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	IL6005904	A. BUILDING: _____ B. WING _____	C 08/15/2023

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S 000	Initial Comments Complaint Investigations: 2395190/IL161263 2395928/IL162156 Investigation of Facility Reported Incident of 05-21-2023/IL160821	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)6) 300.1220)b)3) 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 300.1010 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,	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 but not limited to, the presence of incipient or 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 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 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	S9999		

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S9999	Continued From page 2 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These Regulations are not met as evidenced by: Based on observations, interviews, and records reviewed the facility failed to develop and	S9999		

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S9999	Continued From page 3 implement a plan of care with interventions to reduce and/or prevent the risk of falling to include supervision and monitoring. This affected four of four residents (R1, R10, R19, and R20) reviewed for fall prevention interventions. This failure resulted in R1 not being supervised or monitored by staff resulting in a fall incident sustaining an acute fracture of the anterior and posterior wall of the left frontal sinus, and R10 being left unassisted by facility staff resulting in a fall incident sustaining a right femoral neck fracture. Findings include: 1.R1 is 64 years old with diagnosis including but not limited to Skull and Facial Bones Fracture, Traumatic Subdural and Subarachnoid Hemorrhage, History of Falling, Alcoholic Cirrhosis of Liver, and Psychoactive Substance Dependence. R1's cognitive patterns assessment dated 4/5/23 identifies him with a score of 12, moderately impaired. R1's fall scale evaluation dated 4/30/23 identifies him as a high risk for falling. a. Incident report for R1 dated 5/11/23 states nurse heard a noise and found R1 on the floor bleeding from his head. Nurse witness statement reads she was passing medications when she heard a loud noise. Per record R1 was hospitalized from 5/11/23 until 5/17/23. Hospital records dated 5/11/23 note CT of the head findings Left Frontal Scalp, Forehead and Left Periorbital Hematoma. Acute Fractures of The Anterior and Posterior Wall of The Left Frontal Sinus. b. On 7/26/23 at 12:26PM V21, Certified Nursing	S9999		

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S9999	Continued From page 4 Assistant (CNA), said on 5/21/23 R1 kept getting up from his bed, he was trying to walk. V21 said R1 was put at the nurses' station and then he fell. V21 said she and the nurse heard a sound and then R1 was on the floor. V21 said I was at the nurses' station. V21 said I would have to walk across the nurses' station to get to R1 to prevent him from falling. V21 said I think the nurse was at a medication cart. V21 said neither I or the nurse were next to R1. On 7/26/23 at 1:33PM V24, Registered Nurse (RN), said on 5/21/23 R1 had been in bed and then he became restless. V24 said the CNA brought R1 to the nurses' station, he was sitting in front of the nurses' station, and then "all of a sudden he fell forward." V24 said she did not see R1 fall but heard the sound. V24 said staff was sitting at the desk. V24 said no one was assigned to watch R1 at that time. V24 said the intervention to bring him to the nurses' station was not effective that night to prevent a fall. V24 said R1 sustained a laceration. R1's progress notes dated 5/21/23 at 1:58AM state he became restless and got out of bed. He was sitting at the nurses' station when he fell out of the chair. Laceration observed to right side of head with bleeding. R1's incident report dated 5/21/23 states R1 fell before staff could intervene. R1 hit his head. V21's witness statement states R1 was unsteady and trying to get up. R1 brought to nurses' station for closer monitoring. Heard a noise resident had fallen. V24's witness statement states R1 to be more closely monitored at the nurses' station.	S9999		

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S9999	Continued From page 5 Statement reads V24 said she heard a noise and V24 observed R1 on his stomach. Per records R1 was hospitalized from 5/21/23 and readmitted on 5/27/23. c. R1's incident report dated 5/27/23 states resident on floor. Witness statement of V38, CNA, states on 5/27/23 R1 was sitting in a wheelchair across from the nurses station while she was charting and heard a loud noise. R1 was on the floor. V37, LPN, witness statement states on 5/27/23 V37 was off the floor when R1 fell. R1's record indicated he was hospitalized on 5/27/23 and readmitted on 6/1/23. d.R1's incident report dated 6/3/23 notes R1 on mats next to bed on buttocks. R1 sent to the hospital and readmitted on 6/4/23. R1's records indicate he was hospitalized on 6/3/23 and readmitted to the facility on 6/8/23. R1's progress notes dated 6/30/23 states R1 has poor safety awareness and declining. R1 impulsive to ambulate/transfer unassisted and R1 not realizing he needs assistance. When out of bed kept in common area within view. On 7/26/23 at 2:34PM V13, Director of Nursing, said R1 fell on 5/11/23. V13 said the nurse reported R1 was trying to get to the bathroom. V13 said the root cause of R1's fall was he was attempting to walk unassisted with a history of Ataxic Gait. V13 said after a therapy re-evaluation they said R1 should not be walking unassisted.	S9999		

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S9999	Continued From page 6 V13 said the root cause of R1's fall on 5/21/23 was that he fell asleep in his chair and leaned forward. V13 said he nurse, and CNA were assigned to more closely monitor him. V13 said R1 is a high fall risk and needs to be monitored despite fall precautions used. V13 said R1 is unable to be redirected. V13 said we want R1 in an area where staff can see him at all times and the goal is to intervene. V13 said when R1 fell at the nurses' station he was sitting outside the station, not inside. V13 said since the fall on 5/11/23 R1 was not placed inside the nurses' station. Following his fall on 5/21/23 R1 sustained a laceration requiring 2 or 3 sutures. V13 said if you are not looking at the resident, then you are not monitoring. V13 said R1 had another fall on 5/27/23 and the reclining chair was not in place at that time, we didn't have a chance to put the chair in place. e. R1's progress notes dated 7/26/23 state he slid out of his chair at the nurses' station. On 7/26/23 at 4:12 PM the surveyor watched surveillance camera footage from 12:00PM - 1:33PM. V12, Administrator and V13 in the room. Footage started with resident sitting in reclining chair behind nurses' station, helmet on, legs under desk writing area. Staff at his side initially. Meal tray served to R1. At 1:07PM the staff observed feeding R1. At 1:16PM R1 feeding self, sitting alone at desk, no staff at the station near him. V12 said the person at desk with back to R1 is a third-party Nurse Practitioner (NP). Surveyor observed the NP is not able to see R1 with her back towards him. R1 noted to lean forward 30 to 45 degrees while sitting in the chair. At 1:22PM observed R1 sitting alone no staff looking at him. R1 pushed self-back from desk. Chair in upright position. R1 stood up, chair rolled approximately	S9999		

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S9999	Continued From page 7 2 feet back from him (per view on footage), R1 lost balance, fell back onto floor and onto his buttocks, and his helmet came off. Nurse from cart, outside of station assisted R1 back into chair. V13 said for R1's safety he is at the nurses' station so staff can monitor him. The current interventions are as effective as they can be. He has a tendency to lean forward, and he has a brain tumor. The surveyor asked V13 if the interventions are effective to prevent R1 from falling. V13 said we are doing as much as we can. R1's care plan initiated on 5/18/23 for safety denotes outcome to be R1 will remain safe. Risk for fall care plan initiated on 3/31/23 notes R1 will be free from injury related to falls. Intervention implemented on 6/18/23 denotes R1 to remain in common areas when out of bed, to be visible by staff. R1's fall care plan has no intervention following his fall on 5/21/23 to prevent the fall and injury on 5/27/23. Following the fall on 5/11/23 R1 was transferred to hospital for evaluation. The next intervention is dated 5/19/23 to have Physical Therapy re-evaluate R1. 2. R10 is 81 years old with diagnosis including but not limited to Fracture of Right Femur (6/21/23), Alzheimer's Disease, Dementia, Stiffness of Joint, Weakness, Delusional Disorders, Restlessness and agitation. R10's cognitive states dated 5/26/23 notes R10 is severely impaired with a score of 3. On 7/27/23 at 10:17AM V29, CNA, said I seen R10 going to the bathroom on 6/18/23. V29 said she it was normal for R10 to get up unassisted to use the bathroom. R10 said when I walked into	S9999		

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S9999	Continued From page 8 the room to check on the roommate R10 was on the floor. V29 said R10 did not know how she fell. V29 said R10 said I think she may have slipped on the urine; the floor was wet. V29 said R10 had no bottoms on, her leggings and pull up were not up on R10. V29 said prior to that R10 was calm and sleeping. On 7/28/23 at 12:58PM V13, Director of Nursing, said a leaf on the doorway is a symbol that means the resident has been identified as a fall risk based on the fall risk assessment. V13 said a score of moderate to more risk includes the resident into the fall leaf program. V13 said if a resident falls, they are included in the fall risk program. V13 said the purpose of the program is so staff knows the resident is at risk. V13 said if there is a leaf on the door then staff needs to assist residents when seen standing or walking in the rooms. V13 said the resident may not need staff touch assist but they need staff to at least be present when they have a leaf on the doorway. R10's Fall Scale Evaluation dated 11/22/23 notes a score of 41, moderate risk is scored at 25-44. R10's fall report dated 6/18/23 notes R10 has impaired memory, incontinent and improper foot ware at the time of the fall. On 8/2/23 at 9:34AM V46, MDS Coordinator, said the purpose of the care plan is to provide a road map for care and provide guidelines to help up deliver care to the patient. V46 said the care plan is individualized and reflective of the needs of the patients. V46 said if a fall happens then the care plan would be updated. R10's Investigation Report dated 6/18/23 states at around 4:55AM R10 was observed sitting on	S9999		

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S9999	Continued From page 9 the floor. R10 attempted to transfer and ambulate to the bathroom unassisted. R10 said I slipped and fell. X-Rays completed with findings of possible right neck femoral fracture. R10 transferred to the hospital for further evaluation. R10's care plan initiated on 6/22/23 notes R10 status post right femoral neck fracture status post fall. R10's care plan initiated on 5/31/23 states R10 is at risk for falls related to dementia, poor safety awareness, right femur fracture, history of falling, delusional disorder with agitation. Interventions include educate resident/caregivers about safety reminders and what to do if a fall occurs (5/31/23). Encourage to participate in activities that promote exercise, physical activity for strengthening and improved mobility (5/31/23). These are the only fall interventions listed on the provided care plan prior to the fall on 6/18/23. 3. On 7/25/23 at 10:07AM the surveyor observed R19 self-ambulating out of the bathroom. A leaf is present on the doorway. R19's diagnosis include, but are not limited to, Seizures, Extrapyramidal and Movement Disorder, Tremors, and Unsteadiness on Feet. R19 Fall Scale Evaluation notes a score of 55, high risk is a score 45 and higher. 4. On 7/25/23 at 10:15AM R20 observed walking out of bathroom to the door entryway pushing his wheelchair and wearing a gait belt. No staff nearby. R20's diagnosis include, but are not limited to, Parkinson's Disease and Repeated Falls. R20 had a fall documented on 7/10/23.	S9999		

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S9999	Continued From page 10 On 7/26/23 at 10:06AM V32, CNA, said the leaves on the doors mean the resident is on thin liquids. The surveyor asked V32 while clarifying and showing her the leaves on the door, which resemble an orange/red maple leaf, what these mean. V32 again said thin liquids. V32 said R20 can ambulate on his own, but he should be a 1 assist for standing. While speaking with V32 she said R19 needs supervision, like now he is just walking out of the bathroom. V32 remained in the hall with the surveyor and did not approach R19 or the room. V32 said R19 can go in and out the bathroom on his own. The facility Fall Prevention Policy date 11/21/17 states the program will include measures which determine the individuals needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision. Includes: use and implementation of professional standards of practice. Immediate change in interventions that were successful. Communication with staff members. Residents at risk of falling will be assisted with toileting needs. The facility Falling Leaf Program dated 11/28/12 states the team targets select residents who are at risk for falls. Criteria for the program includes impaired safety awareness that has contributed to a fall. Residents identified may have a leaf placed outside their door. The staff will visually check to ensure safety, assist with care needs, and prevent unsafe self-transfers. (A)	S9999		