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| S 000 | Initial Comments<br><br>Investigation of Facility Reported Incident of 5/24/24/IL174269<br>Investigation of Facility Reported Incident of 6/13/24/IL174791 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations<br><br>300.610a)<br>300.1210a)<br>300.1210b)<br>300.1210c)<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>a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a | S9999 | | |

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comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

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These requirements were not met as evidenced by:

Based on interview and record reviewed the facility failed to provide supervision for one high fall risk resident who was restless and attempting to ambulate unassisted, and failed to provide clinical staff assistance to promote a safe sitting position for a high fall risk resident who was seen leaning in her wheelchair. These failures affect two of three residents (R1, R2) reviewed for supervsion and safety. These failures resulted in R1 sustaining an acute nondisplaced right femoral neck fracture and R2 sustaining a closed nondisplaced fracture of the fourth cervical vertebrae.

Findings include:

1. According to the facility incident report dated 6/13/24 R1 tried to stand from a sitting position and sat on the floor.

R1 is cognitive impaired according to his assessment dated 6/13/24, score of 3. R1's diagnosis include but are not limited to Vascular Dementia, Chronic Kidney Disease, Other Lack of Coordination, Weakness, Alcohol Dependency, Rheumatoid Arthritis, Osteoarthritis, and Spondylosis.

On 7/17/24 at 12:10PM V6, Certified Nursing Assistant (CNA), said R1 was ambulatory, he was walking around most of the shift. V6 said since V6 came at 11:00PM R1 was awake and walking around in the halls. V6 said around 2:00AM and 3:00AM R3 stood up in the hall and he was walking. V6 said R1 was in the hallway the entire night. V6 said R1 said he was waiting for a taxi. V6 said she last saw R1 when he was sitting in a

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chair near the medication room. V6 said she was in the hallway doing rounds. V6 said V6 heard him, and when V6 saw him, he was on the floor. V6 said V8, CNA, was next to R1 and was helping him at his side. V6 said we had snacks available, but V6 did not give R1 any that night. V6 said V6 did not take R1 to the bathroom that night. V6 said usually, R1 may use the bathroom or be incontinent.

On 7/17/24 at 12:32PM V8, CNA, said R1 was walking and then sitting down. V8 said V8 had asked R1 to sit and he did, but then he started walking and he fell. V8 said R1 had been sitting near the nurses station. V8 said to reach R1 when he was sitting, V8 would need to walk out and around of the nurses station. V8 said that was the first time V8 had seen R1 during the shift. V8 said V8 doesn't know if R1 slept during that shift, I did not offer him a snack or assist him to use then bathroom that shift. V8 said when R1 fell, he fell forward, when I saw him he was flat on his belly, his legs straight out, he was not on his face. V8 said V8 was at the desk doing V8's assignment, V8 was not monitoring R1.

On 7/17/24 at 5:26PM V15, Registered Nurse said on 6/13/24, R1 was placed at nurses station to monitor him. V15 said when V15 put him there, V15 was at the nurses station doing paper work. V15 said V15 doesn't know if the CNA was there. V15 said R1 was sitting in a chair. V15 said R3 was awake during the night and not wanting to sleep. So we put him a chair. V15 said they did not tell V15 that R3 was a high fall risk. V15 said V15 did not assign anyone to monitor R1 when V15 went to the restroom. V15 said V15 was not informed if he was taken to the bathroom during the shift. V15 said R1 needed assistance with ambulation. V15 said V15 was in the bathroom

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when R1 fell. V15 said he did not see R1 on the floor because R1 was standing up already when he returned to the unit.

On 7/17/24 at 2:37PM V13, Restorative Nurse, said R1 fell related to confusion and unsteady gait and he sustained an injury. V13 said V13 is not aware of interventions the staff had offered him prior to his fall. V13 said R1 may have been placed close to the nurses station. V13 said R1 could walk, but not independently, it was not safe for him. V13 said if R1 was having behaviors we would do 1 person assist for safety or if he was agitated he would need 2 persons. V13 said R1 had a hip fracture from the fall.

R1's Functional Abilities assessment dated 6/13/24 documents R1 is dependent on staff to come to a standing position from sitting in a chair and walking was not attempted, no score at the time of the assessment. R1 was documented to be dependent on staff to use a motorized wheelchair. R1's Bladder and Bowel assessment dated 6/13/24 documents he was frequently incontinent of both bowel and bladder. Health Conditions assessment dated 6/13/24 indicates R1 had a fall in the last month and up to 6 months prior to admission.

R1's Physical Therapy Notes from 6/9/24 - 6/12/24 notes R1 was able to ambulate with the use of a rolling walker and 1 therapist assistance. On 6/10/24 R1 required manual guidance and Max assistance while ambulating.

R1's care plan initiated 6/8/24 states R1 is a HIGH RISK for falls.

R1's x-ray dated 6/13/24 impression: acute nondisplaced right femoral neck fracture.

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The Facility Reported Incident report states following the fall on 6/13/24 R1 was sent to the hospital for further evaluation.

According to progress notes, R1 returned to the facility on 6/18/24 after having surgery for a right hip fracture and 7 stitches.

2. R2's diagnosis include but are not limited to Dementia, Bilateral Cataract, and Dependency on Wheelchair. R1's cognitive assessment dated 4/30/24 indicates she is severely cognitively impaired with a score of 3.

Progress notes dated 3/19/24 document R2 utilizes a reclining (brand name) chair for mobility.

On 5/24/24 R2 was seen leaning forward in her wheelchair and falling forward. R2 sustained closed fracture of cervical vertebrae.

R2's care plan initiated on 10/12/17 documents R2 is at risk for falls related to poor safety awareness secondary to Dementia and history of falls.

R2's Functional Abilities assessment dated 4/30/24 indicate she is dependent on staff for all activities of daily living.

Facility Reported Incident Report dated 5/24/24 notes R2 was leaning and fell forward onto the floor. R2 was sent to the hospital for evaluation. Facility was notified R2 was admitted with diagnosis of closed fracture of cervical vertebrae.

Progress notes dated 5/28/24 document R2 returned to the facility on 5/28/24 with diagnosis of closed nondisplaced fracture of the fourth

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cervical vertebrae and right shoulder AC joint separation.

On 7/16/24 at 1:56PM V2, Licensed Practical Nurse, said R2 leaned forward and hit the ground. V2 said R2 hit her shoulder and the left side of her forehead. V2 said V2 saw R2 first and the activity aide. V2 said V2 became aware that R2 fell because V2 heard the sound and then V2 looked. V2 said V2 had seen R2 in the TV room before the fall, but was not sure if she was awake. V2 said V2 remembers R2 was in a wheelchair. V2 said the wheelchair stayed in the upright position when R2 fell. V2 said V2 assessed R2 first, did vitals, looked at the bruising on her head and saw redness to her arm. V2 said V2 was sending R2 out because she hit her head, she went out 911. V2 said normally R2 was quiet and non verbal, needs assistance feeding, sits in the chair, does not do activity, she can watch TV. V2 said R2 is assisted by staff and requires total care. V2 said R2 is not able to stand with staff assistance. V2 said R2 was not reaching, she may have gotten tired. V2 said V2 saw her lean in her chair in the past. V2 said the activity staff was in the room when R2 fell, but she was assisting someone else on the opposite side of the room. V2 said R2 was a fall risk. V2 said R2 was at risk because she was not mobile, falls asleep in the chair, and her transfer status is dependent. V2 said R2 was found to have a fractured vertebrae and fracture to right shoulder, and upon readmission to the facility had neck brace and sling. V2 said R2 had a reclining chair as part of R2's fall prevention interventions, and V2 doesn't know if it was reclined when she fell. V2 said it should have been reclined. V2 said the reclining chair was ordered for R2.

On 7/16/24 at 2:44PM V3, Certified Nursing

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Assistant (CNA), said V3 heard R2 fall, V3 went to the TV room to see what happened. V3 said it was "a big sound, like something had fallen." V3 said V3 heard it while V3 was standing by the elevator. V3 said when V3 arrived to the TV room, V3 saw R2 on the floor. V3 said R2 had fallen from a tall wheelchair, it had an extended back, to lean back. V3 said for fall precautions we would recline her back in the chair. V3 said V3 think R2's fall "was like a dead weight fall." V3 said I don't remember what position the chair was in when R2 fell. V3 said V3 was not assigned to R2, V3 did not get her up that day.

On 7/17/24 at 10:29AM V4, Activity Aide stated V4 was in the room giving exercise classes to the resident. V4 said V4 noticed R2 was leaning and V4 adjusted her in her chair. V4 said V4 moved her so she would sit up and not be leaning. V4 said then R2 was leaning again and V4 could not get to her. V4 said R2 fell forward, it happened like in a second. V4 said V4 doesn't know what kind of chair R2 was in, it was some sort of wheelchair. V4 said it was new for her to be leaning like that.

On 7/17/24 at 1:49PM V12, Memory Care Director, said activity staff can not reposition residents. V12 said the activity staff would not use devices or recline residents in the chairs. V12 said the activity staff are not clinical. V12 said the activity staff needs to ask for assistance from a nurse or CNA if the resident needs to repositioned. V12 said none of my activity staff are CNAs.

On 7/17/24 at 2:37PM V13, Restorative Nurse, said the nurse said R2 fell from the chair. V13 said R2 leaned forward from the chair. V13 said R2 had a high back wheel chair with a taller back

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and can be reclined. V13 said V13 doesn't know if the chair was reclined when she fell. V13 said R2 used the reclining chair because she had poor trunk control. V13 said when she needs repositioning in the chair, staff should come and redirect her. V13 said CNA's or nurses, no one else, can recline the chair, the clinical team. V13 said V13 had seen her lean before. V13 said if other staff see R2 leaning, they should call a CNA and say that she is leaning. V13 said V13 had done a physical assessment in the past, to determine if the reclining chair was appropriate for her. V13 said V13 felt it was appropriate for her. V13 said V13 did not document that assessment. V13 said when completing fall investigations the restorative team is responsible for the root cause analysis. V13 said we were not documenting the root cause analysis at the time R2 had her fall.

The facility activity aide job description was reviewed. Job description does not indicate responsibility for repositioning of residents.

The facility policy management on falls dated August 2020 states the facility will assess hazard and risk develop a plan of care to address hazards and risk implement appropriate resident interventions and revise the residents plan of care in order to minimize the risk for fall incidents and or injuries to the resident. Develop a plan of care to include goals and intervention transfers. Provide this probability as appropriate for the resident.

(A)