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	IL6001093	A. BUILDING: _____ B. WING _____	C 08/15/2024

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BRANDEL HEALTH AND REHAB	2155 PFINGSTEN ROAD NORTHBROOK, IL 60062

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S 000	Initial Comments FRI of 6/6/2024/IL175033	S 000		
S9999	Final Observations Statement of Licensure Violation 300.610a) 300.1210b) 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 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.	S9999		

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S9999	Continued From page 1 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 interview and record review the facility failed to develop an effective plan with interventions to prevent falls and falls with injury for a resident identified as high risk for falls, severe cognitive impairment and assessed with decreased safety awareness. This affected one of three residents R1 reviewed for falls and fall prevention. This failure resulted in R1 having multiple falls resulting in a non-displaced hip fracture 5.11.24, and another fall and fracture on 6.5.24 Findings Include: R1 admitted in the facility on 5/6/24 and with diagnoses but not limited to History of Falling, Restless Leg Syndrome, Depressive Disorder, and Dementia. Assessed as High Risk for fall upon admission, assessment date 5/7/24. Facility Reported Incident dated 5/11/24, reads in part: R1 is supervised with walking with lack of	S9999		

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safety awareness as R1 ambulates at a fast pace. On May 11, 2024, R1's wife and personal caregiver were visiting R1. Wife asked R1 to take a walk. Then R1, wife and caregiver proceeded to walk in the hallway without asking for supervision. Upon walking in the hallway, R1 fell. R1 was experiencing pain, and was sent out to hospital, admitted with non-displaced fracture of right femur. Upon interviewing wife, wife does not know how R1 fell. The caregiver stated that R1 lost his balance. There were no staff member to witness this fall.

Hospital record dated 5/17/24, reads in part: Orthopedic surgery was consulted and recommending non operative management and admission for further care.

On 8/13/24 at 2pm, V2 (DON) stated that R1 has poor safety awareness. Wife visited with wife's caregiver and decided to walk R1 without asking for staff to assist. Walked R1 with walker and no wheelchair with them. Staff was not present at the time of the fall, it was just R1's wife and the caregiver. Educated wife and caregiver not to walk R1 without staff assistance for resident safety. R1 had right femur nondisplaced fracture. No surgical intervention needed.

Facility Reported Incident dated 6/6/24, reads in part: On 6/6/24, R1 experienced an unwitnessed fall in the dining area, R1 complained right hip pain. R1 transported to ER for further evaluation. R1 was in the dining area due to wandering. Incontinence care provided as routine care. R1 is confused and needs reminders all the time. R1 sustained a non-displaced intertrochanteric fracture of the right femur and questionable tiny avulsion fratire of the right talar dome, which likely represent the residual of an old trauma. R1

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received on 6/7/24 right transfemoral nailing/pinning surgery. R1 was discharge to facility on 6/9/24.

On 8/14/24 at 2:30PM verified with V1 (Administrator) that the incident happened on 6/5/24 at 8:30PM, and that it was reported to IDPH on 6/6/24.

Hospital record dated 6/6/24, reads in part: right hip x-ray shows non-displaced intertrochanteric fracture. Right ankle x-ray shows questionable tiny avulsion fratire of the right talar dome.

Hospital record with date of service of 6/9/24, reads in part: R1 presented to the hospital with right hip fracture and underwent Open Reduction Internal Fixation (ORIF). Found to have a nondisplaced fratire of the right greater trochanter on 5/12/24 which was deemed non-op at the time. Now with nondisplaced intertrochanteric fracture of the right femur and questionable tiny avulsion fracture identified along the medial aspect of the right talar dome.

On 8/13/24 at 2:215PM, V6 (nurse assigned on 6/5/24) stated R1 had a fall around 8pm in dining room. V6's med cart parked close by in the dining room. It happened so fast, "I picked up something on the floor and found R1 on the floor". Heard a noise and observed R1 laying on the floor. Other residents was in the dining room also. There was no CNA in the dining room when R1 fell. The CNA that was in the dining prior to the fall, was assisting another CNA who called for help with a resident in another room having behavior. Assessed R1 and complaint of right hip pain. Called MD and with order for STAT x-ray. X-ray result came back around 6am and relayed to MD to send R1 to ER for further evaluation. V6 was

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not close to R1 and per V6, staff such as CNAs alternates to watch the resident in the dining room. To staff never leave the dining room, and must be physically present and close enough to monitor and redirect resident.

R1 had another fall in the facility dated 5/27/24 at 10:15AM, reads in part: R1 was observed laying on the floor on his back, his legs were close to his dresser, there was no witness to this fall. R1 stated he slightly hit his head. R1 not on anticoagulant. Neuro check started.

On 8/14/24 at 11:53AM. V8 (Assigned Nurse for the fall incident of 5/27/24) stated that R1 already up on wheelchair. Waiting for activity. R1 was by the door of his room by the hallway, V8 reported that V8 was two rooms away from R1. CNA assigned to R1 was answering call light of another resident. "Next thing I turned around and heard a noise coming from his room and checked R1. R1 was on the floor, sitting on the floor, next to the foot board of his bed. In between wheelchair and walker. R1 stated he was trying to get something in his drawer. We keep an eye on R1 and visualized R1, R1 tends to stand up by himself. R1 was already high risk for fall upon admission. We are keeping close monitoring to redirect R1 to sit back down when observed trying to get up from wheelchair. R1 at that time of his fall needs staff supervision with ambulation and standing from wheelchair. R1 has impulsive behavior of getting up from his wheelchair on his own. We will need to remind R1 repetitively not to stand up from his wheelchair".

On 8/14/24 at 9:30AM, V7 (Therapy Director) stated that R1 was admitted (5/6/24) as moderate to maximum for transfer, bed mobility was independent, walking was contact guard to

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moderate. Eating independent, toilet transfer contact guard. Shower and dressing contact to minimum. Contact guard somebody need to be with Resident walking with using walker with wheelchair behind R1 to follow. "We did not allow the family to walk the resident. Staff will need to supervise the walking with the family. The wife had cognitive issue also and does not realized R1 has impairment. Care giver did not have the wheelchair behind R1 when they walked him that time". R1 was in Speech therapy for cognition. 5/6/24, 5/17/24: moderate to severe cognitive deficit with the SLUMS (cognitive test that assesses short term memory) score of 7/30. Readmission on 6/9/24 R1 score was 8/30 meaning moderate to severe cognitive deficit.

Speech Therapy evaluation note (dated 5/11/24) documented as Reason for referral was exacerbation of decreased safety awareness, cognitive impairment, decreased functional ability tolerance, decreased socialization and decreased ability to respond to cues and instruction.

On 8/13/24 at 2:40PM, V3 (ADON) stated that the fall on 5/11/24 were unwitnessed that the staff was not present at the time of R1's fall. Family came to visit and decided to walk R1. R1 had fallen. Probably due to R1 has a tendency to walk fast and maybe that's what happened during the first fall. R1 is cognitively impaired and very confused and with poor safety awareness, and that is the reason why R1 was being watch closely. Fall on 6/5/24, R1 was in the dining room along with other residents. CNA was supervising residents in the dining, but needed to leave to help another CNA who was having a behavior. The assigned nurse in that unit, was in the nurse's station getting endorsement, but the nurses station is enclosed room and needed to

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have the door open to see resident, but still physically far from residents in the dining room, just visual. Nurse heard the noise and observed resident on the floor. "I cannot recall asking the nurse if the door was open at the time of the fall".

On 8/14/24 at 9:20AM, memory care unit observation of the nurse's station with V3 (ADON. Nurse's station in the dining room enclosed room, can see the dining room but still far physically to any residents present in the dining room. Must also need to have the door open to have visual of the residents in the dining room.

R1's care plan dated 5/10/24, reads in part: R1 is at risk for fall d/t weakness, unsteady transition and walking balance, Right hip and low back pain (s/p Right hip Fracture - non-surgical), daily use of antidepressant, impaired memory and safety judgment (forgetful), and a history of fall at home and nasal bone Fracture within 30 days before admission and one fall since admission to BHR on 5-11-24 resulted in Rt hip Fx (non-surgical). He scored 80 on Fall Risk assessment at re-admission. Unwitnessed fall on 5/11/2024, 05/27/24 and on 06/05/24. Intervention dated 5/26/24: Staff will take R1 to activities during daytime to stay in supervised environment.

Managing Falls and Fall Risk policy dated 3/2018, reads in part: Based on previous evaluation and current data, the staff will identify interventions related to resident's specific risks and causes to try and prevent resident from falling and to try to minimize complication from falling.
The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with history of falls.

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S9999	Continued From page 7 If a systematic evaluation of resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions. If the falling recurs despite initial interventions, staff will implement additional or different intervention of indicate why the current approach remains relevant. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature category of falling, until falling is reduced of stopped, or until the reason for the continuation of the falling is identified as avoidable. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. (A)	S9999		