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	IL6016133	A. BUILDING: _____ B. WING _____	C 01/09/2024

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MANOR COURT OF FREEPORT	2170 WEST NAVAJO DRIVE FREEPORT, IL 61032

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S 000	Initial Comments Facility Reported Incident of January 2, 2024 IL168401	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)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 care needs of the resident. d) Pursuant to subsection (a), general	S9999		

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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 ensure a resident (R1) who is a high risk for falls was provided with the appropriate shower device during a shower. The failure resulted in R1 sustaining a fracture to his right hip.

This applies to one of three residents, (R1) reviewed for showers in a sample of three.

The findings include:

R1's face sheet, printed on 1/5/24, showed diagnoses to include but not limited to systolic/diastolic congestive heart failure, anemia, respiratory failure, atrial fibrillation, chronic kidney disease stage 5, difficulty walking, and generalized muscle weakness.

R1's MDS (Minimum Data Set), dated 1/2/24, showed R1 has no cognitive impairment. R1 requires partial to moderate assist with shower transfers and showers. R1 has had one major fall with an injury.

R1's care plan dated, 12/5/23-1/5/24, showed R1

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is at risk for falls related to recent illness, hospitalization and new environment.

R1's quarterly fall risk assessment, dated 12/6/23, showed R1 as high risk for falls.

R1's fall event, printed on 1/5/24, showed R1 had a fall on 9/29/23 at 9:21 PM. R1 was lowered to the floor by certified nursing assistant. No injuries.

R1's radiology report, dated 1/2/24, showed impression: "There is a questionable right femoral neck fracture. Follow up CT would be helpful."

R1's radiology report, dated 1/3/24, showed conclusion: "Comminuted impacted displaced fractures of the right femoral head neck is seen with minor fragmentation extending to the greater trochanter ..."

R1's progress note, dated 1/2/24 at 8:38 PM, showed, "(V10, Certified Nursing Assistant/CNA) notified this writer (V8, Registered Nurse/RN) that (R1) fell in the bathroom during a shower ... (R1) was found lying on right side partially under the sink with a shower chair under him. (R1) had an abrasion noted to the right forehead and he stated he hit his head. He was unsure if it was on the sink or the floor. (V10, CNA) stated she turned around to the sink to grab a towel and when she turned back around he was on the ground; she stated he fell into her backside and then hit the floor. She stated he hit his head on the floor. Initial assessment, (R1) was alert and oriented stating he was fine and he wanted to get up. PERRLA (pupils, equal, round, react to light, accommodation) and strong equal hand grasp noted. Full range of motion (ROM) noted. (R1) was able to stand up with assistance. Vital signs were stable and (R1) was following commands

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appropriately. Call placed to on call (V15, MD on call) and (V14, Power of Attorney/POA) to notify of fall. Neuro checks were initiated at 7:45 PM, approximately ten minutes later (V10) came and notified this nurse (V8) that there was a change in condition. This nurse assessed (R1) in bed unresponsive and having labored breathing. (R1) was not following commands or with drawing to painful stimuli. Sternal rubs (using the ball of your knuckles of the hand to rub the upper mid chest area to cause pain and get a reaction from the person) were performed with no response from (R1). (R1's) oxygen saturation was found to be sixty-eight percent on room air. Oxygen was applied and EMS (Emergency Medical Support) was called (R1) did open his eyes after the oxygen was applied but was not talking or following commands. (R1) began to dry heave when the EMS transported him to the cart. Call placed to on call (V15) MD again for orders to be sent to the local hospital and the (V14) POA was updated on condition.

On 1/5/24 at 9:26 AM, V8, RN, said, "(V10,CNA) came and got me and said (R1) had fallen that she was giving him a shower. I did an assessment his vital signs were stable and he was answering questions. He said he was ok. We got him up. I called (V15, Medical Doctor) on call and the family. (V10) came and got me he was in bed non responsive. His breathing was not normal. I did a sternal rub and he did not respond. I put him on oxygen and the emergency medical team was called. V8 said, "I think he was a fall risk, I'm not sure. I'm sure he is; he is in a wheelchair. I assume he needed assist with transfer."

On 1/5/24 at 11:34 AM, V13 (Social Service Director) said his last fall was on 9/29/23.

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S9999	Continued From page 4 On 1/5/24 at 11:55 AM, V9, RN said, "I am his regular nurse. I was here during the day shift. It was in his room in the shower where he fell. He was on the shower bench and there are no seat belts. (V2 - Director of Nursing/DON) said it was a gray or white bench that he was sitting on. (V10) said he fell into her back and it was a good thing he did or he would have hit his head on the sink. The progress note said he had an abrasion to the right side of his forehead." V9 said, "She (V10) was not supposed to be using that bench it did not fit him. (R1) was a fall risk and his risk factors are his vision, limited mobility and being in the wheel chair bound. We are an alarm free facility." On 1/5/24 at 12:08 PM, V2, DON, said, "The bench was thrown away. It was a white bench and it was not a facility bench. I don't know who brought the bench in. (V10) was not to use that bench. Anything that is brought in has to be approved. If she would have used one of ours they have arm rest and a back support they look like a regular chair (shower)." V2 said, "It was just a bench with no arms or back. It would be a risk for falls and injuries." On 1/5/24 at 1:45 PM, V11 (Occupational Therapist/OT) said most of the showers have the bench seat that is attached to the wall and folds down. V11 said, "If a bench is used incorrectly it could be a safety fall risk. The bench should be inspected before it is used. There should also be a towel placed on the bench because it could get slippery." On 1/5/24 at 2:07 PM, V10 said, "I used a shower bench. I asked him to sit; usually I put a towel down. I did not put a towel down on the bench. I turned to get the washcloth; he was sitting down	S9999		

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with both hands on the grab bar. I turned for just a minute, and he hit up against my back. He is a 1 assist. There was no seat belt or strap, there was no arm rest or a back support. The bench toppled over and that is when I felt him hit my back." V10 said he was injured, but he did say he was ok. "We used a gait belt to get him up it took three of us. I gave him a shower after the fall. It was a quick shower. I did have someone help me get him into bed. The nurse said it was ok to give the shower. I would not use that bench again. I don't know how long it had been here."

On 1/5/24 at 3:11 PM, V7 (Nurse Practitioner/NP) said when you are sedentary, bed bound, or non-weight bearing, you get a lot of falls. V7 said, "The fall was most likely the cause of the hip fracture. There is no diagnoses of bone disease that I am aware of."

On 1/5/24 at 3:38 PM, V2, DON, said, "The (Unit Coordinator/UC) on the night shift sent me this picture. I said to get that out of there and throw it away. The CNA should not have used that bench. She should have used the facility shower chair." V2 said "(V16 - Unit Coordinator/ R1's daughter) said (R1) told her the bench was/seemed like it was slippery and he slid off the bench. The family said they did not bring the bench type chair into the facility."

On 1/9/24 at 1:45 PM, V17 (2nd shift Unit Coordinator/UC) said, "It was reported to me that (V10) was going to give him a shower and he slipped off of the bench and toppled over. I have a picture of the bench I sent to (V2) they were trying to figure out where the bench came from. I asked (V10) where it came from and who told her to use it to give him a shower on that bench and she said it was a long time ago and could not

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S9999	Continued From page 6 remember." The facility's policy, revised on 4/3/18, showed, "It is the policy of the facility to provide emergency care to a resident in need of it. 4. Check for any apparent dislocation or possible fracture. If any signs of this are noted, stabilize resident until ambulance arrives." (A)	S9999		