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	IL6008064	A. BUILDING: _____ B. WING _____	C 03/30/2023

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S 000	Initial Comments Complaint Investigation: 2391647I/IL156894 Investigation of Facility Reported Incident of February 12, 2023/IL157316	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)1)3)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 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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: A. Based on interview and record review, the facility failed to follow their change of condition policy by not effectively communicating to a resident's physician the extent of the injury related to a fall, including the resident experiencing extreme pain because of a visible leg deformity after a fall. This failure applied to one (R4) of six residents reviewed for quality of care and resulted in R4 not being sent out to the	S9999		

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hospital emergently for assessment after a fall and not being provided with any pain medication while experiencing 10/10 pain as a result of the injury.

B. Based on interview and record review, the facility failed to follow their policy and procedure for pain management by not informing the resident's physician that the resident was experiencing 10/10 pain after a fall and failed to administer any pain medication after the resident verbalized being in pain. This failure applied to one (R4) of six residents reviewed for pain management and resulted in R4 experiencing severe pain (10/10) without any interventions to address R4's pain for over two hours, while waiting for hospital transport.

Findings include:

R4's face sheet shows R4's past medical history not limited to epilepsy, anxiety, pain in thoracic spine, and personal history of (healed) traumatic fracture. MDS (Minimum Data Set assessment) summary dated 11/28/2022 showed R4 is cognitively intact, requires supervision with activities of daily living and requires "setup help only" with locomotion and mobility. R4's care plan last revised on 01/18/2023 showed he is at risk for falls. Last documented fall was on 01/05/2023 with injury, left wrist fracture.

Reviewed final incident report completed by V1 (Administrator) dated 02/23/2023 that showed R4 had a fall on 02/16/2023. Time of occurrence is documented as "n/a" and that R4 was "transferred to the emergency room for evaluation due to complaint of pain to left leg. X-ray revealed left tibia and fibula fracture." Documented actions taken by facility included

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S9999	Continued From page 3 "pain management offered." Reviewed R4's nursing progress notes and noted the following: Note dated 2/15/2023 23:27 showed R4 "was horse playing with peer, fell and sustained injury to the lower limb above the ankle. Cold compress applied and the Dr. (doctor) notified." Orders received for R4 be sent to the hospital. Note dated 2/16/2023 00:45 showed R4 was picked up by emergency medical services. Note dated 2/16/2023 01:03 showed R4 was taken to a different hospital than previously ordered because he was in so much pain. Note dated 2/16/2023 10:15 showed R4 was being evaluated for diagnosis of left fibula and tibia fractures. On 03/27/2023 at 2:33 PM, R4 said on the night of 02/15/2023 while in R7's room, he was walking towards the nightstand and said his pant leg "got caught on the bed frame" of R7's bed which caused him to fall to the floor. He then said while trying to free his leg, he heard a "cracking sound". R4 said another resident helped him get up off the floor and into a wheelchair then went to the central nurse's station and told an unknown nurse. R4 said the nurse told him his leg is probably broken then called an ambulance service, not 911 like he asked. R4 proceeded to say that he was in excoriating pain and begged multiple times for staff to call 911. R4 said it took about "3.5 hours from the time of fall" for the ambulance to pick him up. R4 added that all he received for his pain was a "cold pack."	S9999		

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R4's care plan showed he is at risk for pain related to chronic bilateral thoracic back pain, last revised on 12/05/2022. Interventions showed to monitor/record/report to nurse resident complaints of pain or requests for pain treatment and notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. Date Initiated: 09/02/2022.

Reviewed R4's ambulance transport treatment summary dated 02/16/2023 showed facility notified ambulance service on 02/15/2023 at 11:33 PM and on 02/16/2023 at 12:39 AM, R4 was received by emergency medical staff while sitting in a wheelchair in the hall near room. R4 was observed with extreme left ankle swelling, redness, and general swelling from knees to ankle. R4 reported pain at "10/10." R4 was secured onto a stretcher then left facility enroute to specific hospital ordered by his primary physician. R4 left facility at 12:47 AM. Summary also showed that during transport, R4 "started experiencing more pain and could no longer tolerate such a long transport," so R4 was taken to the nearest hospital where upon arrival, R4 "could no longer bend leg."

Reviewed R4's hospital records dated 02/16/2023 that stated he arrived in the emergency department at 01:16 AM via emergency medical services from the facility post fall. Per his record, R4 stated the incident "happened around "10:15 pm" and he rated his pain upon arrival at "10/10." R4 was admitted to the hospital with closed fracture of distal tibia, closed fracture of distal fibula, closed fracture of proximal fibula which required surgical intervention.

On 03/27/2023 at 2:25 PM, R7 said she and R4

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were in her room the night he fell and broke his leg. She said R4 "went to run from [her] then tripped and fell to the floor." R7 added that at first, she thought R4 was "playing with her" until he started complaining of pain to his leg and ankle. R6 then said after about five minutes or so, she looked at R4's leg and saw that it was swollen so she went to get the nurse. R7 said "they" (doesn't remember names) got him up, told him to lay down, then put ice on his leg. She added that an hour later, R4's leg was swollen even more, and that he was asking to go to the hospital.

On 03/29/2023 at 10:15 AM, V17 (Certified Nursing Assistant) said she walked in around 11:00 PM for her shift on the night R4's incident occurred. She said other aides told her that R4 "fell on second shift." She said that she could hear R4 yelling out profanities and saying he hit his foot.

On 03/29/2023 at 2:44 PM, V18 (Licensed Practical Nurse/LPN) said on 02/15/2023 that she was working second shift on the central unit and saw staff pushing R4 in a wheelchair sometime before 11:00 PM. She said that they were coming from the west wing heading to the east wing, where R4 resided. She then said V15 (Registered Nurse) came to her station and said she (V15) was just told by R4 that he fell in his room. V18 (LPN) told V15 about what she saw previously then headed up front near the double doors with V15. V18 then said she saw R4 sitting in a wheelchair and his leg was swollen. V18 added, "I think I called the doctor" and told him R4 fell and said he needs to get sent out. She added that V15 gave R4 an ice pack, then she (V18) left the facility and went home.

On 03/29/2023 at 3:02 PM, V21 (Licensed

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S9999	Continued From page 6 Practical Nurse) said around 11:00 PM during change of shift report to V15 (RN), an aide brought R4 to the east side and said he fell. V21 said we asked what happened, R4 said he fell and wanted a pain pill. She then said that she finished giving report to V15 then left to go home. V21 added that she did not assess R4 nor give him any pain medication. On 03/27/2023 at 3:27 PM, V15 (Registered Nurse) said that she was just coming in, that it was after 11PM. She then said some aides brought R4 in a wheelchair to her while she was at the east nurse's station. V15 added that staff and R4 told her to call 911. She continued to state that R4 said he fell in his room. When V15 asked how R4 fell, he refused to tell. V15 then said she saw his right leg was "deformed looking and swollen," then took resident in the wheelchair to the central nurse station where she and another nurse assessed R4 and placed a cold compress on his leg. V15 said she next contacted V9 (Director of Nursing/DON) then called the doctor who said transfer resident to "his" hospital. V15 then said she called the ambulance service and was told it would take approximately two hours. When asked why 911 wasn't called given the condition of R4's leg, V15 said, "I don't know what to say, I was new and didn't call 911 because I had already called the ambulance service." V15 added that she did not administer any pain medication to R4 because she was told he already received some. On 03/27/2023 at 3:43PM, V2 (Assistant Director of Nursing/ADON) said after a fall occurs, her expectations are for the nurse to do an immediate risk management assessment immediately after. She then said when there's visible and obvious injury, nursing staff should call 911 immediately,	S9999		

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S9999	Continued From page 7 and not the ambulance service. On 03/28/2023 from 4:14 PM - 4:29 PM, V16 (Medical Doctor) said regarding R4's incident on 02/15/2023 that the facility contacted him about the fall and said, "it doesn't look good." V16 told the facility to send R4 to the hospital then added that the level of emergency determines whether a resident is sent out "911." V16 added that what a nurse tells him is subjective so if the extent of R4's injury had been described in more detail and if his complaints of extreme pain were communicated to him, he would have ordered 911 be called and for pain medication to be administered immediately. V16 then said at this time, knowing R4's reported pain level at the time of incident, the nurse misjudged the timeframe R4 had to wait for the ambulance and the nurse should have understood the significance of the resident having to wait two plus hours for the ambulance to arrive. Reviewed R4's physician's orders that showed transfer resident to hospital emergency room for medical evaluation and treatment (ordered 02/15/2023) and acetaminophen tablet give 2 - 325 milligram tablets every 6 hours as needed for pain (ordered 09/02/2022). Reviewed R4's medication administration record for February 2023 that showed acetaminophen was not administered to him on 02/15 or 02/16/2023. Reviewed condition change policy last revised 11/13/2018 that showed the purpose is to ensure that medical problems are communicated to the attending physician and responsible parties in a timely, efficient, and effective manner. The policy also showed that the facility will consult with the	S9999		

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S9999	Continued From page 8 resident's physician or authorized designee when there is: an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status; a need to alter treatment significantly. A need to alter treatment "significantly" includes to commence a new form of treatment to deal with a problem. Reviewed pain management program policy last revised 07/06/2018 that showed the purpose is to establish a program which can effectively manage pain to remove adverse physiologic and physiological effects of unrelieved pain and to develop an optimal pain management plan to enhance healing and promote physiological and psychological wellness. The policy also showed the goal is to promote resident comfort, to preserve and enhance resident dignity and facilitate life involvement through an effective pain management program. The pain medication used shall be appropriate for the population served with standards to initiate a pain assessment protocol when a change of condition occurs that requires pain control. The policy added that a resident's physician will be notified of the resident's complaints of pain not relieved by comfort measures, including pain medications. "A"	S9999		