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	IL6001101	A. BUILDING: _____ B. WING _____	C 10/16/2024

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S 000	Initial Comments Complaint Investigation: 2448183/IL179046	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210c) 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 300.1210 General Requirements for Nursing and Personal Car 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	S9999		

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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 evidence by:

Based on observation, interview, and record review, the facility failed to provide adequate supervision, implement new care plan fall prevention/interventions, and assure current interventions were in place for 2 of 3 residents (R2 and R3) reviewed for falls in a sample of 3. This failure resulted in R2 having an unwitnessed fall and sustaining a fractured hip that required surgery to repair.

Findings include:

1. R2's Admission Record, with admission date of 09/07/24, documented R2 has diagnosis of but not limited to Dementia, osteoporosis, abnormalities of gait and mobility, and unilateral primary osteoarthritis, right knee.

R2's Minimum Data Set (MDS), dated 09/13/24, documented R2 is severely cognitively impaired with a Brief Interview of Mental Status (BIMS) of 04 out of 15 and requires partial/moderate assistance with toileting hygiene, shower/bathe, dressing of upper half of body, bed mobility, substantial/maximal assistance with dressing of the lower half of body, putting on/taking off footwear, personal hygiene, and transfer. It further documents walking was not attempted due to medical condition or safety concerns.

R2's Care Plan, with admission date of 09/07/24,

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documented R2 had an actual fall with no injury on 09/12/24 and an unsteady gate. R2's goal is she will resume usual activities without further incident through the review date. Intervention is R2 will use a bed/chair alarm.

R2's Admission Morse Fall Scale, dated 09/07/24, documented R2 had a score of 80 and was a high risk for falling. It further documented R2 had a history of falls, had more than one diagnoses on her chart, used ambulatory aides such as crutches, cane, or a walker, had a weak gait, and overestimates or forgets limits. The Morse Fall Scale ranges are as follows: High Risk 45 or higher, Moderate risk 25-44, and low risk 0-24.

R2's Progress Notes, dated 9/12/2024 at 02:15 AM, documented Incident Note: "This nurse was notified by CNA (Certified Nursing Assistant) that resident was found on the floor in the bathroom lying on her side. Nurse completed a physical and neurological assessment on resident. Resident alert, orientated per norm. Able to move all extremities freely with no response of pain or discomfort. Hand grasps equal and strong. No abrasions or abnormalities noted to head or body. Vitals taken - 98.1, 97, 165/90, 20, & 94% RA (room air). No s/s (signs/symptoms) of pain/discomfort noted. Resident assisted back to feet, then bed via CNAs and nurse. Weakness to BIL (bilateral) legs noted on walk over. Neuros initiated due to being unwitnessed. MD (doctor) and DON (Director of Nursing) notified.

R2's Post Fall Morse Fall Scale, dated 09/12/24, documented R2 had a score of 95 and was a high risk.

R2's Fall Investigation, dated 09/12/24 at 02:15 AM, was reviewed and documented Notes:

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Interdisciplinary Team (IDT): FALL: Resident attempted to take herself to the bathroom and fell. Resident has been having more difficulty walking. Short, shuffling steps. More difficulty standing up. Resident unable to say what happened at time of her fall. Range of Motion (ROM) within normal limits (WNL). No complaints of (c/o) pain or discomfort. Upon further review and discussion with IDT team, resident will be evaluated by therapy. Power of Attorney (POA) and MD updated.

R2's Progress Notes, dated 10/3/2024 at 07:38 AM, documented Nursing Note: "Resident was sitting in chair by nursing station, alarm sounded, CNA found resident on floor next to chair laying on left side. Resident was transferred back to chair via (Mechanical) lift. ROM (Range of Motion) in upper extremities wnl (within normal limits), no discomfort. Right lower ext (extremity) rom wnl, no signs of discomfort. left leg is at 90-degree bend, will not straighten. left hip rom wnl while lying, no s/s (sign and symptoms) of pain in it. resident unable to state if she hit her head or not. neuro check is wnl per her norm. hospice called and ordered to send to hospital. Ems (emergency medical services) here at 7:55am, 2 emt (emergency medical technician) transfer with lift pad from wc (wheelchair) to stretcher. hospice to call family. report called to local hospital."

R2's Fall Investigation, dated 10/03/24 at 08:06 AM, was reviewed and it documented Notes: Root Cause: resident has dementia and continues to stand and ambulate without walker or assistance of staff. Intervention: Upon return from hospital stay, staff to perform every 15-minute checks until further actions needed.

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R2's Emergency Department Provider Note, dated 10/03/24, documented 81-year-old female with h/o (history of) dementia had an unwitnessed fall at NH (nursing home). Imaging revealed a hip fracture. Pt. (patient) had been on hospice. I contacted pt's family and they opting to revoke hospice to have surgical repair of hip fracture for pain relief. Family opts to stay at this hospital. Anesthesia requested Echocardiogram prior to procedure. Orthopedic, agrees to consult. Plans for surgery Saturday AM most likely. Hospital team agrees to admit. Other incidental findings noted on computed tomography (CT) scan including pulmonary nodules, sclerotic lesion in sacrum, Lumbar (L)1 compression deformity.

R2's CT scan, dated 10/03/24, documented IMPRESSION: 1. Acute comminuted impacted intertrochanteric left proximal femur fracture.

R2's Procedure Description, dated 10/05/24, documented the operative site was identified and marked prior to taking R2 to the operating room, placed under anesthesia, and then placed onto a fracture table. V13, Surgeon then reduced the left hip to an anatomic alignment, prepped and draped the hip in a sterile fashion. They mad a small incision above the tip of the greater trochanter, dissected through the gluteal fascia, identified the tip of the greater trochanter, the opening reamer guidewire was then placed and advanced into the intramedullary canal, images were taken to confirm the position alignment of the wire, placed the gamma nail into the appropriate position, they confirmed positioning, made a small stab incision laterally advanced the trocar down to the lateral aspect of the femur, and then advanced the femoral neck guidewire into a center position, once satisfied with the positioning they got the appropriate length screw,

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placed the lag screw over the guidewire, placed the top locking screw, and then confirmed the lag screw was locked within the nail. They then utilized an outrigger device made a small stab incision laterally, advanced to the lateral aspect of the femur, drilled and filled out with an appropriate length distal locking screw. All the wounds were then irrigated, the incision was closed with skin staples, and a sterile dressing was then applied.

On 10/15/24 at 11:25 AM, V11, Certified Nursing Assistant (CNA) stated she was working on the day R2 fell and broke her hip. V11 said R2 would not stay in her wheelchair, and they had an alarm on it and her bed. She said they would give her washcloths to fold to keep her occupied, try talking with her, and putting her up at the nurse's station and she would still try to get up. V11 stated on the day she fell she was in the shower room trying to give another resident their shower and had them up in the lift when R2's alarm went off and she said she couldn't leave her resident up in the lift to go and check the alarm. V11 said they placed R2 in a public place to be better observed. She said R2 would always take of her shoes and socks, but she wasn't sure if she took them off on this day. V11 said when the alarm was going off, she wasn't sure if someone was there at the nurse's station or not. V11 stated R2 should have never been here at the facility it was the wrong place for her, and she required a lot of 1:1 attention.

On 10/15/24 at 11:46 AM, V12, CNA she was working the middle hall on the 200 side. She said she was in the first room on the left-hand side of the hall getting a resident up when she heard an alarm going off. She said she wasn't sure if anyone was at the nurse's station due to no one

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answered the alarm right away. V12 no one said they were putting anyone up at the nurse's station, so she was unaware there was anyone sitting up there. She said she covered her resident up and put his bed back down in the low position because he was also a fall risk and went out into the hall and that was when she saw R2 lying on her right side on the floor. She said the nurse was out in the dining room passing medications, so she stayed with R2 and hollered down to the nurse and she came right away to assess R2. V12 said R2 stated to her that she thought her hip was broke so they got the Hoyer lift and assisted R2 up and back into her wheelchair so the nurse could finish assessing her. V12 stated usually they are made aware when they place someone at the nurse's station but if anyone said anything she didn't hear it because she was in a room with a resident trying to get them up for breakfast. V12 said sometimes R2 requires 1:1 attention and they will call the family in to help but she said one time the family told them that is why we brought her to you.

On 10/15/24 at 3:16 PM, V6, ADON stated R2 was pretty much a 1:1 from the day she came to the facility, and they just couldn't accommodate that.

2. On 10/10/24 at 3:33 PM, R3 was sitting up in his wheelchair by the nurse's station he does not have any access to a call light where he is sitting, there were no nurses or CNAs sitting at the nurse's station, R3 did not have any type of cushion observed in his wheelchair, and there were no sensory/wheelchair alarm observed on his wheelchair.

On 10/15/24 at 10:55 AM, R3 was observed sitting in the dining room in his wheelchair. There

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were no sensory/wheelchair alarm observed and there was no (non-slip) cushion observed in his wheelchair.

R3's Admission Record, with an admission date of 06/21/24, documented R3 has diagnoses of but not limited to unspecified nondisplaced fracture of second cervical vertebra, multiple fractures of ribs, and traumatic subdural hemorrhage without loss of consciousness.

R3's MDS, dated 09/23/24, documented R3 is cognitively intact with a BIMS of 13 out of 15 and he requires partial/moderate assist with shower/bathe, dressing of lower body, transfer, independent with upper body dressing, bed mobility, substantial/maximal assistance with putting on/taking off footwear, and he is always continent of bowel and bladder.

R3's Care Plan, with admission date of 06/21/24, documented R3 has had an actual fall with no injury Poor Balance, Unsteady gait on 9/24/2024, 10/2/24-resident had another fall from w/c with no injury. Interventions include but are not limited to I have a sensor alarm in my w/c, I have (non-slip mat) in my w/c, I will be evaluated by PT, and I will be involved in the activity fall program.

On 10/15/24 at 10:55 AM, R3 verified for this surveyor he did not have his wheelchair alarm in place and that he didn't have any cushion under him. R3 stated he has had falls since being here at the facility and sometimes they will put his alarms on and sometimes they don't.

R3's Admission Morse Fall Scale, dated 06/21/24, documented R3 was a high risk for falls with a score of 55.

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R3's Electronic Medical Record and Fall/incident assessments July, August, September, and October were reviewed and documented R3 had an unwitnessed fall on 07/03/24, 07/07/24, 8/27/24, 09/01/24, 09/04/24, 10/02/24, and a witnessed fall on 09/24/24.

On 10/15/24 at 11:10 AM, V9, CNA was questioned what interventions/assistance is needed to prevent R3 from having falls? V9 stated alarms on his wheelchair and his bed, non-skid socks, activities, and they will also place him at the nurse's station to monitor him. V9 stated R3 hasn't had any falls since he has been working here (a couple of weeks). When this surveyor asked V9 if he could show me R3's alarm he stated it isn't on him now, but he usually does have them on. He said you can see it hanging from the back of his chair when it's on him. There is a pad he sits on and when he tries to stand up the alarm will sound. He said R3 will sometimes get anxious and that is when he starts to get up out of his chair.

On 10/15/24 at 12:50 PM, V6, Assistant Director of Nursing (ADON) stated she would expect the staff to make sure the resident's alarms are in place. She said they should know their patients and when they come on shift, they need to be checking to make sure the alarms are in place. V6 said they have been having an increase in falls lately due to some of the new resident's cognitive impairment.

The facility's Resident and Staff Safety Policy, dated 02/14/13, documented "Resident Safety: The Nursing home will ensure that each resident receives adequate supervision and assistance devices to prevent accidents. The intent of this provision is that the facility identifies each resent

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S9999	Continued From page 9 at risk for accidents and or falls, and adequately plans care and implements procedures to prevent accidents." The facility's Fall Prevention Policy and Procedure, not dated, documented "Purpose To provide guidelines for routine fall risk assessments and fall precautions strategies." It further documented "Policy all assessments are to be properly documented and resident specific precautions are to be taken as appropriate." (A)	S9999		