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	IL6000699	A. BUILDING: _____ B. WING _____	C 07/18/2023

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S 000	Initial Comments Complaint Investigation: 2345633/IL161812	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210c) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. (Section 3-202.2a of the Act) 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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 Regulations are not met as evidenced by: Based on interview, and record review, the facility	S9999		

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failed to provide supervision during toileting to prevent falls for 1 of 4 residents (R2) reviewed for supervision. This failure resulted in R2 falling and sustaining a hip fracture.

Findings include:

R2's Admission Record, print date of 7/12/23 documented R2 has diagnoses of weakness, muscle weakness, and unspecified dementia.

R2's Care Plan, dated 2/3/23 initiated, documented R2 had a self-care performance deficit due to weakness, history of falls and dementia and needs mostly limited assistance with all care needs. The Care Plan documented "*Restorative* will continue safe transfers with assist will minimize risk factors for falls thru next review." Care Plan Interventions documented "Assist of one with wheeled walker, ambulate to/from all destination and wheelchair to follow outside of room distance as tolerated."

R2's Fall Risk Assessment, dated 2/8/23, 4/19/23 and 6/26/23 documented R2 as a moderate risk for falls.

R2's, Physical Therapy discharge summary for date of service: 2/3/23-4/21/23, documents, "Patient will increase static standing balance was Fair+ spontaneously righting self when needed in order to decrease LOB (level of balance) during functional mobility." The Summary documented "Standing prior to onset was Fair+." A baseline dated 2/3/23, documented fair (requires minimum assistance or upper extremity support to stand without loss of balance.

R2's Final Discharge Therapy Note, dated 4/21/23, documented "Fair (stands unsupported

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without upper extremity support or loss of balance for 1-2 minutes, referred recommendation to RNP, (Restorative Nursing Program)."

R2's Restorative Program Evaluation, dated 6/27/23, documents, "is safe with assistance and walker, sometimes unable to ambulate due to knee pain."

R2's Minimum Data Set, MDS, dated 6/27/23, documented R2 had Brief Interview of Mental Status (BIMS) score of 12, indicating R2 had moderately impaired cognition. R2's MDS documents R2 required limited (resident highly involved in activity; staff provided guided maneuvering of limbs or other non-weight-bearing assistance) of one staff person physical assistance for transfers and toileting. R2's MDS documents R2 is not steady, only able to stabilize with staff assistance when moving on and off the toilet and walking. R2's MDS documents R2 was frequently incontinent of bowel and bladder.

R2's Nurse's Note, dated 7/8/23 at 7:18AM, documented, "Writer called residents room and observed (R2) lying on the bathroom floor on his left side with his head resting against door frame. The commode riser twisted on toilet, water on floor around toilet when asked (R2), what happened, (R2) states, 'I was trying to get up off the toilet so I could get ready for the day and fell.'"

R2's, Facility Reported Occurrence Report, documented on 7/8/23 at 7:18 AM, R2 was found on floor in bathroom. The Report documented R2 had attempted to transfer self from toilet, did not use call light for assistance. The Report documented areas of injury, scalp, hematoma to head and left hip pain during range of motion assessment. The Report documented there was

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S9999	Continued From page 4 a wet floor, and alarm not activated at time off fall along with Care Plan interventions to be completed upon resident return to facility after assessment of current status completed. R2's entitled, "Fall Details Report", dated 7/8/23 at 7:18 AM, documented visually observed on floor by V6, Certified Nurse's Aide (CNA), call light off, care prior to fall was 7/8/23 at 6:15AM, last documentation. Residents state of motion at time of fall was transferring with no staff assistance." R2's Hospital Imaging Services report, dated 7/8/23 at 8:36 AM, documented R2's final result report study of anterior (front) and posterior (back) of left hip with two radiology views taken, "Exam is positive for mildly displaced left intertrochanteric fracture." On 7/12/23 at 2:30 PM, V2, Director of Nursing, DON, stated it was reported that a fluid substance was found on the floor around the toilet base at the time of R2's fall; however, when V2 went to address R2's incident, there were towels wrapped around the toilet basin. V2 stated that R2 is a one nursing assist with walker to the bathroom. V2 stated V5, CNA from night shift, had gotten R2 up and transferred him to the toilet at 5:45 AM and at 6:00 AM, V5 went to re-check on R2, where he continued to remain on the toilet and that R2 had stated he was not ready to get off the toilet. V2 stated that V5 left her work shift at 6:00 AM and gave report to the on-coming CNA, V6, that R2 remained on the toilet. V2 stated that at 6:15 AM, V6 went to check on R2 and R2 stated "I still need more time." V2 stated V6 continued to care for her residents as she was assigned too. V2 stated I returned to check on R2 at 7:15AM and found him on the bathroom floor lying on his left	S9999		

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S9999	Continued From page 5	S9999		

side. V2 stated prior to this incident, R2 had complained of left knee pain and was recently ordered for a cortisone (steroid) injection) to his left knee. V2 stated R2 has always used his call light, but R2's call light was not activated on 7/8/23 when R2 fell.

On 7/17/23 at 9:02 AM, V2 stated that V3, Licensed Practical Nurse (LPN) went to R2's room around 6:27 AM on 7/8/23 to get R2's oxygen saturation and R2 was still on the toilet. V2 stated V3 had observed towels around the toilet basin and based on V6 fall incident interview that a liquid was observed around the toilet basin V2 stated she notified maintenance. V2 stated maintenance observed no water coming out around the toilet basin, but V2 stated the maintenance man stated, if a person is to sit too far back on the toilet seat it can cause the toilet base to separate from the toilet tank and could cause water to come out around either the tank, the maintenance man found no evidence the toilet seals were broken to cause a leak but ordered for a new toilet parts replacement anyway. V2 continues to state, she feels the facility did no wrong for R2's fall incident, he is known to use his call light.

On 7/17/23 at 9:30 AM, V3 stated on 7/8/23 at 6:29 AM she went into R2's room to get his oxygen saturation monitored while R2 was on the toilet and observed no liquid substance on the floor around the toilet. V3 stated she remained on the same hall across from R2's room attending to resident medication needs and heard no call light activated from R2's room at 7:18A M, V6 found R2 lying on the bathroom floor, performed an assessment on R2 and found towels wrapped around the toilet basin. V3 states, "I feel he (R2) should not have been left alone, his legs are

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weak and especially, after receiving a cortisone injection in his left knee, due to his complaint of pain."

On 7/17/23 at 3:40 PM, V7, CNA stated R2 was a tall guy at least 6 feet and then some and V7 took care of him a lot. V7 states, "(R2) was quick to get up on his own but knew he needed assistance, and when he was taken to the toilet, he was told to use the call light and he would, when he wanted, but would be quick to the draw to get up on his own, so since (R2) got up off the toilet without listening, I (V7) started staying right at his bathroom door, until he was finished, because no one is going to fall on my shift."

The Facility's "CNA Report for Falls, dated 7/8/23 and written by V6, documents, the last time V6 repositioned R2 was 6:15 AM, and the last time fluids were offered was 6:00 AM. The report documented there was water on the floor.

R2's "CNA Statement of Care Provided During Shift", written by V6, dated 7/8/23, documents "Offered fluids at 6:00 AM. Came on shift and at 6:15 AM and at 6:15 AM checked on resident. He stated he was not ready, and he needed more time, so when I came back, and he was on the floor 7:18 AM. Resident did not use his call light R2 usually rings light when done, he has gotten up by (V5)."

Facility's, untitled sheet, dated 7/14/23, documents, "Per interview with (V3) regarding (R2) 7/8/23, documented, during this interview form, V3 was asked was R2 prior to the fall did you remind him to use the call light when he was finished, answer from V3, "Yes, I always tell the residents to use their call light if they need anything before, I leave the room." Interviewer

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S9999	Continued From page 7 asked, "what was his response."? V3 documented "I don't remember". On 7/18/23 at 9:30 AM, V1, Administrator with V2 present, states, "Yes, I see that (R2's) fall resulted in a fracture would be considered harm. But I can't see in the future if the fracture was due to his fall or a weakness in his hip already." V1 stated she reached out to a physician, unknown name, that informed V1 of the possible causes of R2's fracture. The Facility's policy and procedure, entitled, "Accidents & Incidents," date initiated: 7/1/23, documents, "An accident/incident is any occurrence which is not consistent with the routine operation of the facility or the routine care of a particular resident." (A)	S9999		