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|---|---|---|---|
| | IL6007991 | A. BUILDING: _____ B. WING _____ | C 07/18/2024 |

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| BRIA OF CHICAGO HEIGHTS | 120 WEST 26TH STREET SOUTH CHICAGO HEIGHT, IL 60411 |

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| S 000 | Initial Comments<br><br>Complaint Investigation Survey<br>#2494846/IL174595 - F689 cited<br>#2495093/IL174958 - F689 cited | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610a)<br>300.1210b)<br>300.1210d)6)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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 | S9999 | | |

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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:

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 adequately monitor and supervise a newly admitted resident with a known history of falls, confusion, and assessed to be at risk for falls. This failure applied to one (R3) of three residents reviewed for falls and resulted in R3 sustaining a laceration to her left eyebrow that required transfer to local hospital and treatment with sutures after a fall in the facility hallway.

Findings include:

R3 is a 74-year-old female admitted to the facility on 6/14/2024. R3's past medical history includes, but not limited to: unspecified dementia without psychotic disturbance, mood disturbance and anxiety, essential primary hypertension, hypothyroidism, etc.

Fall risk assessment dated 6/14/2024 scores resident as 21, indicatind a high risk for fall due to impaired memory or judgement, unsteady gait,

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and history of falls in the past 1 -6 months, status post fall and/or fracture in the past 6 months.

Minimum data set assessment (MDS) dated 6/16/2024 section C (cognitive pattern) documented that R3 has a memory problem, and R3's cognitive skills for daily decision making are moderately impaired. R3 was also assessed as having inattention with disorganized thinking. Section GG (Functional status) of the same assessment documented that R3 required partial to moderate assist for all Activities of daily Living (ADL) care and requires supervision for walking 10 to 50 feet. Interim fall care plan dated 6/14/2024 documented that R3 is at risk for falls, interventions include call light within reach, provide clutter free environment, provide proper well-maintained footwear. There was no provision for any type of assistive device for the resident.

Progress note dated 6/16/2024 at 1:03AM states the following: Staff reported to the writer that the resident was observed on the floor of the hallway sitting with a laceration to her left eyebrow with moderate bleeding. Pressure applied to area. PROM performed to bilateral upper and lower extremities without limitation. Resident transferred to wheelchair with standby assist. Resident unable to give statement of incident, 911 called for transportation to the hospital.

Ambulance run sheet dated 6/16/2024 states in part: dispatched to location for fall victim, crew found patient at the nursing station in wheelchair, nurse stated that patient was walking in the hallway when she fell and one of the residents came and told the nurse, staff did not witness the fall, patient had a 2 inch laceration above her left eyebrow.

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Hospital record dated 6/16/2024 documented in part: chief complaint fall, diagnosis laceration to left eyebrow, bleeding controlled. Under history, the document states in part: 74-year-old female brought by ambulance for evaluation of facial laceration. Patient was found on the floor in the hallway at her facility. She has a history of frequent falls, and she has known dementia. R3 underwent a laceration repair, length was documented as 4 inches, requiring some sutures.

On 7/16/2024 at 2:30PM, V3 (DON) said that she is not very familiar with R3, she came to the facility on a Friday and fell a day or two later, the family stated that resident sustained some injuries requiring sutures, facility was unable to obtain the hospital records because resident was not returning to the facility. V3 stated that she spoke to the nurse that was assigned to the resident and she said that resident was very confused, she was ambulatory with an unsteady gait, she was alerted by the CNA that the resident fell in the hallway, the fall was not witnessed.

On 7/16/2024 at 4:32PM, V20 (LPN) said that she recalls R3, she was alert with some confusion, ambulatory with an unsteady gait. Resident will be considered a fall risk due to her unsteadiness, her fall incident occurred on the night shift between 12:00 and 1:00AM, R3 was not yielding to redirection and was continuously walking up and down the hallway. V20 said that she was notified by another nurse that the resident was on the floor, when V20 arrived at the scene, she noted moderate amount of blood coming from a laceration to the resident's left eyebrow, V20 applied pressure to the site and assessed the resident, no other injuries were noted. V20 said that the bleeding continued, she called the doctor and received an order to send the resident to the

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hospital, V20 called 911 and notified the daughter/POA.

On 7/17/2024 at 1:55PM, V24 (RN) stated that she is the fall coordinator for the facility. When residents are newly admitted, the admitting nurse evaluates the resident and initiates a baseline care plan and any required interventions, the entire care plan will then be completed according to facility policy. V24 said that R3 was admitted to the facility on a Friday evening and had a fall incident on Sunday. Residents should be monitored during the night shift, the CNAs are supposed to stay close to resident's rooms for monitoring and to see the call lights. Nurses and CNAs are also supposed to round every 1 to 2 hours on residents, resident interventions should be individualized and for a new resident that is confused, and being a fall risk, staff could have tried putting her on a one-to-one supervision or have her sit in a wheelchair and put her in the nursing station.

On 7/17/2024 at 11:18AM, V27 (CNA) said that he works the 11:00 PM to 7:00 AM shift and was assigned to R3 the day she had a fall, he did not witness the fall incident because he was in another room with another resident, he was informed that the resident fell by another staff. V27 added that the CNAs are supposed to monitor the hallway, but they usually do that after rounds, while they are rounding, he does not think that anyone monitors the hallway because all the CNAs are rounding at the same time.

Fall prevention and management policy revised 07/2022 stated in part that the facility is committed to maximizing each resident's physical, mental and psychological well-being. While preventing all falls is not possible, the

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| S9999 | Continued From page 5<br>facility will identify and evaluate those residents at risk for falls, plan for preventive strategies and facilitate as safe an environment as possible.<br><br>Under guidelines, the policy states: a fall risk evaluation will be completed upon admission, readmission and quarterly, significant change and after each fall. Residents at risk for falls will have fall risk identified in the interim plan of care and the ISP with interventions implemented to minimize fall risk.<br><br>(B) | S9999 | | |