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	IL6011571	A. BUILDING: _____ B. WING _____	C 10/10/2024

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S 000	Initial Comments Investigation of Facility Reported Incident of 9/28/24/IL179174 Investigation of Facility Reported Incident of 9/29/24/IL179179	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 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 300.1210 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.

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.

These Regulations are not met as evidenced by:

Based on observation, interview, and record review the facility failed to develop and implement fall interventions and safety measures, provide effective supervision to prevent a fall, and thoroughly investigate falls for two (R2, R3) of three residents reviewed for falls in the sample list of four. These failures resulted in R2 sustaining two falls with head lacerations that required suture and staple closure.

Findings include:

1.) R2's Admission Minimum Data Set (MDS) dated 9/23/24 documents R2 admitted to the facility on 9/13/24. R2 had moderate cognitive impairment, was always incontinent of bowel and bladder, and required dependence on staff for toileting, moving from sitting to standing, and with

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chair/bed transfers. R2's Nursing Notes document R2 expired on 10/8/24.

R2's Fall Risk Assessment dated 9/13/24 documents R2 as a high fall risk, R2 would overestimate or forget limits, R2 was bedbound and did not walk.

R2's Hospice Comprehensive Assessment and Plan of Care Update Report dated 9/19/24 documents R2 admitted to hospice on 9/13/24 with a history of multiple falls. This care plan documents R2 as weak and drowsy, and a fall risk. This care plan documents R2 had increased anxiety about getting up from bed but was too lethargic to be up safely.

R2's Care Plan dated 9/12/24 documents R2 had impaired self-performance of Activities of Daily Living and requires two staff for transfers. This care plan documents R2 as a high fall risk and includes interventions dated 9/12/24 for appropriate footwear, keeping items and call light within reach, orientation to room, anticipate and meet resident's needs, follow facility's fall protocol, review past falls to determine root cause, remove potential causes, and educate family and caregivers of potential causes. R2's Care Plan dated 9/18/24 documents R2 had a fall and includes an intervention dated 9/17/24 to bring R2 to the common area when awake and anxious. and interventions dated 9/18/24 to encourage R2 to ask for assistance, fall prevention program, hospice to provide bolsters (padded raised edge) to bed and high rise fall mats, and place frequently used items in reach.

R2's Nursing Note dated 9/17/2024 at 5:42 AM documents R2 was restless throughout the night, often found sideways in bed, R2 tried to get up by

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himself, denied pain/discomfort, was easily directed back to bed, and the call light was within reach. There is no documentation that any new fall or safety interventions were implemented at this time. R2's Nursing Note dated 9/17/24 at 11:28 AM documents R2 was found lying on the right side of the floor, beside R2's bed, and the overbed table was away from the bed. R2's incontinence brief was wet, R2 was barefoot, and R2 had a skin tear to the left hand. R2 reported that he was reaching for his phone and fell out of bed. The post fall intervention is to bring R2 to the common area when anxious. There are no other documented new safety interventions that were developed and implemented to keep R2 safe if R2 fell out of bed.

R2's Nursing Note dated 9/18/2024 at 12:07 AM documents R2 was found on the floor face down, between the wall and the bed. R2 had multiple skin tears to right forearm, left elbow, and left hand, a large laceration/hematoma (bruising/swelling) to his right forehead, and a large hematoma to his left knee. This note documents the cause of the fall as R2 was very restless and fell out of bed causing R2 to hit his head on the wall and baseboard, and the post fall intervention was to put the bed in lowest position.

R2's Emergency Room Notes dated 9/18/24 document R2 presented to the Emergency Room after a reported fall. R2 reported that he has occasional leg pain and weakness, and that R2's legs gave out as he was trying to get to the bathroom. This note documents R2 appears to have struck his head and R2 had a 2-centimeter laceration with 3-millimeter depth to the right forehead that required four sutures to close.

R2's Fall Investigation, provided by V2 Director of

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Nursing (DON), documents R2 had an unwitnessed fall from bed on 9/17/24 at 11:00 PM and sustained a head laceration. This investigation documents V3 Licensed Practical Nurse (LPN) reported R2 had been restless the entire shift, PRN (as needed) medications were administered, R2 was last observed in bed sleeping approximately 15 minutes prior to the fall and the bed was at knee level. This investigation documents V8 LPN administered Ativan at 8:15 PM for anxiety/restlessness. This investigation documents staff will bring R2 to the common area when he is anxious/restless as the new post fall intervention.

R2's Nursing Note dated 9/29/24 at 11:41 PM documents R2 was found lying on the floor on his right side with his right arm underneath of him. R2 had a large laceration to the top of his head, a large hematoma to the right forehead, and a large skin to tear to his right elbow.

R2's Emergency Room Notes dated 9/29/24 documents R2 presented to the emergency room with dementia, R2 had fallen out of his wheelchair and hit his head. R2 had a 6-centimeter curved laceration to the top of his head that required 13 staples to close.

R2's 9/29/24 Fall Investigation, provided by V2, documents on 9/29/24 around 6:10 PM R2 had an unwitnessed fall from his reclining geriatric chair and sustained a head laceration. This investigation documents V3 LPN saw R2 in the geriatric chair in the television room with some restlessness approximately five minutes prior to the fall. R2 was given scheduled anxiety medication at 4:41 PM. This investigation documents R2 attempted to get out of his chair without assistance causing R2 to fall and hit his

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head on another resident's (R4) chair. This investigation documents R2's anxiety and cognition have declined since his admission, and he continues to have poor safety awareness. Hospice consultation and evaluation of medications was the post fall intervention. There is no documentation that R2 was offered/given pain medication prior to the fall.

R2's fall investigations were not thoroughly completed to include the last time R2 was toileted or provided incontinence cares prior to R2's falls to determine if this was a contributing factor.

On 10/10/24 at 9:46 AM there was a thick fall mat folded up in the hallway outside of R2's room, and V8 LPN confirmed this was R2's fall mat. V8 recalled R2 and described R2 as very restless, stripping off his clothing and trying to get out of his chair. V8 stated staff would get R2 up in the morning and he would be trying to crawl out of bed at that time. V8 stated on 9/17/24 R2 was up in his chair until 7:30-8:00 PM, R2's bed was in the lowest position, but R2 did not use fall mats on the floor at that time. V8 stated the fall mats and bolsters were implemented after the falls on 9/17/24.

On 10/10/24 between 11:29 AM and 11:47 AM V3 LPN stated the first week R2 admitted he would try to get out of bed on his own and take himself to the bathroom. V3 confirmed R2 was a high fall risk. V2 stated usually if R2 was fidgety it was a sign that he needed to be toileted and that helped calm him. V3 stated R2 had an unwitnessed fall on the evening of 9/17/24 during shift change; R2 had been very "fidgety" that day, up and down from chair/bed, and R2 was given Ativan. V3 stated V3 saw R2 in bed asleep approximately 15 minutes prior to the fall, R2's bed was

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approximately knee height in the lowest position, but it was a hospice bed, so it did not go as low as the facility's beds. V3 confirmed R2 was found between the bed and the wall and sustained a head laceration. V3 stated a fall mat probably would have helped prevent R2's injury, but hospice didn't bring in the thick fall mat until after R2's fall. V3 stated on 9/29/24 R2 had an unwitnessed fall from his reclining geriatric chair while sitting in the television area, and R4 reported that R2 struck R2's head on R4's wheelchair during the fall. V3 stated R2's chair was reclined back because R2 would try and touch R2's feet. V3 described R2 as being a little "fidgety" leaning forward in his chair that night, and staff told him to sit back and relax. V3 stated R2 almost needed constant supervision, which is why we frequently had R2 sit at the nurses' station where staff frequently passed by. V3 confirmed there was no staff directly supervising R2 when R2 fell. V3 stated other than someone sitting there watching R2 and providing one to one supervision, I don't know what else could have been done to prevent his fall. V3 was asked if V3 administered any medications to address R2's restlessness, and V3 stated R2's scheduled Ativan was given at 4:30 PM.

On 10/10/24 at 12:19 PM V9 Certified Nursing Assistant (CNA) stated on 9/29/24 V9 witnessed R2 leaning forward in his chair a few times prior to R2's fall and V9, as well as other staff, told R2 to "sit back". V9 stated V9 did not witness R2's fall.

On 10/10/24 at 2:59 PM V2 DON stated when R2 admitted R2 walked with assistance of two staff and then had a decline within a few days and began using the geriatric chair. V2 stated R2 had a decline between 9/17/24 and 9/18/24. V2 stated

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V2 was not aware that R2 was restless and swinging his legs over the side of the bed on the night prior to R2's 9/17/24 falls. V2 stated if the night nurse would have reported that to V2, V2 probably would have implemented the floor fall mats at that time. V2 stated the fall mats and bolsters were implemented on 9/18/24 as a post fall intervention. V2 confirmed there were no new safety interventions implemented prior to R2's fall on 9/17/24. V2 confirmed R2's fall investigations do not identify when R2 was last toileted or provided incontinence cares prior to each fall and confirmed R2's falls were unwitnessed. V2 stated staff should have given pain medication if R2 was restless. V2 confirmed there is no documentation that R2 was administered pain medication prior to the 9/29/24 fall and confirmed restlessness can be a sign of pain. V2 confirmed staff should have supervised R2 or laid R2 down to address R2's restlessness. V2 stated hospice evaluated R2's medications after the 9/29/24 fall and Dilaudid (pain medication) was scheduled routinely. On 10/10/24 at 4:20 PM V2 stated R2 fell on the morning of 9/17/24 and the post fall intervention was to bring R2 to the common area when restless and bolsters to his bed. V2 stated R2's bolsters were not applied until the next day when provided by hospice.

On 10/10/24 at 3:49 PM V13 Nurse Practitioner confirmed the facility should develop and implement new safety interventions when there are changes in a resident's condition that increase the risk of falling and injury. V13 stated a floor mat possibly could have prevented R2's injury when he fell from bed. V13 stated if Ativan is given and is ineffective, then pain should be considered as a possible contributing factor of restlessness. V13 confirmed R2's head lacerations would be consistent with an injury

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sustained from a fall.

2.) R3's MDS (minimum data set) dated 10/1/24 documents R3 has severe cognitive impairment, R3 requires substantial/maximal staff assistance for sitting to standing and bed/chair transfers. R3's Fall Risk Assessment dated 6/28/24 documents R3 as high risk for falls.

R3's Care Plan dated 11/14/23 documents R3 has a history of falls and includes an intervention dated 6/28/24 to offer to lay R3 down after lunch and an intervention dated 9/7/24 for staff re-education on fall interventions.

R3's Fall Investigation dated 9/7/24 documents the following: R3 had an unwitnessed fall at approximately 2:30 PM when R3 was found sitting on her knees on the floor against her bed without injury. R3 reported R3 was attempting to get into bed. R3 self-propels her wheelchair throughout the facility and into her room and does not ask for assistance with transferring to bed or the toilet. Staff have been educated to offer to lay R3 down after lunch to prevent R3 from attempting to self-transfer into bed. The root cause of the fall was R3 attempted to self-transfer and staff were re-educated on R3's care plan and the need to lay R3 down to help minimize falls.

On 10/10/24 at 9:53 AM R3 was sitting in a wheelchair on the 100 hallway, which is on the opposite end of the facility of where R3 resides. On 10/10/24 at 1:11 PM V7 CNA applied a gait belt and transferred R3 from the wheelchair onto the toilet. R3 attempted to self-transfer from the toilet and V7 stated "that is why we have to stay with her."

On 10/10/24 at 1:56 PM V14 CNA stated V14

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found R3 on the floor of her room the day she fell, and V14 was R3's assigned CNA that day. V14 stated it looked like R3 had tried to self-transfer. V14 stated R3 was toileted after lunch that day, but V14 did not offer to lay R3 down. V14 stated that is not something that R3 likes to do, so it is not offered. V14 stated no education was provided to V14 regarding R3's fall, but the facility may have conducted an in-service on R3's fall interventions.

On 10/10/24 at 2:59 PM V2 DON stated R3's fall was unwitnessed in R3's room when R3 attempted to self-transfer into bed. V2 confirmed V14 did not offer to lay R3 down after lunch, which was a post fall intervention per R3's care plan. V2 stated R3's 9/7/24 post fall intervention was staff re-education on R3's fall interventions and to offer to lay R3 down after meals.

The facility's Fall Risk Assessment dated 8/2/17 documents "1. Assess resident for potential of being a high-risk faller. 2. Care Plan accordingly."

The facility's Accidents & Incidents policy dated November 2023 documents "The Charge Nurse must conduct an immediate investigation of the accident/incident and implement immediate appropriate interventions to affected parties." "The DON/Designee will conduct an investigation of the accident/incident. Findings will be indicated on the Accident/Incident Report Form in appropriate area." "The IDT (Interdisciplinary Team) will be notified of the accident/incident to stay appropriate changes may be made to the care plan as needed."

(B)