: Res (R2's) shoes were on and (R2) was continent at the time of the fall. Walker was off to the side near (R2's) head. Res (R2) was conscious when found and alert to baseline orientation. Immediate Action Taken: Laceration noted to right forehead above the eyebrow. Wound cleansed with NS (normal saline), skin, scalp and hair also cleaned. Wet to dry dressing placed over wound. (Unidentified family member) and on call Nurse Practitioner (V11, NP) notified. Vitals taken Neuros (neurological assessment) checked. Res (R2) should be monitored with a baby monitor or 1:1 (one on one) assistance at all times. Resident taken to the hospital? Yes." The same report "Unwitnessed" Fall "Incident Description" and investigation note documents: "Camera footage (at the nurse station) was reviewed and showed R2 got up from a chair less than a minute after staff went to answer a call light. Resident (R2) walked to the call light box located near the nursing station, without (R2's) walker and pushing buttons on the call light box. Resident (R2's) gait appeared unsteady during the entire event. Root Cause: Weakness, unsteady gait, ambulating without walker. Intervention- transported to ER (Emergency Room), continue to work with PT/OT/ST (Physical Therapy/Occupational	S9999		

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	IL6001804	A. BUILDING: _____ B. WING _____	C 12/13/2022

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S9999	Continued From page 12 Therapy/ Speech Therapy). Place signage on walker reminding resident not to get up without assistance, educate staff to place walker directly in front of resident if leaving (R2) unattended." R2's Hospital Discharge Summary dated 10/27/22 documents R2 was admitted to the hospital, from the emergency department 10/23/22 post fall in the facility. Discharge diagnoses included: "AMS (Altered Mental Status) possibly in setting of underlying (D) dementia, Fall suspected mechanical, per chart review, Physical deconditioning - PT/OT (Physical Therapy/Occupational Therapy) recommending ECF (Extended Care Facility), Failure to Thrive, Decreased Oral intake." The same report documents an extensive work-up was completed while R2 was hospitalized, and five sutures were placed in R2's forehead that are to be removed from forehead laceration in one week. The same Hospital Discharge summary documents: "Fall precautions recommended." R2's additional fall "Unwitnessed" Fall "Incident Description" and investigation note signed by V18 (RN) dated 12/01/22 documents the following: "CNA (unidentified) watching camera (in R2's room), looked away (stopped observation) to chart and when looked back, (R2) was out of view of camera. When CNA (unidentified) went to check on resident (R2), (R2) was on (the) floor mat. This RN (V18) alerted, went to room. Resident (R2) found next to be prone no visible wounds. This RN and 2 (two) CNA's (unidentified) moved resident (R2) back to bed and this RN did a full assessment with no adverse findings. Resident (R2) brought out to sit by the nurse's station for closer observation. Root cause: Poor safety awareness r/t (related to) resident's (R2) baseline mentation. Fall	S9999		

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S9999	Continued From page 13 intervention: To have res (R2) in the common area for supervision when not sleeping." On 12/09/22 at 1:45 pm V2 (Director of Nursing/DON) confirmed R1, and R2 are at high risk for fall. V2 confirmed V2 does all the fall investigations and determines root cause and targeted interventions to prevent further falls. V2 DON reviewed fall investigations and stated R1 and R2 were confused at the time of their falls and should have had closer supervision by staff. The facility policy "Fall Risk Assessment and Protocol" dated 4/21/22 documents the following: "Policy Statement, The purpose of this policy is to outline methods of assessment of risk, interventions, to attempt to prevent falls and provide guidance on actions should a fall occur. Fall definition: a fall is defined as failure to maintain an appropriate lying, sitting, or standing position, resulting in an individual's abrupt, undesired relocation to a lower level." The same policy documents: PROCEDURES A. Assessment 1. Residents will be assessed upon admission, quarterly, prn, or upon a change in condition that affects their fall risk. 2. Those residents whom have been identified as being at risk for falls will have this noted within their care plan. B. Interventions 1. Call light within reach 2. Bed in low position 3. Nonslip footwear when ambulating Individualized additional interventions will be determined and implemented for the individual resident based upon decisions by the interdisciplinary team.	S9999		

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S9999	Continued From page 14 C. Documentation 1. Individualized interventions will be documented in the resident care plan 2. An evaluation of the effectiveness of the identified interventions will be done quarterly at a minimum. Interventions will be reviewed and updated as necessary based upon the guidance of the team. D. Fall Occurrence 1. Residents shall be assessed immediately after a fall by the nurse 2. The residents MD/APN and family will be notified of the fall, as well as informed if there is an injury 3. Resident will be assessed each shift X 72 hours and this assessment will be documented in the medical record 4. If the resident is injured, refer to the Incident and Accident Reporting Policy." The facility policy "Incident and Accident Reporting Policy" dated 07/18/13 documents the following: "Policy Statement, Accidents or incidents occurring in (facility name) Health Center or involving (facility name) Residents shall be investigated and reported to the Director of Nursing or his/her designee. Numerous and varied accident hazards exist in our everyday life. Not all accidents are avoidable. The condition of some or our residents increases their vulnerability to hazards in the resident environment and can result in life threatening injuries. We are responsible to provide care to our residents in a manner that helps promote quality of life. This includes respecting residents' right to privacy, dignity and self-determination, and their right to make choices about significant aspects of their life in the facility.	S9999		

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S9999	Continued From page 15 For a variety of reasons, residents are exposed to some potential for harm. Although hazards should not be ignored, there are varying degrees of potential for harm. It is reasonable to accept some risks as a trade-off for the potential benefits, such as maintaining dignity, self-determination, and control over one's daily life. Staff are encouraged and expected to report incidents/accidents immediately. DEFINITIONS, Accident: Refers to any unexpected or unintentional incident, which may result in injury or illness to a resident. Assistance Device/Assistive Device: Refers to any item (i.e. handrails, transfer lifts, canes, etc.) that are used by, or in the care of a resident to promote, supplement, or enhance the resident's function and/or safety. Fall: Refers to unintentionally coming to rest on the ground, floor, or other lower level but not as a result of an overwhelming external force. An episode where a resident lost his/her balance and would have fallen, if not for staff intervention, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. Hazards: Refers to elements of the resident environment that have the potential to cause injury or illness. Resident Environment: Includes the physical surroundings to which the resident has access. Risk: Refers to any external factor or characteristic of an individual resident that influences the likelihood of an accident. Supervision: Refers to an intervention and means of mitigating the risk of an accident."	S9999		

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