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	IL6011746	A. BUILDING: _____ B. WING _____	C 09/12/2024

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S 000	Initial Comments Facility Reported Incidents: of 8/10/2024-IL176826 of 8/17/2024-IL177141	S 000		
S9999	Final Observations Statement of Licensure FindingViolations: 300.610a) 300.1210b) 300.1210d)3) 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	S9999		

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care and personal care shall be provided to each 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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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 meet as evidenced by:

Based on observation, interview, and record review, the facility failed to adequately supervise residents assessed as being at risk for falls and in the dementia unit, failed to make sure that fall interventions were implemented for 2 residents (R2 and R3) and failed to have any base line fall intervention/ adequate supervision for a newly admitted resident with history of falls (R1). These failures affected three (R1, R2 and R3) of five residents reviewed for falls/injury. These failures resulted in R1 having a fall in the dining that resulted in a right femur fracture, requiring surgery; R2 had a fall in her room and sustained

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a femur fracture requiring a surgical procedure; and R3 had a fall in her room and sustained a right distal clavicle fracture, which required treatment at a local hospital.

Findings include:

1. R1 is 88 years old admitted to the facility on 8/9/2024, past medical history includes, but not limited to other specified sepsis, fracture of unspecified part of neck of right femur subsequent encounter for closed fracture with routine healing, muscle wasting, other lack of coordination, dementia cognitive communication disorder, dysphagia oropharyngeal phase, insomnia, unsteadiness on feet, etc.

On 9/10/2024 at 10:20AM, R1 was observed in the dining room in a wheelchair with peers, awake and alert with some confusion not able to answer any questions but was asking if his wife is here.

Minimum Data Set (MDS) assessment dated 8/10/2024 section C (cognitive patterns) score R1 with a BIMs of 2, section GG (functional abilities) of the same assessment coded R1 as requiring partial/moderate assistance to substantial/maximal assistance for all Activities of Daily Living (ADL) needs.

Progress note dated 8/10/2024 at 14:19:49, documented that R1's wife informed a staff that R1 has had 5 falls in the past, this information was communicated to a nurse practitioner. Physician progress note dated 8/9/2024 documented that R1 was in the hospital for low blood pressure and has been experiencing bradycardia for some months, plan of care indicated fall precautions. Base line care plan

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dated 8/9/2024 indicated that R1 is cognitively impaired, needed assistance with ADLs, incontinent of bowel and bladder, but did not have any provision for supervision or fall precaution.

Facility reportable incident dated 8/10/2024 stated that resident was in the dining room with family, approximately 5 minutes after family left, R1 was noted lying on the floor in the dining room on his right side. R1 was sent to the hospital, diagnostic test at the hospital revealed a right femur fracture.

On 9/9/2024 at 3:11PM, V5 (LPN) said that the day R1 had a fall, the family was visiting with him in his room, they got ready to go and wheeled resident to the dining room because it was close to dinner time. V5 was passing medications, left for a few seconds to get something from the medication room and heard a sound, she ran out from the medication room and saw R1 on the floor, V5 said that he did not see when the family members left.

On 9/10/2024 at 10:38AM, V10 (Family member) said that she was not present when R1 had a fall and did not push him to the dining room. She visited R1 with her daughter. They were there all day. V10 received a call about an hour after they left the facility informing her that R1 fell, one of the aides pushed him to the dining room for dinner to the table, R1 got up and fell. V10 said that she does not recall being in the dining room at all. R1 was previously in an assisted living and kept on falling, he came to this facility for rehabilitation due to frequent falls.

On 9/10/2024 at 11:27AM, V11 (C.N.A) said that she is familiar with R1 and was assigned to him the day he had a fall. It was dinner time, R1 got

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his tray, V11 went to go pass a tray in the hallway. There was no other C.N.A in the dining room, V11 did not see R1's family members at all. There were about 5 other residents in the room, V11 was informed by the nurse that R1 was on the floor.

On 9/9/2024 at 4:31PM, V9 (C.N.A) said that he is familiar with R1 but did not witness resident's fall. V9 was passing trays in the hallway when the nurse called him to assist in getting resident up from the floor. V9 said that R1 was in the dining room, there were other residents also. There should have been another C.N.A in the dining room but V9 is not sure.

On 9/11/2024 at 11:39AM, V14 (LPN/Restorative Nurse) said that when the facility gets a new resident, herself and the three restorative CNAs will assess the resident to determine what type of interventions they need and will put it in the care card in the resident's room. The assessment is usually done the same day or the following day depending on when the resident arrives at the facility but is done as soon as possible. V14 said that R1 came on a weekend and fell the following day, she did not even see him before he went to the hospital, V14 is not sure if they placed a wheelchair and floor mat in R1's room but stated that R1 could have been monitored closely until his activity level is determined. For the second floor (dementia unit), V14 said that all the residents are out of the room and in activity, the fall incidents on that floor all boils down to supervision.

2. R2 is a 93-year-old female who has resided at the facility since 2022 with past medical history of Fracture of unspecified part of neck of left femur, encounter for other orthopedic aftercare,

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dysphagia oropharyngeal phase, muscle wasting and atrophy, unspecified fall sequela, difficulty walking, shortness of breath, dementia, Alzheimer's disease, need for assistance with personal care, unsteadiness on feet, etc.

Facility reported incident dated 8/23/2024 documented that resident was observed on the floor in her room and complained of pain to the left lower extremity, X-ray revealed a left femur fracture, R2 was sent to local hospital for further evaluation. Hospital record dated 8/18/2024 states in part, 93-year-old female...presents to ED from nursing home after sustaining a mechanical fall. Per nursing home staff, resident was walking to the bathroom, this morning, patient did not want to bear weight on the left lower extremity and staff noticed that the left lower extremity was externally rotated and shortened.

During the Facility Reported Incident investigation on 9/9/2024 at 11:40AM, R5 was observed in bed, bed was noted to be very high, resident stated that he does not know where his call light is, surveyor observed the call light on the floor, behind resident's head of bed. At 11:50AM, Surveyor presented this observation to V3 (LPN) who said that resident's bed is not supposed to be that high, V3 let the bed down to the lowest position and picked up resident's call light from the floor behind his bed.

On 9/11/2024 at 10:45AM, R6 was observed in bed sleeping, bed was very high, wheelchair at bedside. At 12:00PM, surveyor presented this observation to V14 (LPN) who went and lowered resident's bed to the floor...adding that resident's bed is supposed to be lowered to the floor when she is in bed.

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Fall risk assessment dated 5/3/2024 scored R2 as 15, indicating high risk for falls, MDS assessment dated 5/31/2024, section C (cognitive) scored R2 with a BIMs of 2, section GG (functional abilities) of the same assessment indicated that R2 is dependent on staff for all ADL cares, including rolling from left to right, sit to lying, transfers and ambulation. Section H (bowel and bladder) documented that R2 is frequently incontinent of bowel and bladder. Fall care plan dated 7/25/2024 indicated that R2 is a high risk for falls, interventions include, R2 needs a safe environment, a working and reachable call light, bed in low position, slide rails as ordered, handrails on walls, etc.

Per record review, R2 had a fall on 7/24/2024 in the dining room while walking to find a seat for breakfast. R2 was readmitted to the facility on 8/22/2024 post ORIF related to left femur fracture, R2 had another fall in her room on 8/28/2024 while going to the bathroom. Physiatry note dated 9/8/2024 documented that R2 was noted to have functional decline because of the hospitalization. Fall care plan dated 7/25/2024 states that R2 is a high risk for falls related to her diagnosis of low back pain, dementia, Alzheimer's, etc. Interventions includes, R2 needs a safe environment with even floors free from spills, clutter, bed in low position, call light within reach, slide rails as ordered, handrails on walls, etc.

On 9/10/2024 at 10:50AM, V15 (LPN) said that she works afternoon and night shift, she is familiar with R2, resident is confused, was assigned to her the day she had a fall. The C.N.A changed the resident who was in bed, later she was found on the floor by the door, her call light was within reach, and her bed was low. R2 walks

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and eats by herself, does not use wheelchair or walker and not able to use the call light, V15 is not sure if the resident has a floor mat, R2 could not explain what happened, just nodded no to pain assessment.

3. R3 is 95 years old and has resided at the facility since 2021, past medical history includes Metabolic encephalopathy, other intervertebral disc degeneration thoracic region, fracture of unspecified part of right clavicle, complete rotator cuff tear or rupture of right shoulder, fall from bed, essential primary hypertension, weakness, cognitive communication deficit, hypotension, etc.

Facility Reported Incident dated 7/25/2024 stated in part that at approximately 5am, R3 was observed on the floor in her room, next to her bed, R3 was noted with a laceration to the right side of face and complained of right shoulder pain. R3 was sent to the hospital and an X-ray showed a right distal clavicle fracture.

MDS assessment dated 7/2/2024 scored R3 with a BIMs score of 6, section GG of the same assessment indicated that R3 uses a walker for ambulation, independent for eating but requires substantial to maximal assistance from staff for most ADL cares, and requires partial to moderate assistance for transfers, including rolling from left to right, lying to sitting and sit to stand, R3 requires supervision to touching assistance for all ambulation. Section H of the same assessment indicated that R3 is always incontinent of bowel and bladder.

Care plan dated 7/2/2024 indicated that R3 is at high risk for falls related to confusion, gait/balance problems, incontinence, unaware of safety needs, etc. Interventions include bed in low

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position, call light within reach. Bilateral floor mats while in bed and wing mattress was initiated on 7/26/2024, after resident's injury.

On 9/11/2024 at 3:26PM, V18 (LPN) said that she is familiar with R3 and was assigned to her the day she had a fall. V18 responded to resident yelling for help, she does not use her call light, none of the residents on the second floor uses their call light. V18 said that R3 gets up and goes to the bathroom by herself with her walker, V18 cannot tell exactly how the resident got the injury, she documented that the bed was low, but maybe it was not to the lowest for the resident to sustain a fracture. V18 is not sure the last time resident was seen prior to the fall; she was passing medication at the time.

A document presented by V1 (Administrator) titled Fall- clinical protocol (undated) stated in part that as part of the initial assessment, the physician will help identify individuals with a history of falls and risk factors for subsequent falling.
a. Staff will ask the resident and the caregiver or family about a history of falling.
b. The staff and physician should document in the medical record a history of one or more recent falls.
Under monitoring and follow-up, the document states in part that the staff and physician will document the individual's response to interventions intended to reduce falling or the consequences of falling. If the individual continues to fall, the staff and physician will re-evaluate the situation and consider other possible reasons for the resident's falling.

(A)