Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002950	A. BUILDING: ______ B. WING ______	C 02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR HAVENS SENIOR LIVING	1790 SOUTH FAIRVIEW AVENUE DECATUR, IL 62521

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Facility Reported Incident of January 23, 2023 IL156424	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.690 b) 300.690 c) 300.1210 b) 300.1210 c) 300.1210 d)3) 300.1210 d)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 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

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:
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and

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S9999	Continued From page 2 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. 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 requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure two staff were present for care as directed in the assessment, failed supervise residents and develop post fall interventions, failed to report a fall with injury to the State Agency, failed to ensure wheelchair restraint equipment was functioning properly for	S9999		

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transport, and failed to complete post fall assessments for four of four residents (R4, R1, R2 and R3) reviewed for falls on the sample list of four residents. These failures resulted in R4 rolling out of bed and R4's gastrostomy tube becoming dislodged and causing tissue damage when only one staff was providing care, R1 falling and obtaining a femur fracture when staff failed to supervise R1 and failed develop post fall interventions to prevent subsequent falls, and R2 falling and obtaining a clavicle fracture when staff failed to supervise R2 during ambulation.

Findings include:

1.) R4's Undated Face Sheet documents medical diagnoses of Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left non-dominant side, Left Side Weakness, Dysphagia, Aphasia, Nothing by Mouth (NPO), Gastrostomy Tube (G-tube), Trans Ischemic Attack (TIA), Convulsions and Chronic Embolism and Thrombosis of Deep Veins of Right Upper Extremity.

R4's Minimum Data Set (MDS), dated 1/17/23, documents R4 as severely cognitively impaired. This same MDS documents R4 as requiring extensive assistance of two people for bed mobility, dressing, toileting, personal hygiene, and total dependence of two people using a mechanical lift for transfers.

R4's Care Plan documents a fall intervention, dated 7/17/22, of, "Staff to position (R4) in center of bed."

R4's Nurse Progress Note, dated 2/15/23 at 11:49 PM, documents, "Fall Details: Date / Time of Fall: 02/15/2023 11:00 PM Fall was witnessed. Fall

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occurred in the Resident's room. Activity at the time of fall: rolled out of bed. Did fall result in an emergency room (ER) visit/hospitalization: Yes. ER Visit/Hospitalization Details: per physician request. Conclusion: Did environmental factors contribute to the fall: No. Did Resident's current medical condition(s) contribute to the fall: No. Any additional needs identified: Yes. Needs identified: Re-education. Needs identified: Floor Mat."

R4's Fall Investigation, dated 2/15/23, documents, "(V19) Certified Nurse Aide (CNA) giving care to (R4) and (R4) slid off of bed. (V19) CNA notified (V16) Licensed Practical Nurse (LPN). (V16) LPN observed (R4) laying on Left side of body on floor area and (R4) assessed. (R4's) G-tube was pulled out when (R4) fell. (R4) alert, nonverbal, unable to do Range of Motion (ROM) due to position (R4) was in. Ambulance called, Physician notified and orders given to send to emergency room for evaluation and treatment and to reinsert G-tube. (R4) unable to give description." This same report documents, "Summary of event/situation: At 11:31 PM (V19) CNA notified (V16) LPN that (R4) was on the floor. (V16) entered room and noted (R4) on floor. During assessment (R4's) G-tube was observed to be displaced. Root Cause: (R4) not positioned correctly during care. Intervention: (V19) educated and in serviced on turning an repositioning correctly during care."

R4's Emergency Room record, dated 2/16/23, documents, "(R4) arrives via ambulance service from facility for evaluation of a fall out of bed. (R4) is nonverbal, bedbound from prior stroke. Per facility staff, (R4's) bed was approximately four feet in the air and (R4's) Gastrostomy tube (G-tube) was pulled out on the way down. (R4)

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alert, nonverbal and drooling." This same report documents, "G-tube replacement Narrative notes: Procedure specific details: Tract greater than four weeks old. Dilated with 20 French (F) and 22F catheter. Could not get a 24F G-tube in. Downsized to 22F that went in smoothly. . Inflated balloon with 10 cubic centimeters (cc) sterile water and pulled back taught."

R4's Electronic Medical Record (EMR) does not document notification to the Illinois Department of Public Health of the fall with injury.

On 2/16/23 at 3:00 PM, V16, Licensed Practical Nurse (LPN), stated, "(V19) Certified Nurse Aide (CNA) was providing incontinent care to (R4). (V19) is a new CNA and did not know (R4) requires two staff for most cares. (R4) had a major stroke and no longer has use of his entire left side and right Leg. (R4) can move his right arm a little bit, but nothing significant. (R4) requires two staff for incontinence care and turning and positioning in bed. (R4) also has an air mattress so we (staff) know how dangerous those can be. (V19) CNA should not have been providing cares to (R4) by herself. That is why (R4) fell out of his bed. That is how (R4) got hurt. I had to send (R4) to the hospital because (V19) accidentally pulled out (R4's) feeding tube when trying to turn (R4). The hospital had to put in a smaller tube because the tissue was damaged around where the feeding tube goes in. They (hospital) told me in report that the tissues were swollen around the stoma site so the same sized feeding tube would not fit."

On 2/17/23 at 11:10 AM, V19, Certified Nurse Aide (CNA), stated, "I am a new CNA. I just got my CNA a month ago and started working for this facility. I did not receive report the day (R4) fell

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out of bed. The other CNA's had all left. I know there is a care plan to follow, but I do not know how to see it in our (staff) computerized charting. I had (R4) propped up on his right side in bed. (R4) was laying on the side of the bed facing the door to his room and I was on the opposite side by the window. I was holding (R4) over with one hand and providing incontinence care with my other hand. Apparently, (R4) began to roll towards his side of the bed. (R4) is so big. I am very small built, so I couldn't stop (R4) from rolling off the bed. As (R4) was rolling, I used both hands and was grabbing at everything I could to keep him from falling. I must have grabbed on to the feeding tube, because by the time (R4) hit the floor, his feeding tube was out. It still had the bubble on the end and everything. I had (R4) positioned too close to the edge. (R4) is supposed to have two staff members helping with turning and positioning in bed since he can't do anything for himself. I should have had another CNA in there with me."

On 3/17/23 at 3:40 PM, V23, Medical Director, stated, "(R4) is a resident who requires total care from the staff. (R4) could never fall out of bed on his own. This is a direct example of staff negligence. That staff member (V19) should have had another person helping. (R4) requires the assistance of two staff member for all cares. This facility is lucky (R4) did not have any fractures or bleed since he is on a significant amount of Coumadin. The facility caused trauma to (R4's) stoma site by ripping out the feeding tube when they (staff) caused him to fall out of bed. There is no excuse for this." V23, Medical Director, stated R4's fall on 2/15/23 requiring R4 to be sent to the emergency room to have the G-tube replaced, should have been a reportable incident. V23 stated, "The facility definitely

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should have reported this incident. (R4) did not need to have his G-tube replaced if it weren't for the fall caused by the facility. The tissues around (R4's) stoma site were damaged from the G-tube being ripped out."

On 2/17/23 at 3:50 PM, V1, Administrator, stated, "They (staff) called me and told me that (R4's) Gastrostomy tube (G-tube) was pulled out during (R4's) fall. (R4) did go to the emergency room to have it replaced. I did not think of this as a reportable at that time, but now can see how it should have been. (R4's) fall with treatable injury did not get reported to IDPH (Illinois Department of Public Health). I just sent in the initial today."

2.) R1's undated Face Sheet documents medical diagnoses of non-Displaced Intertrochanteric Fracture of Right Femur, Liver Cell Carcinoma, Weakness, Chronic Systolic and Diastolic Congestive Heart Failure, Chronic Obstructive Pulmonary Disease (COPD), History of Falling, Ischemic Cardiomyopathy, Abnormalities of Gait and Mobility, and Dizziness.

R1's Minimum Data Set (MDS), dated 1/13/23, documents R1 as cognitively intact. This same MDS documents R1 as requiring extensive assistance of one person for bed mobility, transfers, locomotion on and off unit, dressing, toileting and personal hygiene.

R1's Fall Risk Evaluation, dated 1/14/23, documents R1 was at risk for falls.

R1's Careplan documents a fall intervention, date 1/25/23, of, "Educate (R1) to ask for assistance from dining room to room."
This same Care Plan does not include a fall intervention for R1's 1/18/23 fall.

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R1's Post Fall Evaluation, dated 1/18/23, documents, "(R1) trying to ambulate to (R1's) room from dining room and slid out of wheelchair."

R1's Interdisciplinary Team Note, dated 1/18/23, documents, "Fall Details: Date / Time of Fall: 01/18/2023 4:45 PM Fall was not witnessed. Fall location: dining hall. Activity at the time of fall: ambulating to dining room. Was a safety evaluation completed/documented prior to the fall: No. Did an injury occur as a result of the fall: No. Did fall result in an emergency room (ER) visit/hospitalization: No. Fall Details Note: (R1) was trying to ambulate to his room from the dining hall and slid out of his wheelchair. Conclusion: History of prior falls: Yes. Any similarities between current and post falls: Yes. Prior Fall Note: Resident attempted to ambulate himself and fell. Any additional needs identified: No."

R1's Nurse Progress Note, dated 1/23/23 at 11:40 AM, documents, "(R1) found lying on floor in the dining room in front of his wheelchair. (R1) alert and verbal, complains of pain on his right side, arm, hip and leg. (R1) was able to move his left arm and leg,but not his right side. (R1) denied hitting his head, (R1) was unable to assist with getting back in wheelchair. Ambulance service called. Paramedics administered Fentanyl injection at the facility. Ambulance service transported resident to hospital."

R1's Post Fall Evaluation, dated 1/23/23, documents, "(R1) was ambulating without assist in dining room"

R1's Nurse Progress Note, dated 1/23/23 at 4:15

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PM, documents, "Writer spoke to nurse at hospital. (R1) admitted due to rght hip fracture."

R1's Nurse Progress Note, dated 1/23/23 at 9:53 PM, documents, "Fall Details: Date / Time of Fall: 01/23/2023 11:00 AM Fall was not witnessed. Fall location: Dining room. Activity at the time of fall: ambulating without assist. Reason for fall: ambulating without assist Did an injury occur as a result of the fall: Yes. Did fall result in an emergency room (ER) visit/hospitalization: Yes. Contributing Factors: Recent change in environment: No. Was fluid spilled on floor: No. Clutter present on the floor: No. Floor mat was on floor: No. Poor lighting in the area: No. (R1) complains of pain. Pain Description: Right arm, Right Leg, Right Hip Pain: 10/10. Conclusion: Did environmental factors contribute to the fall: No. Did Resident's current medical condition(s) contribute to the fall: No. History of prior falls: Yes. History of falls at the facility. Any similarities between current and post falls: Yes."

R1's Right Hip X-Ray Report dated 1/23/23 documents "Impression: Near nondisplaced Intertrochanteric Fracture on the Right"
R1's Emergency room report dated 1/23/23 documents "(R1) is a 69 year old male who presents to emergency department after a fall resulted in a Closed Nondisplaced Intertrochanteric Fracture of the Right Femur. Orthopedics was consulted and will see (R1)."

R1's Nurse Progress Note, dated 1/27/23 at 6:09 PM, documents, "(R1) returned to facility from hospital. (R1) had a closed non-displaced fracture of right femur. Three incisions noted to the right lateral leg. Superior incision on right upper leg has 19 staples, middle incision on lateral upper leg has five staples and incision on

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lateral side of right knee has eight staples."

On 1/16/23 at 12:50 PM, V14, Restorative Lead Certified Nurse Aide (CNA), stated, "(R1) required a mechanical lift when he was first admitted. (R1) used that lift for two weeks until about 1/20/23 and was then upgraded to one assist with pivot transfers. I remember (R1) telling me 'I just can't do it. I am too weak' referring to being upgraded. (R1) wanted to stay on the mechanical lift."

On 1/17/23 at 3:30 PM, V23, Medical Director, stated R1 had a general decline in health due to advancing disease processes. V23 stated, "(R1) had lost a lot of strength and should have had staff assisting him with ambulation. If (R1) fell on 1/18/23 by walking by himself and falling, then the staff should have care planned that event so it would not happen again. If the staff would have been monitoring (R1) and care planned the 1/18/23 fall, the chances that (R1) would have fallen again on 1/23 the same way would be nil. (R1) may have not gotten the fractured hip on 1/23/23 if the staff were following their fall policies and paying attention to (R1)".

3.) R2's undated Face Sheet documents medical diagnoses of Nondisplaced Fracture of Right Clavicle, Moderate Dementia with Psychotic Disturbance and Atrial Fibrillation.

R2's Fall Risk Assessment, dated 12/8/22, documents R2 is at risk for falls.

R2's Restorative Assessment, dated 1/2/23, documents, "(R2) is able to walk with no devices with supervision and verbal cues for direction as needed."

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S9999	Continued From page 11 R2's Minimum Data Set (MDS), dated 1/12/23, documents R2 as severely cognitively impaired. This same MDS documents R2 as requiring extensive assistance of one person for bed mobility, transfers, walking in room and corridor, locomotion on and off unit, dressing, eating, toileting and personal hygiene. R2's Nurse Progress Note, dated 1/30/23 at 5:07 PM, documents, "(V15) Certified Nurse Aide (CNA) reported that (R2) was on floor in dining room. (R2) has discolored area on right forehead. Neurological assessments initiated. (R2) up walking independently right after this incident" R2's Nurse Progress Note, dated 1/30/23 at 5:36 PM, documents, "Fall Details: Date / Time of Fall: 01/30/2023 5:00 PM Fall location: Dining room. Activity at the time of fall: ambulating. Reason for the fall was evident. Did an injury occur as a result of the fall: Yes. Injury details: Hematoma to Right Forehead. Did fall result in an emergency room (ER) visit/hospitalization: No. Contributing Factor Note: (R2) self ambulated and tripped in dining room. Conclusion: Any similarities between current and post falls: Yes. Conclusion Note: (R2) self ambulates and has tripped in past." R2's Post Fall Evaluation, dated 1/30/23, documents ,"Alerted (R2) was on the floor in the dining room. (R2) assessed, stood back up and continued to ambulate independently. Hematoma to Right Forehead." This same evaluation documents R2 was not sent to emergency room for evaluation. R2's Nurse Progress Note, dated 2/4/23 at 9:32 AM, documents, "(R2) was ambulating when	S9999		

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noticed that (R2's) right shoulder appeared to not be in alignment with the rest of his upper body. Assessed (R2) and noticed some swelling with a small bruise to the right shoulder area. (R2) did grimace and say "ouch" when palpating the distal end of right clavicle."

R2's X-Ray Report, dated 2/4/23, documents, "Impression: Right Clavicle: Fracture of the distal end of the Clavicle."

R2's Final Incident Report to Illinois Department of Public Health (IDPH), dated 2/7/23, documents, "Incident category: Fall with physical harm or injury". This same report documents, "Investigation was conducted and after interviewing staff, it was found that (R2) had fallen on 1/30/23 while ambulating in dining room. On 2/4/23 (R2) was ambulating down hallway from room when (V9) Registered Nurse (RN) noted that (R2) had an abnormality of Right Shoulder. (V9) RN assessed (R2) and noted swelling and bruising to Right Shoulder and while assessing range of motion (R2) said 'ouch'. (R2) unable to give description. (R2) did not have any unusual incident that might have caused the injury aside from the fall on 1/30/23. Staff interviewed were not aware of anything else happening. (R2) stated no one hurt him. There is no evidence of abuse. (R2's) X-Ray results showed non-displaced fracture of distal end of right clavicle."

On 2/16/23 at 1:45 PM, R2 was walking in hallway on a different unit than where R2 resides, with no staff present.

On 2/16/23 at 12:55 PM, V14, Restorative Lead Certified Nurse Aide (CNA), stated, "(R2) walks all over the place. (R2) is supposed to have

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supervision with ambulation. You have to keep your eyes on (R2) or who knows where he will end up."

On 2/16/23 at 2:05 PM, V9, Registered Nurse (RN), stated, "(R2) was walking down the hall towards me on 2/4/23. I have been (R2's) nurse plenty of times and I noticed he wasn't holding his shoulders like normal. I asked (R2) if there was anything wrong with his right shoulder because he was just holding it weird. I assessed (R2's) shoulders and that is when he said 'ouch' when I palpated his right shoulder. There was a small bruised area on the top of (R2's) right shoulder. The bruise didn't look fresh but it was hard to tell since it was small."

On 2/16/23 at 2:10 PM, V15, Certified Nurse Aide (CNA), stated, "I was pushing another resident to the dining room to supper on 1/30/23. I saw (R2) so I told him to follow us to the dining room. (R2) was behind me a few feet. (R2) can walk on his own. (R2) just needs directions where to go. (R2) had bent down to pick a cookie up off the floor and fell. (R2) got a goose egg on his forehead. If I had been able to see (R2) I could maybe have prevented him from falling and breaking his shoulder, but I was in front of (R2). I should have been walking beside (R2) instead of in front of him. I should have been where I could see (R2)."

On 2/16/23 at 2:45 PM, V16, Licensed Practical Nurse (LPN), stated, "I was called by staff to come check out (R2) after because he fell. (R2) was sitting on his bottom on the floor of the area between the two dining rooms. (R2's) forehead area was starting to swell. I started neurological checks, assessed (R2) who had no obvious injury at that time so we (staff) sat him up in a dining

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room chair. (R2) then got up on his own and walked away. I guess (R2) was not hurt since he got up and walked away. There was no reason to continue the neurological checks. After dinner, (R2) was laying down in bed so we (staff) put ice on (R2's) head. (R2) had a nice sized goose egg. I told the doctor that (R2) had a goose egg on his forehead, and the doctor said 'there was no reason to send (R2) to the emergency room unless he 'lost consciousness'. At the time (R2) fell, I was focused on his head injury, not his shoulder. (R2) could have had an injury but not noticed by the staff, since we (staff) were all focused on the goose egg on his forehead."

On 2/17/23 at 3:45 PM, V23, Medical Director, stated, "(R2) more than likely got a hairline fracture from the fall on 1/30/23. That is why the staff did not notice directly at that time. (R2) walks all over the place without supervision. (R2) is not supposed to walk without supervision, but I have seen him do it. (R2) does not require hands on assistanc,e but he certainly needs closer monitoring. How are you going to monitor someone who is walking behind you? The staff should have been supervising (R2) more closely. That would have prevented (R2's) major injury of a fractured clavicle."

4.) R3's Undated Face Sheet documents medical diagnoses of Hemiplagia and Hemiparesis following Cerebral Infarction affecting Right dominant side, Dysphagia, Muscle Weakness, Lack of Coordination, Need for Assistance with Personal Care and Anemia.

R3's Minimum Data Set (MDS), dated 1/11/23, documents R3 as cognitively intact. This same MDS documents R3 requires extensive assistance of two people for transfers, total

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S9999	Continued From page 15 dependence of one person for locomotion on and off unit and extensive assistance of one person for personal hygiene and dressing. R3's Post Fall Evaluation, dated 2/7/23, was initiated but not completed. This same evaluation had categories listed of "fall details, contributing factors,education review, physical findings, vital, skin, conclusion" which were all completely blank. R3's Electronic Medical Record (EMR) does not document fall, neurological, skin or pain assessments for R3's fall on 2/7/23. R3's Nurse Progress Notes, dated 2/7/23 at 10:30 AM, documents, "Fall Details: Fall location: transport bus Activity at the time of fall: (R3) in route to physician appointment. Reason for fall: (R3) wheelchair tipped over during transport. Was a safety evaluation completed/documented prior to the fall: Yes. Date of safety evaluation: 02/07/2023 Safety teaching documented before the fall: No. Did an injury occur as a result of the fall: Yes. Injury details: skin tear/abrasion. Skin Issue: Skin Tear Left Forearm. Skin Issue: Skin Tear Location: Right Elbow Skin Issue: Skin Issue Location: Left Shin. Conclusion: Did environmental factors contribute to the fall: Yes. Environment Factor Note: seatbelt malfunction Did Resident's current medical condition(s) contribute to the fall: No. Conclusion Note: (R3) fell due to environmental causes." On 2/16/23 at 2:30 PM, R3 stated, "I was going to an appointment so they (staff) put me in the van that belongs to the facility. (V18) Certified Nurse Aide (CNA)/Transport Aide put me in the van and buckled me in. I know I had a strap over my lap, but couldn't see if (V18) buckled any of the other straps. (V18) hit a huge pothole as she was	S9999		

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S9999	Continued From page 16 turning the van into the hospital parking lot. That is when I fell over in my wheelchair. I fell to my right side. I don't think I was hurt, but I was so scared I wet all over myself. I can hold my bladder, but not if I get thrown around like that. I was really scared. They (staff) told me later that one of the straps was loose on the bottom side so that is why I fell over. My daughter is riding with me from now on to make sure I am safe." On 2/17/23 at 7:45 AM, V18, Transport Aide/Certified Nurse Aide (CNA), stated, "I was taking (R3) to an appointment that morning. I was turning into the hospital parking lot when I heard a commotion in the back so I looked in my rearview mirror and saw (R3's) wheelchair and (R3) leaning to (R3's) right. (R3) did not fall completely over. I would guess (R3) ended up at about a 45 degree angle to his Right side. I did not see if (R3) hit his head, but I did not see the entire fall. I do not think (R3) hit his head, but I can not say for sure. I noticed (R3) was bleeding a small amount from his Right hand. I got some wet wipes and cleaned off the blood from (R3's) hand. I just lifted (R3's) wheelchair back into position. That is when I noticed that the strap that was supposed to hold down (R3's) wheelchair was loose. That is how (R3) fell over, because the latch on the floor malfunctioned. For some reason the tensioner did not hold tension on the safety belt. After I got (R3) situated again, I continued to drive to the hospital to drop him off. (R3's) daughter met (R3) at the hospital, and I reported (R3's) fall to (R3's) daughter. I did not tell any medical personnel from the hospital about (R3) falling. I got back to the facility and let (V22, Assistant Director of Nurses/ADON) know about the incident. After I picked (R3) back up from the hospital and returned him to the facility, that is when staff obtained a set of vital signs. I did not	S9999		

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get any vital signs after (R3) fell. I do not keep the blood pressure cuff or stethoscope on the van. I let (V21, Maintenance Director) know that the seatbelt latch had malfunctioned. I should have called the facility right after (R3) fell in the van. I have been educated on the policy for that now. "

On 2/17/23 at 2:00 PM, V22, Assistant Director of Nurses (ADON), stated V18, Transport Aide, notified V22 of R3's fall during transport upon V18's return to facility. V22, ADON, stated, "(V18, Transport Aide) stated she had seen (R3) fall so I told her since it was a witnessed fall we (staff) did not have to do neurological assessments. After talking with (V18) again about that incident, it is apparent (V18) did not actually see (R3) fall, but heard it, and looked back to see (R3) had already fallen."

On 2/17/23 at 2:10 PM, V2, Director of Nurses (DON), stated, "There was some confusion about (R3's) fall being witnessed or not. Initially, it was reported that (V18) did see (R3) fall but that was because of the way the questions were asked of (V18). I have educated (V22) on investigative questions and not to assume anything. I have also educated (V18, Transport Aide) on reporting falls as soon as they happen and being clear on reporting if a fall is witnessed or not. With (R3's) fall, (V18, Transport Aide) should have immediately called the facility for guidance. We (facility) should have started and completed the neurological assessments, the post fall evaluation should have been completed, the pain assessment and fall assessment should have been completed, there should have been assessment, treatment and follow up for (R3's) injuries and the notifications were not made timely due to a delay in reporting the fall initially.

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S9999	Continued From page 18 This was a mess. This is also a learning process for myself and staff so that we (facility) can do better next time." On 2/17/23 at 3:10 PM, V21, Maintenance Director, stated, "On the day (R3) fell in the van I was notified after (V19) returned to the facility with the van. I looked at the safety belt system in the van and saw that the latch tensioner on one of the tie downs did not function like it was supposed to. Those latch tensioners run on gears within an outer casing. You can't see the gears. We do monthly inspections on the vans. There is a whole checklist. I had just checked that van a week or so before (R3) fell over. Everything else worked ok then but like I said, there is no way to tell when those tensioners are going bad. It just happens. Unfortunately (R3) fell in the van that day because the equipment was faulty. I am just glad no one was hurt too bad." On 2/17/23 at 3:35 PM, V23, Medical Director, stated the facility should have documented the fall, the neurological assessments, the fall evaluations, injuries and the follow up orders from the minor injury should have been initiated. V23 stated, "It may seem like a skin tear but if the licensed staff are not monitoring that area it becomes infected and then requires antibiotics which would all be unnecessary if the staff would follow their policies and do their job. That fall should have been reported immediately to licensed nursing staff who could have directed (V19) on what to do for (R3). Instead (V19) took matters into her own hands and broke a lot of rules." The facility policy titled 'Falls-Clinical Protocol',	S9999		

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S9999	Continued From page 19 revised August 2008, states as a part of the initial assessment, the nurse shall assess and document/report the following: vital signs, recent injury, musculoskeletal function, change in cognition or level of consciousness, neurological status, pain, precipitating factors and details on how fall occurred. Based on assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. The staff, with the physician's guidance, will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or Subdural Hematoma have been ruled out or resolved. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. The facility policy titled 'Serious Injury Incident Reporting Requirements Policy and Procedure-Illinois', revised January 2022, includes any serious incident or accident. The policy states "Serious" means any incident or accident that causes physical harm or injury to a resident. The facility shall notify the Department of any serious incident or accident. The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If the facility is unable to contactthe Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. (A)	S9999		