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S 000	Initial Comments Complaint Investigation 2465550/IL175590	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.690 a) 300.690 b) 300.690 c) 300.1210 b) 300.1210 d)3)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 a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any	S9999		

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serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.
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.
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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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 interview and record review, the facility failed to implement recommendations to prevent a fall for a resident recently on anticoagulant therapy with a history of a fall with a serious injury; failed to report a fall resulting in a new subdural hematoma (R3); failed to

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establish/assess a resident's level of safety; and failed to ensure a walker was maintained in safe operating condition prior to permitting outside unsupervised outings (R1), for two of three residents reviewed for accidents on the sample list of three residents. These failures resulted in R3 falling and suffering an acute subdural hematoma when R3 was left unsupervised on the toilet, and R1 falling while out of the facility and sustaining a fracture of the first metatarsal bone.

Findings include:

1. The Facility's "Quality Care Reporting" Form, dated 5/18/24 at 5:00 AM, documents, "(R3) was found on bathroom floor by (V8), Licensed Practical Nurse (LPN) lying on left side after (R3) self-transferred in restroom stating, 'left leg went out.' (R3) stated (R3) 'smacked (R3's) head on the ground.' (R3) was sent to the Emergency Room via ambulance at 5:45 am."

R3's nurse's note, dated 5/19/24 at 7:23 PM, documents, "(R3) was admitted to (local hospital) Intensive Care Unit for subdural hematoma."

The Quality Care Reporting Form, dated 5/20/24, for R3's 5/18/24 fall documents, "Resident is educated to call for assistance. PT (Physical Therapy) to screen for appropriate transfer status upon return."

R3's nurse note, dated 5/20/24 at 2:20 PM, documents "(R3) returned from hospital with a new order for PT/OT/ST (Physical Therapy, Occupational Therapy, Speech Therapy) evaluation and to hold Eliquis (anticoagulant) until 6/8/24." This note also documents, "Bruising to face and neck. 15 min checks for 24 hours."

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The Physical Therapy Plan of Care, dated 5/22/24, documents, "Reason for Referral: Pt (patient) w/ (with) recent mechanical fall and subsequent decline in functional mobility/independence."

The A.I.M. for Wellness Form (Assess, Intercommunicate, Manage), dated 5/26/24, documents R3 had an unwitnessed fall in the bathroom and was found on the floor. The Form documents R3 had a swollen area to R3's middle forehead, R3 was recently on Eliquis (anticoagulant), and R3 was sent to the emergency department.

R3's Emergency Room (ER) Physician's note, dated 5/26/24, at 9:11 PM by V13 (ER Physician) documents, "I personally spent 45 minutes providing critical care for this patient. This required my direct attention, intervention, and personal management because of the high probability of imminent or life-threatening deterioration due to acute subdural hematoma, ground level fall, end stage renal disease, atrial fibrillation, schizophrenia, vascular dementia, hypothyroidism, nursing home resident."

R3's Computerized Axial Tomography (CT) scan, dated 5/27/24, documents, "New Left Hemispheric Convexity Subdural Hematoma. No significant midline shift. Redemonstrated Right Anterior Frontal Subdural Hematoma."

The Facility's Quality Care reporting form, dated 5/26/24, documents, "care plan intervention is assistance with toileting." R3's Care plan with last revision date of 7/5/24 does not document this intervention.

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S9999	Continued From page 5 R3's Nurse's Note, dated 5/28/24 at 4:20, documents, "(R3) returned to facility with a diagnosis of subdural hematoma and a referral for Hospice." R3's Nurses notes, dated 7/4/24 at 9:25 AM, documents "(R3) expired on 7/4/24 at 9:22 AM. Family and Hospice updated." On 7/23/24 at 10:42 AM, (V8) stated on 5/18/24, (V8) "was doing (V8's) morning medication pass and heard a scream. (V8) ran to the bathroom where (V8) heard (R3) screaming. (R3) told (V8) 'I fell trying to get in my chair.' (R3) was found lying on bathroom floor on (R3's) left side." (V8) stated "(V8) noticed a large bump on (R3's) forehead immediately. (V8) obtained (R3's) vitals (Temperature, Pulse, Respirations, and Blood Pressure) and called Emergency Medical Services." (V8) stated "when (V8) came to work that night on 5/18/24 at 7:23 PM, (V8) called the hospital to get an update on (R3) and was told (R3) was in the Intensive Care Unit with a subdural Hematoma." (V8) stated, "After the fall on 5/18/24, (R3) was shaky and afraid of falling when sitting on toilet. (R3) didn't like to be in bathroom alone. (V8) noticed a decline after (R3's) second fall on 5/26/24." On 7/23/24 at 3:15 PM, V12 (Director of Rehabilitation) stated, "On 5/21/24 (V12) told the Intradisciplinary team in morning meeting that (R3) should always have supervision while in bathroom." (V12) stated, "After the fall on 5/18/24, (R3) told (V12) (R3) pulled her call light in the bathroom, 'but it took too long,' so (R3) transferred self and that's when (R3) fell. When (R3) came back (5/20/24) (V12) educated all staff to not leave (R3) alone in the bathroom as (R3) was not safe."	S9999		

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On 7/23/24 at 2:34 PM, V2 (Director of Nursing) stated, "After (R3) fell on 5/18/24 and came back to the facility, nursing staff were educated to stay with (R3) while in the restroom to prevent falls. A staff member should have stayed with (R3) while in the restroom." V2 confirmed, "This intervention is not on care plan." The facility's Employee In-service, dated 5/24/24, documents, Staff educated that "no resident is to be left alone while on toilet. Provide privacy but do not leave. Especially those who need assistance." V2 stated V2 came in on third shift to In-service staff and the rest of staff were in serviced by V2 on 5/24/24, but V2 cannot find the sign in sheet.

On 7/23/24 at 1:30 PM, V6 (Nurse Consultant) stated, "The care plan was not revised after the fall on 5/18/24 to update new interventions."

On 7/23/24 at 1:00 PM, V4, Care Plan Coordinator, stated, "We have a red binder at the nurse's station that has current Care Plans. They are accessible to staff. (V4) is not aware of staff being educated to look at the binder for updates." (V4) stated "(V4) has never had staff ask (V4) where to find a care plan. Staff typically ask the nurse or other staff member questions about resident transfer status."

On 7/23/24 at 11:21 AM, V9, Registered Nurse (RN), confirmed (V9) was working when (R3) fell. (V9) stated (V9) "was called to the hallway restroom because (R3) was on the floor. A Certified Nurse's Aide (CNA) who's name (V9) can't remember put (R3) on the toilet in the hallway restroom and gave (R3) a call light to pull when finished. (R3) was alert when (V9) came into bathroom and denied hitting (R3's) head. (V9) noticed an area on (R3's) middle forehead

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that looked like a bruise, so (V9) called the physician who gave an order to send (R3) to the Emergency Room because of (R3's) past fall and taking blood thinners. (R3) never pulled the call light when (R3) was finished which wasn't usual for (R3) after the last fall." V9 stated if V9 has questions on transfers status or ADLs (Activities of Daily Living) for a resident, this facility does verbal communication, or staff must ask someone. V9 stated, "At times if a resident is alert, we ask them." V9 stated V9 was not aware of any other communication tools for resident changes or ADL function.

On 7/23/24 at 12:10 PM, V10 (Certified Nursing assistant) stated on 5/26/24, V10 put R3 on the toilet after lunch in the hallway bathroom. V10 said R3 was tired and crying. V10 said R3 asked for a new gown, so V10 gave R3 the call ligh,t and left the bathroom to get R3 a new gown, and when V10 came back the nurse said R3 was on the floor.

On 7/24/24 at 11:57 AM, V14 (Family Nurse Practitioner) stated, "It was not safe for (R3) to be left alone in the restroom because (R3) had a cognitive decline for several months prior to the fall on 5/18/24. I recommended Hospice due to (R3's) decline. (R3) had multiple medical issues related to Kidney failure and was passing out at Dialysis. I am aware staff had been told several times (R3) should not be left alone in the restroom as (R3) was impulsive and could fall. (R3's) hemoglobin was always low (R3) had anemia. A subdural bleed is usually the result of trauma. I originally brought up Hospice to previous DON (Director of Nursing) in February 2024; the DON was supposed to discuss with family. We realized (R3) was continuing to decline, however, family wasn't ready for (R3) to

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be on Hospice at that time."

On 7/24/24 at 1:00PM V2 Director of Nursing stated "I did not report the 7/26/24 fall to the state since I assumed it was the same subdural hematoma (R3) had after (R3) fell 5/18/24 which we reported."

On 7/24/24 at 1:15PM V6, RN (Registered Nurse) consultant confirmed (R3) sustained the initial bleed following the fall 5/18/24 and sustained a new bleed in a different region of the brain following the unsupervised fall 7/26/24.

R3's Nurses notes document ultimately R3 expired on hospice care 7/4/24.

The facility's "Accidents and Incidents" policy, last revised 9/6/23, states, "All accidents/incidents involving a resident shall require an incident report. The interdisciplinary team (IDT) will complete an investigation to determine root cause and implement appropriate interventions."

2. R1's Physician's Order Sheet (POS) for July 2024 includes the following diagnoses: Anxiety, History of Frost bite with Amputation to Left Lower Extremity, and Seizure Disorder.

R1's Minimum Data Set (MDS), dated 6/5/24, documents R3 is Cognitively intact and uses a walker to complete his ADLs (Activities of Daily Living). This MDS also documents R1 had functional limitations in both lower extremities.

R1's Protocol for Outside Independent Passes, dated 4/27/23 and 5/16/23, documents, "Residents are on a 30 day probationary period with regard to outside unsupervised outings. No resident will be allowed to leave the facility

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unsupervised until they are reviewed by the IDT (Intradisciplinary team) during the last day of the probationary period. However, the resident can go out with family, Power of Attorney, (POA) or guardian. Resident must notify a staff member prior to going out in the patio area or fenced area. After safety review and meeting with IDT, if deemed safe and responsible, the resident will be able to go out on walks on a limited basis in a progressive manor as safety permits." There is no documentation to support the IDT (Intradisciplinary team) met or a safety assessment was completed for R1. R1's level of safety for unsupervised outings is not addressed on R1's Care Plan. R1's substance use Disorder is not addressed on R1's Care Plan.

R1's Nurse's note, dated 3/15/24 at 3:30PM, documents, (R1) "swaying and stumbling. Alcohol smell present. Afternoon medication held. APN (Advanced Practice Nurse) notified. OK to hold. Resident left facility with walking cane transport with acquaintance car."

On 7/22/24 at 12:33PM, V5, Witness to R1's 7/14/24 fall, stated, "I was driving on a busy local road when I saw a man (R1) with a slate blue wheeled walker going down the road in the left lane of traffic. The walker looked wobbly, like maybe it was broken. I saw (R1) stumble and fall. (R1) could have been hit by a car. This is a busy road. The speed limit is 45 miles per hour. There is no sidewalk. I stopped my car and got out to help (R1). (R1) was drenched with sweat, weak, and smelled of alcohol. (R1) couldn't get out of the road, and I could not get (R1) out of the street. I called EMS (Emergency Medical Services), and a bystander helped me get (R1) to safety. (R1) told me (R1) was at his brother's trailer where (R1) 'had a few drinks and jammed

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to some music.' (R1) told me he stayed at (the facility). I called the facility. The phone rang and rang. It was about 8:30PM. The phone rang so long it stopped ringing. When I called again, they finally answered. (V7), Licensed Practical nurse (LPN) called the Administrator, and called me back stating (V7) would pick up (R1). By that time, the Fire Department arrived, but (R1) refused an ambulance. The only injury I saw was a small open area to (R1's) left leg."`

On 7/22/24 at 1:00PM, R1 stated, "The day (V5) helped me I was at my brother's trailer. We drank some alcohol. I was walking to the bus stop. The bus hadn't come, so I started to walk back to (the facility). It was hot and I fell in the road. I had to get help to get on my feet again. My foot hurt that night. I told the nurse. That's the only time I fell. Anyway, in a couple of days my foot hurt so bad I went to the Emergency Room and my foot was broke. I do leave on my own. I'm 36 years old. I was supposed to be here for rehab for my amputation and go somewhere else. I have no place else to go, and I got frost bite when I was homeless. I thought This facility was going to find me a place. Yes. I drink; wouldn't you if you were me? I have the choice of either sitting here with old people staring at the walls or going out to fish and drink. I know the door alarm code a lot of us do. I leave on my own."

R1's Nurse's Note, dated 7/14/24 at 9:00PM, documents, R1 "complained of Left stump pain 4/10 with 10 being the worse pain ever. PRN (as needed) Ibuprofen given 200MG (milligrams) one tablet administered by mouth." No follow up-documented as to response to pain medication. No notification of physician documented.

R1's hospital ER discharge, dated 7/16/24,

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S9999	Continued From page 11 documents a diagnosis of: "Nondisplaced Fracture of First Metatarsal Bone Left Foot." R1's X-ray report from the Emergency Room, dated 7/16/24 at 12:47 PM, confirms this diagnosis. On 7/23/24 at 9:00AM, R1 stated, "My walker is broke. I have told the staff, but I still have to use it." The left rear wheel of R1's slate blue walker was loose and wobbly. On 7/23/24 at 1:00PM, R1 was in the front parking lot sitting on the seat of the broken walker. R1 stated R1 was "waiting on a ride to a doctor's office." On 7/24/24 at 11:57 AM, V14 (Family Nurse Practitioner) stated, "(R1) was sober for quite a while, but I know (R1) has been leaving the facility lately and drinking. Of course that is not a safe situation for (R1). (R1's) walker should be in good repair to maintain safety." No policy for safety assessment prior to unsupervised outings was provided. (A)	S9999		