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LITTLE SISTERS OF THE POOR	2325 NORTH LAKEWOOD AVENUE CHICAGO, IL 60614

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S 000	Initial Comments Investigation of Facility Reported Incident of July 13, 2024/IL176000	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.690a) 300.690b) 300.690c) 300.1210a) 300.1210b)5) 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 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the	S9999		

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S9999	Continued From page 1 progress notes or nurse's notes of that resident. 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. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. Section 300.1210 General Requirements for Nursing and Personal Care 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 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	S9999		

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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.

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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.

This REQUIREMENT is not met as evidenced by:

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A. Based upon observation, interview, and record review the facility failed to ensure that (R1's) care plan was congruent with the fall risk assessment, failed to implement fall prevention interventions and failed to provide supervision to three of three residents (R1, R2, R3) reviewed for falls. These failures resulted a laceration to the left lower leg from R1's 6/25/24 fall. These failures also resulted a laceration, abrasion, and bruises to the forehead, bridge of nose, and both arms along with a C1 fracture from R1's 7/13/24 fall.

B. Based upon record review and interview the facility failed to report to the state surveying agency a serious incident/accident involving a laceration requiring steri-strips, failed to report serious injuries including fracture/laceration within regulatory requirements, and failed to document actual injuries in the progress notes for one of three residents (R1) reviewed for falls.

Findings include:

1.) The facility's fall incident log affirms R1 fell on 6/25/24 and 7/13/24. The facility falls incident log includes R1's (6/25/24) laceration to left lower leg. The facility falls incident log includes R1's (7/13/24) C1 fracture with multiple injuries on arms and head.

R1's (6/25/24) incident report states "Unwitnessed Fall." Called to resident room by CNA (Certified Nursing Assistant). Upon entering resident room noted sitting on her bottom with both legs extended out in front of her, with hands palm side down with upper body erect next to closet. Noted moderate amount of blood from open old wound on lower inner left leg. Resident

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states she was getting her walker and lost her balance, states "I hit my leg on my walker when I fell." Injury: laceration to inner lower left leg. Predisposing factors: gait imbalance, improper footwear, using wheeled walker.

R1's (6/25/24) progress notes state Doctor here and seen skin tear (incongruent with actual injury) to left lower leg. It is 3.5cm (Centimeters) long x 0.5cm wide. Steri-strips in place.

R1's (7/13/24) incident report states "Unwitnessed Fall." Resident was sitting behind the door close to the closet. Blood was dripping from her forehead. Injury: open area top of scalp. Predisposing factors: confused, gait imbalance, ambulating without assist, improper footwear.

R1's (7/13/24) progress notes state (4:42pm) CNA (Certified Nursing Assistant) came to NOD (Nurse on Duty) and informed that resident is on the floor. NOD went to resident room and notices she was sitting on the floor behind the entry door, close to the closet and leaning on right elbow. Blood was dripping form the tip of the nose. NOD noticed injury on forehead pressure was put on the injury. NOD assessed for other injuries, there were none.

R1's (7/13/24) final injury investigation report states resident returned from hospital with a fracture of C1. Resident also noted with laceration/abrasion/bruises to forehead, nose bridge and both arms. Left arm covered with steri-strips [R1's laceration/abrasion and/or bruises were not documented in the progress notes]. The state surveying agency was notified of R1's (7/13/24) injuries on 7/22/24 (9 days after

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the incident).

R1 is 103 years old with diagnoses include bilateral hearing loss, atrial fibrillation, chronic kidney disease and osteoarthritis.

R1's (7/22/24) functional status affirms resident is dependent on staff for chair/bed to chair transfers and toilet transfers.

R1's (6/20/24) admission fall risk assessment determined a score of 10 (high risk).

R1's care plan states resident is a medium risk for falls [R1 is "high risk" - per fall assessment] due to impaired balance, osteoarthritis, chronic shoulders contracture related to torn rotator cuff and history of falling. (6/25/24) Resident fell and sustained laceration to left leg. Interventions: Re-educated to call and wait for help. Staff educated to place call light within reach and remind resident to call for help. (7/13/24) Fall with injury to forehead and nose. Returned from ER (Emergency Room) with cervical fracture. Interventions: Nursing staff will continue to check on resident frequently especially when she's in her room. Bring resident to the Nurse's station area for close observation during morning/evening shift change and as needed.

On 8/27/24 at 12:15pm, V3 (CNA) affirmed that she's assigned to R1. Surveyor inquired about R1's fall prevention interventions. V3 stated "She (R1) stays supervised in the glass room here (pointing to the glass enclosed room - adjacent the Nurse's station) or in the dining room. If she's in bed she has the call light and there's regular rounds.

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R1's (7/22/24) BIMS (Brief Interview Mental Status) determined a score of 11 (moderate impairment).

On 8/27/24 at 12:21pm, V4 (CNA) was observed seated next to R1 in the dining room. Surveyor inquired about R1's fall prevention interventions. V4 stated "We (staff) just round on her (R1)." Surveyor inquired if R1 can walk. V4 responded "She (R1) uses the wheelchair." R1 was noted to be wearing a neck brace, a large dressing was covering her forehead, and bruises were observed across the bridge of the nose and cheeks. Surveyor inquired how R1 fell. R1 stated "I don't remember. When did I fall?" V4 responded "You (R1) fell I think in July [6 weeks prior]. She (R1) looks much better now. She looked bad when she came back from the hospital."

On 8/27/24 at 2:49pm, surveyor observed R1 (alone) in the (1st floor) glass enclosed room adjacent the Nurse's station. R1 was seated in a recliner watching television however a call light was not observed in the room.

On 8/27/24 at approximately 2:51pm, surveyor inquired if the glass enclosed room (where R1 was placed) has a call light available. V3 (CNA) stated "We do not."

On 8/28/24 at 10:56am, surveyor inquired if R1's (6/25/24) laceration was reported to the state surveying agency. V2 (Director of Nursing/DON) stated "No, there was no injury for 6/25." V2 reviewed R1's (6/25/24) incident report and stated, "I thought it was no injury, I did not know about that."

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S9999	Continued From page 7 On 8/28/24 at 12:05pm, surveyor inquired about R1's (7/13/24) incident. V2 (DON) stated "She (R1) just moved in not too long ago. She told us she fell once before coming here from home. I try to allow her to do things without limiting her too much and she had a fall." Surveyor inquired what fall prevention interventions were implemented post R1's fall. V2 responded "We did invite her to activities to see what she likes doing, CNAs monitor her quite closely." Surveyor inquired what staff are required to do prior to leaving R1 in a room. V2 replied "We just keep an eye on her and if she uses the call light, we go in her room." Surveyor inquired how dependent residents can request help if they are not provided a call light. V2 stated "They (residents) have a call light. They all have a call light right next to them." Surveyor inquired if there's a call light in the (1st floor) glass room. V2 responded "There's no call light in the glass room." Surveyor inquired about the regulatory requirement for reporting serious injuries. V2 (DON) stated "To report it within 24 hours with the preliminary and the final report after 5 days." Surveyor inquired why R1's (7/13/24) final report was submitted 9 days after the incident. V2 responded "To be honest, I do not know what happened. I think the smart sheet was not working and we tried to fax it, but I guess that was not working too so I had to fax it again." Surveyor inquired why the documentation in the progress notes was incongruent with actual injuries and/or non-descriptive. V2 affirmed the Nurses need to be re-educated. The fall incident/accident reporting policy (revised 08/2017) states DON/Designee will submit a preliminary fall report to the state within 24 hours of fall with major injury and final report will be submitted within five (5) days of incident.	S9999		

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2.) The facility fall incident log affirms R2 fell on 6/29/24 in the bedroom.

R2's (6/29/24) incident report states "Unwitnessed Fall." CNA called Nurse to resident. Noted resident on his knees next to the bed with both arms on the bed and the wheelchair behind. Resident said, "I was trying to get in bed and fell on my knees." Noted slight redness at the right knee. Predisposing factors: gait imbalance, impaired memory, during transfer.

R2 is 91 years old with diagnoses which include dementia, cognitive communication deficit, generalized muscle weakness, lack of coordination, abnormalities of gait/mobility and history of falling.

R2's (5/28/24) functional status affirms substantial assistance is required for chair/bed to chair transfer and toilet transfer.

R2's (6/4/24) fall risk assessment determined a score of 8 (moderate risk).

R2's (11/14/18) care plan states resident is high risk for falls related to gait/balance problems, history of fall with right hip fracture, alert/oriented x 1-2 with periods of forgetfulness, has tendency of transferring/toileting self without calling for help. Intervention: (6/29/24) Bring resident to his room when ready to go to bed. Resident has an ADL (Activities of Daily Living) self-care performance deficit related to impaired balance, lack of coordination and cognitive communication impairment. Intervention: Low bed due to risk for injury secondary to tendency to get up from bed without calling for help.

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R2's (5/28/24) BIMS determined a score of 5 (severe impairment).

On 8/27/24 at 1:47pm, R2 was observed alone in the room lying in bed. R2's bed was not in low position. Surveyor inquired how R2 fell on 6/24/29. R2 stated "I fell down and got back up. I stepped off a curb to get across the street. The sole of my shoe got loose, and it tripped me." Surveyor inquired if R2 was injured when he fell. R2 responded "Yeah, I hurt my arm."

On 8/27/24 at 1:51pm, surveyor inquired about R2's cognitive status. V6 (Registered Nurse/RN) stated, "He's alert times 2 and at times he's confused." Surveyor inquired if R2 can walk. V6 responded "No, he's in the wheelchair and needs assistance." Surveyor inquired about R2's fall prevention interventions. V6 replied "I think bed in lowest position and assist with transfer." Surveyor inquired what staff should implement when R2 is placed in bed. V6 stated "When he's in bed, the bed should be in the lowest position with the call light in reach."

On 8/27/24 at 1:54pm, surveyor inquired if R2's bed was in low position prior to V3 (CNA) entering the room. V3 stated "No, it was mid-way about."

3.) The facility fall incident log affirms R3 fell on 7/12/24 in the bedroom.

R3 is 96 years old with diagnoses which include vascular dementia, age related osteoarthritis, psychotic disturbance, mood disturbance and anxiety.

R3's (5/20/24) BIMS determined a score of 6

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(severe impairment).

R3's (5/20/24) functional status affirms substantial assistance is required for chair/bed to chair transfer and toilet transfer.

R3's (5/20/24) quarterly fall risk assessment determined a score of 16 (high risk).

R3's care plan includes unwitnessed falls on the following dates: 12/13/23, 12/27/23, 1/2/24, 1/10/24, 3/25/24, 4/11/24, 4/19/24, 5/8/24, 5/15/24, and 7/12/24. Interventions: (1/2/24) Nursing staff members will take turns every 30 minutes and sit with resident in her room from 8pm to 10pm for close observation to help assist with her needs.

R3's (7/12/24) incident report states (8:40pm) writer called to resident room by CNA. Resident observed sitting upright on floor between the wheelchair and the bed. Resident states she just slid off the bed while trying to get into her wheelchair to go to the bathroom. No visible injuries observed. Resident reminded to use call light for assistance. Predisposing factors: gait imbalance during transfer. [Per R3's care plan - Nursing staff were supposed to be sitting with resident from 8pm-10pm].

On 8/27/24 at 1:42pm, R3 was observed alone in the room lying in bed asleep however the bed was not in low position. The height of R3's bed frame was noted to be near the seat of the wheelchair (which was adjacent the bed).

On 8/27/24 at 1:44pm, V5 (CNA) affirmed she's assigned to R3. Surveyor inquired about R3's fall prevention interventions. V5 stated "We check on her every 2 hours. Sometimes we just sit her

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S9999	Continued From page 11 (R3) up here (Nurse's station) with us (staff) so we can monitor her and take her to the bathroom. We (staff) make sure her (R3's) bed is lowered to the floor." The falls prevention program (revised 08/2017) states the resident care plan will alert the staff to the following: enhanced direct observation of resident. Ensure that the call light is always within reach for those who comprehend its use as documented on the care plan. "A"	S9999		