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S 000	Initial Comments Investigation of Facility Reported Incident of 11/22/23/IL167381	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1010i) 300.1210b)5) 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 of five percent or more within a period of 30 days.	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 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. i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid procedures. 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. Restorative measures shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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	S9999		

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S9999	Continued From page 2 and assistance to prevent accidents. These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to implement fall interventions, provide supervision to prevent a fall, provide safe transfer assistance, and thoroughly investigate falls to identify root cause and develop post fall interventions for three (R1, R2, R3) of three residents reviewed for falls in the sample list of nine. These failures resulted in R1 falling and sustaining a subdural hematoma and R3 falling and sustaining a scalp laceration that required sutures. Findings include: 1.) R1's Minimum Data Set (MDS) 10/16/23 documents R1 has moderate cognitive impairment, has upper/lower extremity range of motion impairment, and requires substantial/maximal assistance for chair/bed transfers. R1's Care Plan revised on 5/1/23 documents R1 transfers with extensive assistance of two staff. R1's Care Plan revised on 5/4/23 documents R1 has decreased ability to self transfer due to Parkinson's Disease and spastic movements/tremors. R1's Care Plan revised 11/28/23 documents R1 is at risk for falls and continues to self transfer even after being educated to call for assistance and includes an intervention dated 6/12/23 to offer to lay R1 down after meals. R1's November 2023 Medication Administration Record documents R1 receives Plavix (antiplatelet, blood thinning medication) 75 milligrams by mouth daily.	S9999		

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The facility's Report to IDPH (Illinois Department of Public Health) Regional Office dated 11/29/23 documents R1 fell on 11/22/23 at 6:21 PM while attempting to self transfer from the wheelchair to the bed and R1's head hit the floor. R1 was found on the floor with a laceration and hematoma (bruising/swelling) to the right side of R1's head. R1 was transferred to the local emergency room and was diagnosed with a subdural hemorrhage (brain bleed).

R1's Fall Investigation for 11/22/23 6:21 PM fall, provided by V2 Director of Nursing, documents V3 Licensed Practical Nurse's (LPN) incident description that R1 self propelled R1 to R1's room, attempted to self transfer into the low bed, and R1 fell to the floor hitting R1's head which caused a laceration and hematoma. V5 Certified Nursing Assistant (CNA) interview is the only documented interview as part of this investigation. V5's statement dated 11/22/23 documents V5 walked past R1's room and found R1 partway on the low bed and partway on the floor. R1's call light had not been activated, R1 was wearing nonskid socks, and R1's wheelchair lap cushion had been in place when V5 last saw R1 at 6:15 PM in the hallway. There is no documented interviews with staff to determine when staff last observed R1 prior to the fall, what R1 was doing at that time, if any staff had offered to lay R1 down after supper, or if R1 had requested to lay down prior to the fall.

R1's Hospital Emergency Department Notes dated 11/22/23 at 6:58 PM, recorded by V6 Advanced Practice Registered Nurse, documents R1 presented to the emergency room for complaints of a fall and R1 hitting R1's head. This note documents R1 has a hematoma to the right

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scalp, R1 takes Plavix, and a head CT (computed tomography) was ordered. R1's Head CT without Intravenous Contrast dated 11/22/23 at 7:17 PM documents the indication for this test was "fall- on Plavix" and there was a small left anterior frontal subdural hemorrhage with a depth of up to 7 millimeters. R1 was transferred to another hospital for further treatment. R1's Hospital Emergency Department Note dated 11/22/23 at 10:33 PM document R1 had an unwitnessed ground level fall with the following injuries - right frontal subdural hemorrhage, right scalp laceration, and hematoma. R1 was admitted with principal diagnoses of Trauma and Subdural Hemorrhage.

On 12/11/23 at 10:37 AM R1 was next to the dining room sitting in a wheelchair. R1 had bruising to R1's right forehead. R1 stated R1 recalls falling recently and R1 was "hurt bad". R1 was unable to recall any additional details of R1's fall.

On 12/7/23 at 12:14 PM V7 LPN stated V7 was not assigned to R1's care the day R1 fell. V7 stated it was R1's norm to go back to R1's room and lie down after supper, R1 had not asked to lay down, and R1's call light was not on when R1 fell. V7 stated R1 doesn't always call for help and R1 is very impulsive with transfers.

On 12/11/23 at 10:48 AM V3 LPN stated V3 last saw R1 in the dining room prior to R1's fall, R1 had finished eating and had made R1's way to R1's room. V3 stated "that's (R1's) norm." V3 stated R1 did not mention that R1 wanted to lay down and V3 did not offer to lay R1 down after supper. V3 stated R1 does not have a routine bedtime. V3 stated R1 was found partway on the floor and partway on the bed with a bleeding head

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laceration. V3 stated V3 was unsure what R1 hit R1's head on as R1 has a lot of items in R1's room including totes and an overbed table. V3 stated R1 told V3 that R1 was trying to go to bed and attempted to self transfer from the wheelchair to the bed. V3 stated R1 usually tells staff when R1 wants to lay down.

On 12/11/23 at 10:57 AM V5 CNA stated V5 was R1's assigned CNA on the evening of 11/22/23. V5 stated V5 did not witness R1's fall and V5 was walking past R1's room and found R1 with R1's upper body on the bed in low position and R1's legs on the floor. R1 had a bump and a bleeding cut to R1's right forehead. V5 stated V5 last saw R1 around 6:15 PM when V5 washed R1's face as R1 was leaving the dining room. V5 stated V5 did not recall if V5 offered to lay R1 down that day, after R1 was finished with supper. V5 stated R1 does not have a routine bed time and R1 attempts to self transfer at times.

On 12/7/23 at 10:43 AM V2 Director of Nursing (DON) stated R1's fall investigation includes interviews that were conducted, and V3 LPN and V5 CNAs were the only staff interviewed as part of the investigation. On 12/11/23 at 12:17 PM V2 stated R1 doesn't like to stay put and we are unable to restrain R1. V2 stated V2 was told R1 removed R1's wheelchair lap cushion and attempted to self transfer for R1's fall on 11/22/23. V2 stated we try to keep R1 in the hallway to keep eyes on R1. V2 stated V1 Administrator, V2 and V8 Assistant DON conducted R1's fall investigation. V2 confirmed R1's head hematoma and laceration were injuries from R1's fall. V2 stated the root cause of the fall was R1's attempt to self transfer after removing the lap cushion. V2 stated V2 inquired with V1 for the post fall intervention, and was told the

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intervention was that R1 was sent to the emergency room. V2 confirmed staff interviews for R1's fall investigation do not document what R1 was last observed doing, if staff had offered to lay R1 down, or if R1 had requested to lay down prior to the fall. V2 stated V2 expects staff to follow the interventions listed on the resident's care plan.

2.) R3's MDS dated 9/7/23 documents R3 has short/long term memory loss and requires extensive assistance of two staff for transfers/ambulation. R3's cumulative diagnoses list documents R3 has Alzheimer's Disease and Severe Dementia with Agitation. R3 has impaired balance with standing/walking/transfers and requires staff assistance to stabilize balance. R3's Care Plan revised 9/21/23 documents R3 requires extensive assistance of two or more staff for transfers/walking. R3's Care Plan dated 10/14/22 documents R3 is at risk for falls related to gait/balance problems, history of falls, poor safety awareness, and wandering. This care plan includes interventions to follow up with hospice that R3 is still not resting during the night (11/28/23), review information on past falls to attempt to determine the cause and educate R3/family/caregivers/interdisciplinary team as to cause as needed.

R3's Report to IDPH Regional Office dated 11/21/23 documents R3 was found lying on the floor of another unidentified resident room on 11/13/23. R3 had moderate bleeding from the back of R3's head, R3 was transferred to the emergency room and received staple closure of the laceration. This report documents R3's medications were reviewed by hospice and adjustments were made to ensure better sleep to avoid daytime exhaustion/weakness. R3's Fall

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S9999	Continued From page 7 Investigation, provided by V2, documents R3 had an unwitnessed fall on 11/13/23 at 10:15 AM. V10's (LPN) incident description documents a CNA (V11) reported that R3 was on the floor and V10 found R3 lying on the floor on R3's right side with a head laceration and blood noted on the floor near. R3 was not able to explain what happened. This investigation does not contain interviews with V11, V10, or any other staff to determine when R3 was last observed prior to the fall and what R3 was doing when R3 was last observed. R3's Hospital After Visit Summary dated 11/13/23 documents "fall" as R3's reason for hospital visit, R3 was diagnosed with a scalp laceration, and R3 required laceration repair. This summary documents to remove R3's staples in 7-10 days. R3's Nursing Note dated 11/13/2023 at 4:31 PM documents R3 returned from the emergency room with two staples to the back of R3's head. R3's Fall Investigation, provided by V2, documents R3 had an unwitnessed fall on 11/25/23 at 7:57 AM. V12 Registered Nurse (RN) incident description documents R3 was found lying on R3's right side in the common bathroom/shower room. R3 was unable to give a description of the fall. R3's Fall Follow Up Note dated 11/28/23 at 10:01 AM documents the interdisciplinary team reviewed R3's fall, R3 wandering the unit was the root cause, and a code lock for the shower room door was the intervention. There are no documented interviews conducted with staff in regards to this fall. This fall investigation does not identify the last time R3 was observed prior to R3's fall and what R3 was doing at that time. R3's Fall Investigation, provided by V2,	S9999		

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documents R3 had an unwitnessed fall on 11/28/23 at 5:40 AM. V13 LPN incident description documents R3 was walking back and forth in the hallway, became unsteady, and fell. R3 was then assisted to R3's reclining geriatric chair. V14's (CNA) interview is the only documented interview in this investigation. V14's interview dated 11/28/23 documents V14 was assisting other residents with morning cares, R3 was wandering in the hallway, and many attempts were made to have R3 sit in a chair. This note documents R3 got R3's self up and began wandering the hallway, and as V14 left an unidentified resident room V14 found R3 lying on the floor. R3's Fall Follow up Note dated 11/28/23 at 10:17 AM documents the interdisciplinary team reviewed R3's fall, R3 was observed walking in the hallway after early morning medication pass, and R3 fell. This note documents the root cause as R3 fell in the hallway and the intervention was for hospice to review medications to ensure sleep at night and prevent drowsiness during the day. There is no documentation in R3's medical record that hospice reviewed R3's medications or that any new medication changes were made after R3's fall on 11/28/23.

On 12/7/23 at 2:22 PM V11 CNA stated V11, V15, and V16 were the CNAs on R3's unit (on 11/21/23), V16 had went on break, leaving V11 and V15 on the unit. V11 stated V15 was in another resident's room. V11 stated V11 was in another resident's room when R9 came to report that R3 had fallen in R9's room. V11 stated V11 had just observed R3 walking in the hallway a few minutes prior to the fall, R3 was able to walk independently, staff did not have to provide walking assistance just monitor R3 and direct R3 out of other resident rooms. V11 stated V11 had to leave the hallway where R3 was walking, to

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S9999	Continued From page 9 assist another resident who was up by herself and was a high fall risk. On 12/11/23 at 10:19 AM V3 LPN stated R3 has not been a walker and one day R3 just got up and started walking. V3 stated R3 is very hard to re-direct when R3 is up walking so staff will walk with R3. On 12/11/23 at 12:17 PM V2 DON stated R3 ambulates/wanders constantly, R3 can get R3's self up, R3 needs staff assistance to safely transfer. V2 stated once R3 is up, R3 can ambulate on R3's own with visual supervision/monitoring of staff. V2 stated staff should redirect R3 out of other resident rooms. V2 stated R3 had an unwitnessed fall on 11/13/23, R3 was wandering, and R3 was found on the floor of another resident's room. V2 stated staff applied a towel to the back of R3's head to stop bleeding from the laceration that was believed to be caused by hitting the base of the bedside table. V2 stated V10 and V11 were interviewed, they were in the next room, and they heard R3 fall. V3 stated the root cause of the fall was R3's confusion and weakness due to lack of sleep. V2 confirmed the fall investigation does not document staff were interviewed to determined when R3 was last observed prior to the fall and what R3 was doing at that time. V2 stated R3 had an unwitnessed fall on 11/25/23 where R3 fell in the shower room and a code lock was then installed on the shower room door. V2 confirmed there are no documented staff interviews as part of this fall investigation to determine when R3 was last observed prior to the fall. V2 stated R3 had an unwitnessed fall in the hallway on 11/28/23. V2 stated V2 viewed video surveillance that showed the nurse V13 was administering medications while R3 was walking in the hallway,	S9999		

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there were no other staff present in the hallway, V13 went into another resident room, and R3 "just fell down". V2 confirmed the investigation documents the CNAs were in resident rooms providing care at the time of R3's fall. V2 stated R3 almost needs a buddy to walk with R3 at all times and during the mornings R3 just wants to walk. V2 stated the root cause of the fall was that R3 fell in the hallway and the intervention was a medication review by hospice requesting medication to help R3 sleep through the night. V2 stated Trazodone was ordered by hospice following R3's fall, and on 12/4/23 or 12/5/23 an unidentified hospice nurse reported the Trazodone order to V2. V2 stated hospice verbally gives orders to the floor nurses and V2 did not implement this order. V2 stated V2 thought hospice enters their own orders into the resident's electronic medical record. V2 confirmed R3's current orders do not include Trazodone. At 2:33 PM V2 stated V2 was unable to locate documentation of R3's Trazodone order and hospice visit note/medication review. V2 stated hospice provides a form after their visit that includes new orders, and V2 is awaiting a call back from hospice to request this documentation.

3.) R2's MDS dated 11/17/23 documents R2 is cognitively intact, R2 uses a walker and wheelchair, and R2 requires substantial/maximal assistance of staff for transfers. R2's Care Plan dated 10/25/22 documents an intervention with a revised date of 9/20/23 for extensive physical assistance of one staff person for transfers.

R2's Fall Investigation, provided by V2, documents R2 fell on 11/29/23 at 12:00 PM while V9 CNA assisted R2 in transferring. R2 lost R2's balance and fell face first onto the floor. R2 stated R2 lost balance and fell forward. R2 had a small

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laceration under the left eye, bleeding bleeding skin tear to middle and fourth right finger knuckles, and bruising to the right middle finger. R2 was transferred to the emergency room for evaluation. This investigation documents interviews were conducted with V17 LPN and V9 CNA. V17's interview dated 11/29/23 documents V9 was transferring R2 and R2 was not wearing any footwear. V9's interview dated 11/29/23 documents V9 was transferring R2, R2 lost balance, R2 fell forward, and V9 was unable to stop R2 from falling. This interview does not document if R9 was wearing footwear. These interviews do not document whether a walker and gait belt were used for R2's transfer. The Fall Follow Up note dated 11/30/23 documents at 12:49 PM the interdisciplinary team reviewed R2's fall, R2 was not wearing appropriate footwear and the intervention was to apply nonskid socks for transfers.

On 12/7/23 at 11:57 AM R2 was sitting in a wheelchair in R2's room. R2 had faded bruising below R2's left eye. R2 stated R2 fell about a week ago while V9 CNA transferred R2 from the wheelchair to the bed. R2 stated staff do not use a gait belt for R2's transfers and one was not used that day. R2 stated V9 applied nonskid socks prior to R2's transfer. R2 stated "I think my leg just gave out" and that has happened before. R2 stated R2 had hit R2's eye on the bottom of the overbed table during the fall and the whole right side of R2's head had turned purple/bruised. At 2:11 PM R2's wheeled walker was folded beside R2's dresser.

On 12/7/23 at 12:06 PM V9 stated V9 had applied R2's gripper socks prior to R2's transfer on 11/29/23 and R2 got dizzy when R2 stood causing R2 to fall forward. V9 stated R2 tried to

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ARCADIA CARE BLOOMINGTON	1509 NORTH CALHOUN STREET BLOOMINGTON, IL 61701

(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
S9999	Continued From page 12 grab R2's incontinence brief during the fall, and a gait belt was not used during the transfer. V9 stated R2 hit R2's eye on either the overbed table or dresser, and R2 was transferred to the emergency room. V9 stated R2 had been in bed bad with COVID-19 for a few days prior to R2's fall. At 2:09 PM V9 stated a walker was not used during R2's transfer and R2 has never used a walker. On 12/7/23 at 2:01 PM V18 Physical Therapy Assistant stated R2 has been on therapy prior to R2's fall, R2 had COVID-19 about a week prior to R2's fall, and R2 transferred with a wheeled walker and standby/contact guard assist. V18 stated R2 has had balance issues. R2 has a history of R2's legs giving out, and R2 doesn't have good standing tolerance. V18 stated staff should be using a gait belt and R2's wheeled walker for R2's transfers. V18 stated the walker would have helped stabilize R2's upper body during the transfer. On 12/7/23 at 12:17 PM V2 DON stated R2 fell while transferring from the bed to wheelchair and R2 is a stand/pivot transfer. V2 stated V9 reported that R2 lost balance and fell forward during R2's transfer, the root cause was that R2 was not wearing nonskid socks during the transfer, and nonskid socks were provided as the intervention. V2 stated V2 just went by what the nurse had reported, that R2 did not have on nonskid socks. V2 confirmed V9's interview does not document if R2's footwear at the time of the fall and R2 was not interviewed about R2's footwear. V2 stated staff should use a gait belt for residents who require extensive assistance for transfers and ambulation. V2 stated V2 was not aware that a walker and gait belt was not used during R2's transfer.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 13 The facility's Fall Prevention Program revised May 2022 documents nursing personnel are responsible for ensuring the ongoing use of fall precautions, the interdisciplinary team reviews the falls to determine possible safety interventions, and the Director of Nursing/Designee is responsible for monitoring the Fall Prevention Program and providing further staff education. This policy documents fall interventions are documented on the resident's care plan, and fall interventions may include using assistive devices and transferring residents in accordance with their plan of care and monitor resident's gait for balance and fatigue. The facility's Transfers-Manual Gait Belt and Mechanical Lifts dated as revised August 2023 documents resident transfer needs are designated into categories including using a gait belt for a one person transfer that requires 25% or less assistance from the caregiver, and the use of a gait belt is mandatory in all physical assist transfers, and failure to comply with lifting guidelines may result in disciplinary action. This policy documents the resident's transfer needs are documented on the resident's care plan. (B)	S9999		