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S 000	Initial Comments Complaint Investigation 2427064/IL177571	S 000		
S9999	Final Observations Statement of Licensure Violaions : 300.610a) 300.690b) 300.1210b) 300.1210c) 300.1210d)6) This requirement was not met as evidenced by: 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. 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. Section 300.1210 General Requirements for	S9999		

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S9999	Continued From page 1 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: 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 were not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure safe resident transfers for two (R1 and R2) of three residents reviewed for falls with transfers in a sample of three. The facility also failed to report a resident fall with injury to State Agency for one (R2) of three residents reviewed for falls in a sample of three. This failure resulted in R1 and R2 being	S9999		

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sent out to the hospital. R1 suffered from pain and a left hip fracture requiring surgery. R2 suffered from pain and a left hip sprain and sacral contusion.

Findings include:

The facility's undated Safe Resident Handling/Transfers policy documents, "Policy: It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. Policy Explanation: All residents require safe handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them. While manual lifting techniques may be utilized dependent upon the resident's condition and mobility, the use of mechanical lifts are a safer alternative and should be used. Compliance Guidelines: 3. Mechanical lifting equipment or other approved transferring aids will be used based on the resident/s needs to prevent manual lifting except in medical emergencies. 4. Mechanical lifts may include equipment such as full body lifts, sit to stand lifts, or ceiling track mounted lifts (add any others that may apply). 5. Handling aids may include gait belts, transfer boards, and other devices (specify as applies)".

The facility's undated Use of Gait Belt policy documents, "Policy: It is the policy of this facility to use gait belts with residents that cannot independently ambulate or transfer for the purpose of safety. Policy Explanation and Compliance Guidelines: 1. Each nursing department employee will be given a gait belt

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during orientation ...3. It will be the responsibility of each employee to ensure they have it available for use at all times when at work."

The facility's undated Fall Prevention Program policy documents, "Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls."

The facility's undated Incidents and Accident policy documents, "Policy: It is the policy of this facility for staff to utilize (electronic) risk management to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident ...Policy Explanation: The purpose of incident reporting can include: Meeting regulatory requirements for analysis and reporting of incidents and accidents."

1. R1's current Face Sheet documents diagnoses including, but not limited to: Fracture of Unspecified part of neck of left femur; Diabetes Mellitus Type II; Unspecified Dementia, Unspecified severity with other behavioral disturbance; Weakness; History of falling; and Unsteadiness on feet.

R1's Fall Risk Evaluation, dated 7/30/24, documents R1 is a high risk for falls.

R1's Minimum Data Set/MDS Assessment, dated 7/30/24, documents R1 is cognitively intact and is dependent on staff for toilet transfers.

R1's current Care Plan includes but is not limited to "(R1) requires extensive assist of 1 (one) with toileting and ileostomy cares" and "(R1) is at risk

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for falls related to Confusion, Gait/balance problems, and Unaware of safety needs..."

R1's Fall Nursing Progress note, dated 8/31/24 at 10:30am by V7 Licensed Practical Nurse/LPN, documents, "Fall occurred on 8/31 at 9:45am in the resident's bathroom. Resident (R1) was transferring from toilet to sink with gb (grab bar) and walker. While transferring, (R1's) left leg gave out and (V6 Certified Nursing Assistant/CNA) caught resident's head from hitting the floor. Resident landed on L (left) hip. When nurse (V7) walked in the room, resident (R1) was sitting on her bottom laying against the bathroom wall. Full assessment initiated. Full range of motion in upper and lower extremities. Resident able to move both legs up and down along with her arms. Slight pain noted in L (left) hip. (V6 CNA) and nurse (V7) helped resident (R1) up to walker, no complaints of pain during that time. Resident (R1) walked back to her bed from bathroom. VS (vital signs) WNL (within normal limits). (V6) CNA denies resident hitting her head. No visible injuries noted at the time. Assisted resident back to bed."

R1's Progress note, dated 8/31/24 at 3:00pm by V7 LPN, documents, "Reassessed resident's pain and rates 8/10 pain. Noted pain in L (left) groin area. Notified V12 R1's Nurse Practitioner/NP and new order to obtain STAT (immediate) x-ray of L (left) hip/femur and Tramadol 50mg (milligrams) TID (three times per day) x (times) 3 days."

R1's Progress note, dated 8/31/24, at 7:40pm by V7 LPN, documents, "X-ray results came back and noted L (left) femoral neck fracture. Notified (V12) NP. Administered Tramadol 50mg for pain. New order to send resident to ER (Emergency

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Room) for evaluation and treatment."

R1's Progress note, dated 9/5/24, documents, "Resident arrived to facility via ambulance from (named hospital) at 5:45pm, primary diagnosis closed left hip fracture, WBAT (weight bearing as tolerated) to LLE (left lower extremity). C/o (complains of) pain 8/10, received PRN (as needed) Tramadol at 6:30pm. Resident received a Norco prior to arrival at 4:25pm. Colostomy changed today at hospital. Surgical incision to left lateral thigh with 9 staples, dry blood on dressing..."

The facility's Reportable for R1's fall on 8/31/24, documents V6 CNA's statement as, "(V6) states resident was transferring from toilet to sink with grab bar and walker. While transferring (R1's) left leg gave out and I caught her head from hitting the floor. (R1) landed on her left hip/leg. (V6) states the nurse did a full ROM (range of motion) assessment and resident c/o (complained of) minimal soreness. (R1) was pulling and trying to get up so they assisted (R1) and (R1) said I have no pain and ambulated with no difficulty."

R1's radiology report of left femur, dated 8/31/24, documents, "Results: There is a fracture involving the left femoral neck with minimal to no displacement. The joint shows no dislocation. Pubic rami are intact. Osteopenia is present."

R1's Witness Fall Investigation report, dated 8/31/24, documents, "Resident was transferring from toilet to sink with gb (grab bar) and walker. While transferring, her left leg gave out and CNA caught resident's head from hitting the floor. Resident landed on L hip. When nurse walked in the room, resident was sitting on her bottom laying against the bathroom wall. Full assessment

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initiated. Full range of motion in upper and lower extremities. Resident able to move both legs up and down along with her arms. Slight soreness noted in L hip. CNA and nurse helped resident up to walker due to resident insisting on getting up and was pulling at that time we assisted to prevent further incident, no complaints of pain during that time. Resident walked back to her bed from bathroom. VS WNL. CNA denies resident hitting her head. No visible injuries noted at the time. Assisted resident back to bed. Administered PRN (as needed) Tylenol for pain. 'I turned too fast, and my leg gave out.'"

On 9/10/24 at 11:25am, R1 sat in a wheelchair in the therapy room. R1 stated the following occurred on 8/31/24: "I went to the bathroom with (V6 Certified Nursing Assistant/CNA) and my walker. (V6) did not put a gait belt on me. There were none in my room and (V6) did not bring one with him. He stayed in the bathroom with me while I was on the toilet. I stood up holding the grab bars and (V6) pulled my pants up. I went to use hand sanitizer and he asked if I wanted to wash my hands. I turned around and did that. I shook my hands off. Then I think I turned too quickly to get paper towels and I hit the wall with my back. I slid down and couldn't grab the bar. I slid down the wall and hit the floor. (V6) caught my head as it was only about six inches from the stone floor. I couldn't get up and needed two people, so he (V6) and a nurse (V7 Licensed Practical Nurse/LPN) got me up and walked with me to the bed. Later, I went to the lobby, but by 4pm I couldn't take the pain. I went to the (local) hospital then they transferred me to (named) hospital for surgery for a left hip fracture."

On 9/10/24 at 3:05pm, V6 CNA stated the following: "She (R1) needed to use the restroom

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and empty her colostomy bag. She was in her wheelchair, and we went down to her room. (R1) was dumping out her stool into a measuring cup and I said, 'hey, let's wash our hands' and I got her up to the sink. I tried to reposition the wheelchair behind her while she washed her hands. I was in visual view of her but was hands off. She turned and then did a weird jerk and I said, 'oh snap'. (R1) fell on her left side. I was able to catch her head. The moment (R1) was on the floor I went to get my nurse (V7 LPN). (R1) insisted she could get up on her own and with a walker, so we helped her. I should not have let go of (R1) to get the wheelchair. I should have grabbed the (mechanical lift) instead of letting her walk to the wheelchair after the fall. Protocol is we (mechanical lift) after a fall. (R1) insisted and felt good to get up." V6 could not recall for sure if V6 used a gait belt for R1's transfer.

On 9/10/24 at 3:19pm, V7 LPN stated the following, "I did not witness (R1's) fall (on 8/31/24). I was doing med pass and (V6 CNA) came and grabbed me. (V6) explained that (R1) turned around to wash her hands too fast and went down. (V6) said he caught (R1's) head before hitting the floor. I went with him and assessed (R1). I should have used a (mechanical lift) to get (R1) up, but (R1) insisted on getting up with me and (V6's) help." V7 confirmed that "gb" in the progress note V7 wrote meant grab bar. V7 said, "(R1) was not wearing a gait belt. After the fall we got her up without a gait belt by going under her arms to lift her up then walked her to her bed. A gait belt would be ideal, give resident more time to wash her hands, not let go of her or have her out of site. If I'd known she had that injury I would have used the (mechanical lift). (V1) told me we are a no lift facility which means everybody is a (mechanical lift) after a fall. I did

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know that, but in the heat of the moment we thought it was just easier to help her up. (R1's) transfer status was a stand-by one assist so a gait belt should be used."

On 9/10/24 at 11:35am, V4 Physical Therapy Assistant/PTA stated that prior to (R1's) fall on 8/31/24, (R1) was receiving therapy and was a one assist with walker. (R1) was walking 75-100 feet. V4 confirmed that a gait belt is to be used for transfers and is the house-wide facility policy.

On 9/11/24 at 9:25am, R1 was lying in bed with a mechanical lift sling under her. V5 and V11 CNAs prepared to transfer R1. V5 brought the mechanical lift into R1's room. V5 and V11 hooked the lift to the sling, V5 supported R1's left leg while they lifted her up then lowered her into her wheelchair. R1 grimaced and stated her left hip hurts right where the staples are.

On 9/11/24, at 12:30pm, V1 Administrator confirmed a gait belt should have been used for R1's transfer. V1 stated that after a resident fall the staff are to use a mechanical lift to get the resident up. V1 confirmed that when V6 and V7 didn't use a mechanical lift they should have then used a gait belt to assist R1 to get off the floor. V1 stated, "We are a no lift facility, and we train staff to use a mechanical lift and they understand that."

2. R2's current Facesheet documents diagnoses including, but not limited to Diabetes Mellitus Type II; Unspecified Dementia, Unspecified severity; Obesity; Unsteadiness on feet; and Muscle Weakness (generalized).

R2's Fall Risk Evaluation, dated 7/3/24,

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documents R2 is a high risk for falls.

R2's Minimum Data Set/MDS Assessment, dated 7/3/24, documents R2 is moderately cognitively impaired; uses a wheelchair and walker; requires substantial/maximal assistance for sit to lying - the ability to move from sitting on side of bed to lying flat on the bed; and partial/moderate assistance for chair/bed-to-chair transfer - the ability to transfer to and from a bed to a chair (or wheelchair).

R2's current Care Plan documents R2 has an "ADL (Activities of Daily Living) self-care performance deficit related to Limited Mobility, confusion, multiple comorbidities and Dementia with interventions including but not limited to "Transfer: Requires extensive assist of 1-2 with gait belt and wheeled walker for stand and pivot transfers" and "(R2) is at risk for falls related to Confusion and Gait/balance problems."

R2's Progress note, dated 9/3/24 and signed by V8 Licensed Practical Nurse/LPN, documents, "Summoned to the resident room on 9/2/24 at 7:10pm. (V9) CNA (Certified Nursing Assistant) was transferring resident stand and pivot from wheelchair. When CNA was moving wheelchair out of the way resident slid out of bed onto left side of the floor and did not hit head." This note states that V12 (R2's Nurse Practitioner) ordered to send (R2) to ER (Emergency Room) to evaluate and treat..."Resident was transferred with the assist of four to stretcher and left for ER at this time."

R2's Progress note, dated 9/3/24 at 00:10am by V8 LPN, documents, "Resident returned from (named ER) had left hip and lumbar spine (back) x-ray with DX (diagnoses): left hip sprain and

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contusion of sacrum. No complaints of pain or discomfort at this time."

R2's Witness Fall Investigation report, dated 9/2/24, documents, "Resident was transferring to bed and was sitting on the side of bed. CNA (V9) moved the wheelchair out of the way to help resident put legs in bed. When CNA was moving the wheelchair, resident slip out of the bed onto her left side. Complained of left hip pain...Resident unable to give description." This report documents V9's statement as, "I was transferring resident to bed from the wheelchair stand and pivot. Resident was sitting on the side of the bed, and I moved the wheelchair out of the way so I could help resident get her legs in bed. As I was moving the wheelchair resident slid off bed and landed on her left side. Did not hit her head."

On 9/10/24 at 3:48pm, V8 Licensed Practical Nurse/LPN stated the following, "I was getting report and (V9 CNA) came up to me and said (R2) just fell. (V9) said she was transferring and (R2) was sitting on her bed. (V10 Registered Nurse/RN) and I went down there. (R2) complained of a lot of pain, back, hip and whole left side which she was laying on. (V9) did not use a gait belt and (V9) should have. (R2) is a stand and pivot. (V9) had (R2) on the bed and went to move the wheelchair to make room for (R2's) legs and as (V9) moved the wheelchair (R2) went down. (V9) should not have left (R2) to move the wheelchair. (V9) could have just pushed it out of the way. The wheelchair was over by the closet door when I walked in. (R2) had a sprain of the hip and a contusion to the sacrum. We had ordered her Tylenol 1000 mg every 6 hours as needed and I felt she needed something stronger, so we got an order for Norco."

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On 9/11/24 at 10:13am, V9 CNA stated the following: "I had taken (R2) back to bed and had her on the bed sitting. (R2) usually has to scoot back a little bit when she sits on the bed. We hadn't got back to that part. I pulled the wheelchair away to the end of the bed. Maybe she was reaching for the remote or something. (R2) fell off the bed. I turned a little bit, but was right next to her, but the wheelchair was in front of me. I helped transfer (R2) from her wheelchair to her bed. I did not have a gait belt on her. I should have used it and usually do. I had left it in the resident's room prior. When I use a gait, I usually keep my hands on the gait belt. I could have kept the wheelchair there or given her the remote. (R2's) legs were bad that day and (R2) has a hard time standing. Possibly could have prevented (this fall) if I wouldn't have taken my eyes off her. I hadn't taken care of her for a long time either." V9 confirmed that the facility policy is to use gait belts on all transfers. V9 stated, "(R2) self-transfers but needs one assist and that's where the use of the gait belt comes in. I don't trust her. I feel awful. I stayed with her until ambulance came and got her. She had pain at first in one of the hips."

R2's hospital After Visit Summary, dated 9/2/24, documents, "Reason for visit: fall. Diagnoses: Fall in elderly patient; Hip sprain, left, initial encounter; Contusion of sacrum, initial encounter. Imaging Tests: Left Hip X-ray, Lumbar Spine (Back) X-ray."

R2's September 2024 Medication Administration Record/MAR documents R2 received Tylenol 650 mg (milligrams) on 9/3/24 at 5:49am for 10/10 pain and Tramadol HCl (Hydrochloride) 50 mg at 7:35pm for 9/10 hip pain.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLURE OF MENDOTA	1201 FIRST AVENUE MENDOTA, IL 61342

(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 On 9/10/24, at 10:40am, R2 sat in a wheelchair in her room. R2 stated that she had fallen off the bed. R2 said, "I must have wanted to get up to go to the bathroom or something. The ambulance came and took me away. I hurt my buns. It still hurts when I sit." On 9/11/24, at 12:30pm, V1 Administrator stated that a gait belt should have been used for R2's transfer; (V9 CNA) got written up for not using a gait belt. Also, V1 Administrator stated V1 did not report R's fall since, "It was just a bruising and not a fracture." The facility's Employee Disciplinary Form, dated 9/2/24, documents that V9 CNA received a verbal warning for "Transferred a stand a pivot resident without the use of a gait belt." The facility's past three months of reportables do not include any for R2's incident on 9/2/24. (A)	S9999		