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	IL6005276	A. BUILDING: _____ B. WING _____	C 02/20/2024

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S 000	Initial Comments Investigation to Facility Reported Incident of 2-5-2024/IL170013	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b)5) 300.1210c) 300.1210d)6) 300.2210b)2) 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 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	S9999		

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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. Restorative measures shall include, at a minimum, the following procedures:

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:

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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.

Section 300.2210 Maintenance

b) Each facility shall:

2) Maintain all electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems in safe, clean and functioning condition. This shall include regular inspections of these systems.

These requirements were not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure the safety of a resident while ambulating in the shower room. This applies to one of three residents (R1) in the sample of three reviewed for safety and supervision. This failure resulted in R1 falling and sustaining a fractured right humerus, a fractured nose and a right frontal lobe brain hemorrhage.

The findings include:

The facility face sheet for R1 shows she has diagnoses to include congestive heart failure, hypertension, chronic kidney disease and has a history of falls. The facility assessment dated 1/18/24 for R1 shows her to be cognitively intact and uses a walker for ambulation. The same assessment shows R1 requires moderate

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assistance with showering. The fall risk assessment dated 1/8/24 shows R1 to be at a high risk for falls.

The facility state report dated 2/6/24 shows R1 was walking into the shower room for her shower when she fell and obtained fractures to her right arm, a laceration to her right side of her forehead and a skin tear to her right arm. The report shows R1 was transferred to the local emergency room.

On 2/20/24 at 10:00 AM, R1 was observed in her wheel chair with her right arm in a cast, a large scabbed area to her right fore head and bruising to her face. R1 said she was walking with her walker into the shower room for her shower with V5 CNA (Certified Nursing Assistant) walking behind her. R1 said she was not wearing a gait belt as one was not offered to her. R1 said there was a blanket on the ground where she was supposed to walk. R1 said she did not know why there was a blanket on the ground where she was walking. R1 said the blanket was wrinkled up and she must have tripped over it. R1 said if she had been wearing a gait belt, V5 would have had something to grab to try and keep her from falling so hard on the floor of the shower room. R1 asked, "Why would they have a blanket on the floor?" R1 said she had to be transferred to the hospital and now she needs help with things she used to be able to do for herself. R1 said the injuries have caused her a lot of pain.

On 2/20/24 at 10:15 AM, V5 said she had prepared the shower room for R1's shower by turning on the water to warm up, locked the wheels of the shower chair and placed a blanket down on the floor to absorb the water collecting on the floor. She then went and got R1 and was

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walking with R1 into the shower room to give her a shower. V5 said R1 was walking to the shower chair and she had asked R1 to stop so she could get next to R1, but R1 did not stop and kept walking towards the shower. V5 said R1 fell to the ground. V5 said it happened very quickly and she attempted to grab R1's waist to stop the fall but was not able to. V5 said if R1 had been wearing a gait belt she would have had something to grab her with and maybe she wouldn't have fallen so hard. V5 said R1 always refuses to use the gait belt.

On 2/20/24 at 11:20 AM, V4 RN (Registered Nurse) said she responded to the shower room after R1 fell. V4 said R1 was lying on her right side and blood was seen on her head. V4 said a blanket was observed on the floor of the shower room near R1's walker. V4 said R1 was not wearing a gait belt. V4 said when 911 arrived at the facility a skin tear to her right arm was observed as well as her right wrist looked misshaped. V4 said R1 was confused after the fall for about 5 minutes, but then became more aware of what was going on.

On 2/20/24 at 12:08 PM, V6 CNA said she has just left the shower room when R1 and V5 walked in. V6 said she was in the hall and heard V5 ask R1 to stop and then she heard R1 fall. V6 said she ran into the shower room to help, and she saw R1 lying on the floor on her right side. V6 said she saw a blanket on the floor near where R1 had fallen and R1 was not wearing a gait belt.

On 2/20/24 at 12:25 PM, V3 Medical Director said he was not present when R1 fell and can only say what he was told. V3 said he was told R1 refused the gait belt, but this could have helped prevent the fall or lessened the severity of the fall. V3

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said he was told R1 was given instructions about a wet towel on the floor and R1 was not responding to the instructions. V3 believes R1 was experiencing an altered mental status around the time of the fall. R1's labs at the hospital showed evidence of it but no further testing was done at the hospital.

On 2/20/24 at 12:45 PM, V2 Director of Nursing said a gait belt should be used, but R1 refuses to wear a gait belt. V2 said she expects the staff to clean up the shower rooms before use. Remove excess linen and make sure the floor is free of clutter and water.

On 2/20/24 at 12:50PM, V1 Administrator said it is not a safe practice to have a blanket on the floor of the shower room. At 1:55 PM, V1 said after the fall, the facility re-enacted the incident and discovered the shower was leaking out onto the floor, and that is why a towel was being used on the floor.

A nursing narrative note from the hospital R1 was first sent to on 2/5/24 shows a phone call was placed to the facility regarding the fall. The note shows the facility RN, V4 telling the hospital nurse that R1 was walking into the bathroom and there was a bath blanket on the floor. The notes goes on to show the hospital discovered R1 had a nasal fracture, a brain hemorrhage and a fracture to her right elbow.

The emergency department note dated 2/5/24 for R1 shows the facility was called regarding the fall and were told R1 walking in the bathroom with a walker and her walker got caught and she tripped and fell forward on her face, hitting her head and face against the floor. The note goes on to show R1 was transferred to another facility for a higher

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level of care.

The x-ray report dated 2/5/24 for R1 shows a fracture to the distal humerus. The CAT scan dated 2/5/24 shows a nasal fracture and a suspected hemorrhage to the right frontal lobe of the brain.

The neurosurgery notes from the second hospital R1 was transferred to dated 2/6/24 shows R1 was receiving assistance with a shower and had walked over a crumpled up towel with her walker and she fell onto the floor. The notes also show R1 had a right frontal hemorrhage.

The facility care plan dated 11/15/2019 for R1 shows R1 requires one staff participation with transfers with walker. R1 prefers to not have a gait belt during ambulation and transfers. The intervention was updated after the fall on 2/5/24 to show education to resident on safety and importance of gait belt use. The same care plan also shows an intervention that R1 requires a safe environment with even floors free from spills and or clutter...

The nursing progress note dated 2/5/24 shows R1 fell in the shower room. R1 was observed on the floor lying on her right side. R1's right arm was pinned under her body, and a small pool of red blood near her head. 911 was called and when the paramedics arrived and moved R1, a skin tear was observed to her right arm that was bleeding, bruising to her right hand and purple bruising to her right temple and right cheek. R1 was transferred to the hospital.

The facility fall policy with a revision date of 9/17/2019 shows the facility shall ensure that a fall management program will be maintained to

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S9999	Continued From page 7 reduce the incidence of falls and risk of injury to the resident and promote independence and safety. (A)	S9999		