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	IL6001150	A. BUILDING: _____ B. WING _____	07/27/2023

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S 000	Initial Comments Annual Licensure Survey Facility Reported Incident of 06/17/23/IL161894	S 000		
S9999	Final Observations Statemement of Licensure Violations: 300.610a) 300.1010h) 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 300.1010 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 manifest decubitus ulcers or a weight loss or gain	S9999	Attachment A Statement of Licensure Violations	

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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.

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 requirements are not met as evidenced by:

Based on observation, interview and record review, the facility failed to safely transfer and immediately report a fall for one (R22) of seven

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residents reviewed for risk of falls in the sample of 34. This failure resulted in R22 falling against the toilet during a one assist transfer and sustaining a rib fracture with resulting pain. This past noncompliance occurred between 6/17/23 and 7/12/23.

Findings include:

R22's Face Sheet documented an admission date of 6/10/23 and diagnoses including Alzheimer's Disease, Chronic Obstructive Pulmonary Disease, Diabetes Type 2, and Heart Failure.

R22's 6/30/23 Care Plan dated documented a problem area, "I am at risk for falls related to unsteady gait/balance, (and a) history of falls."

R22's Fall Risk Assessment dated 6/10/23 documented a score of 11, indicating that R22 is at risk for falls.

R22's Minimum Data Set dated 6/15/23 documented that R22 requires extensive assistance from at least two staff members for transfers and toileting.

Nurses Notes documented the following:
6/17/23 at 5:46pm: "Resident started complaining of left rib pain after being transferred from shower chair to wheelchair. Family requested that the resident be sent out to (hospital) for xrays of ribs. I contacted (V8, Physician) who is on call for (V9, Physician) this weekend and he gave orders for left side rib xray and chest xray. Resident left facility via our transportation department."
6/17/23 6:30pm: "Resident returned from having xray of left rib area and chest."
6/18/23 at 4:58am: "Nurse went to check on

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resident and she was observed holding her left side and moaning in pain, (as needed) pain med(ications) given for discomfort."
6/18/23 at 11:14am: "This nurse got xray results back for resident and xray results showed a Left 11th thoracic rib fracture. This nurse reported to (V8) which had called to check up on resident which was the Medical Doctor that gave orders to get xray. This nurse called (V11, POA/Power of Attorney) to inform them of the results. This nurse did let (V8) know that resident was doing normal activities when this nurse got results back and went to check up on pain level, but resident was participating in church activity. At this time resident has (as needed) Tylenol as ordered for the pain."

A Fall Investigation dated 6/17/23 at 5:30pm documented, "Residents POA approached this nurse regarding this resident experiencing a significant amount of pain in the left side rib area. POA stated to this nurse that she spoke to (V10, Certified Nursing Assistant/CNA) and (V10) stated to POA that she (V10) was trying to transfer the resident by herself and was unable to transfer her completely and sat her roughly on the toilet. This was not reported to the nurse (me) until the POA brought this to my attention. I assessed the resident in the area she was complaining of pain in. I did not note any significant marks on the resident at the time. I called (V8) who was on call for (V9) this weekend and explained the situation. (V8) gave orders to send the resident for xrays. Resident is unable to provide information at this time."

An Xray Report dated 6/17/23 documented, "Exam Description: Xray ribs left chest. Reason for study: Left lower ribs hurt after an aid helped her up ...Findings: Left anterior 11th rib fracture."

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R22's Physicians Orders for June 2023 and July 2023 documented an order for Acetaminophen Extra Strength Oral Tablet 500 mg (milligrams), give 1 tablet by mouth every 6 hours as needed for pain.

A MAR (Medication Administration Record) for June 2023 documented that the Acetaminophen was given on the following dates:
6/17/23 at 9:57pm, pain level '3' (On a zero to ten scale). Administration effective.
6/18/23 at 5:02am, pain level '3' Administration effective.
6/18/23 at 4:53pm, pain level '7' Administration effective.
6/28/23 at 11:58pm, pain level '3' Administration effective.
6/30/23 at 7:20pm, pain level; '5' Administration effective.

A MAR for July 2023 documented that the Acetaminophen was not administered from 7/1/23 through 7/25/23.

A document entitled "Behavior Reports" dated 6/17/23 handwritten and authored by V10 documented the following: "Had resident on the toilet, my partner had to go do something, (I) tried to stand her (R22) up to clean her off and she fell sideways onto the toilet. My partner was outside the door and (I) had her help me get her off the toilet. She can stand up sometimes, and sometimes she can't."

On 07/23/23 at 10:55am, R22 was observed in her room, sitting in a high backed wheelchair. R22 was alert and oriented only to herself. R22 stated she does not think she has sustained any falls at the facility. R22 had no complaints.

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S9999	Continued From page 5 On 7/25/23 at 1:31pm, V2 (Director of Nurses) stated on 6/17/23 at some time in the morning, V10 was trying to get R22 off the toilet by herself and R22 fell backward onto the toilet. V2 stated the Nurses Note dated 6/17/23 at 5:46pm stating the transfer from shower chair to wheelchair is inaccurate. V2 stated R22 was to be transferred by two staff and that V10 should have been aware of that when V10 got report at the beginning of her shift that morning. V2 stated V10 did not report the incident to the nurse when it happened but did report it to V11 (POA) in the afternoon of the same day when R22 complained of rib pain, with V11 reporting it to R22's nurse. V2 stated V8, the Physician covering for V9 (R22's Physician) gave the order to send R22 for x-rays, where it was discovered R22 had fractured a rib. V2 stated the new intervention added after the fall is that R22 is always to be transferred with two staff to assist, and V2 stated all staff were re-educated to do this. V2 stated all staff were also educated that falls are to be reported immediately. V2 stated R22 did not display sequelae from the fracture with the exception of some complaints of pain immediately after which were resolved with administration of Acetaminophen. On 07/25/23 at 02:01 PM, V10 stated that on 6/17/23 at some point in the morning, she and another CNA transferred R22 onto the toilet and the other CNA then went to answer a call light. V10 stated R22 wanted to get off the toilet, so V10 stood her up, but R22 stumbled backward, and her buttocks hit the seat 'pretty hard.' V10 stated she did not witness R22's chest make contact with the toilet. V10 stated she waited till the other CNA returned and they then transferred R22 off the toilet without incident. V10 stated she	S9999		

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S9999	Continued From page 6 was busy and did not report the incident to the charge nurse. V10 stated V11 reported to V10 that R22 was having rib pain, V10 told V11 about the transfer incident and V11 reported it to the charge nurse. V10 stated she does not know why the 6/17/23 Nurses Note stated the resident was being transferred from the shower chair to the wheelchair. V10 stated she was aware R22 was to be transferred with two staff. V10 stated after the incident, all staff were re-educated that R22 is to always be transferred by at least two staff members, and falls are to be reported immediately. On 7/26/23 at 1:54pm, V9 (Physician) stated R22 was admitted on 6/10/23 as a transfer from another facility. V9 stated the facility notified her about the 6/17/23 injury as described above. V9 stated it is definitely possible the rib fractured occurred during the 6/17/23 fall. V9 stated R22 has no known history of osteoporosis, and there was no sequelae associated with the fall except complaints of pain relieved by Tylenol. V9 stated to her knowledge, R22 had no previous rib fractures and no previous complaints of rib pain. On 7/26/23 at 2:35pm, V1 (Administrator) stated all nursing and CNA staff were re-educated that R22 is to be transferred with two staff, and falls are to be reported immediately to the charge nurse. V1 stated the Quality Assurance interdisciplinary team met and discussed the fall and implemented the action of adding residents' transfer status prominently in the CNAs charting section so that when they log into the residents record, the transfer status is immediately seen. V1 stated V2 (DON) met with V10 three times weekly and provided transfer observation on the floor which occurred without incident, and V1 stated V10 has met her re-training objectives. V1	S9999		

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stated V10 is a seasoned CNA, and a dependable employee and administrative staff believe there will be no further issues with V10 performing unsafe transfers.

On 07/27/23 at 8:33am, V11 (POA) stated she came to see R22 around lunchtime on 6/17/23. V11 stated R22 began complaining that her left side hurt. When V11 questioned R22, R22 stated, "I was going to the bathroom, and they dropped me." V11 stated she questioned V10, who initially denied anything had occurred. V11 stated V10 finally admitted, "She was taking (R22) to the bathroom, and she slipped out of her (V10's) hands." V11 stated V10 admitted she had not told any other staff members about this. V11 stated she informed the charge nurse, who knew nothing about it, and R22 was sent for an xray, which showed a rib fracture. V11 stated R22 complained about pain for a few days, but the pain resolved. V11 stated R22 has no history of rib fractures or rib pain. V11 stated when R22 was admitted to the facility, she recalls specifically telling V10 that R22 required the assistance of two staff for transfers. V11 stated it is her understanding that administration re-educated staff that R22 is always supposed to be transferred with two staff, and falls are to be immediately reported. V11 stated she has now noticed there are always two staff present during R22's care.

A Fall Prevention Program Policy dated 11/21/17 documented, "Purpose: To assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as

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S9999	Continued From page 8 necessary ...All assigned nursing personnel are responsible for ensuring ongoing precautions are put into place and consistently maintained. Fall/safety interventions may include but are not limited to: ...Transfer conveyances shall be used to transfer residents in accordance with the plan of care. Residents at risk of falling will be assisted with toileting needs as identified during the assessment process and as addressed in the plan of care." Prior to the survey date, the facility took the following actions to correct the non-compliance: 1. From 6/23/23 through 6/30/23, all nursing and CNA staff were inserviced that R22's transfers are to be with the assistance of two staff at all times, and difficulty with any transfers are to be reported to the residents nurse immediately. Staff signed off on the attendance sheet, including V10. 2. For a total of four weeks, from 6/20/23 through 7/22/23, V10's resident transfers were audited three times weekly, with V10 demonstrating proficiency in all observations. 3. R22 is engaged in therapy services twice weekly to assist with core strengthening, transfers, and ADL's. (Activities of Daily Living). 4. The facility's electronic health records system has been updated so that when CNAs initially log into the system to document, resident's transfer status is prominently displayed. 5. On 7/12/23, the facility's Quality Assurance Committee met to review the above referenced fall. The Committee approved of the corrective Action Plan that had been submitted and reviewed the status of the plan without corrections. (B)	S9999		

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