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S 000	Initial Comments Facilty Reported Incident of 3/10/2024/IL170853	S 000		
S9999	Final Observations Statement of Licensure Violations: 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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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 are not met as evidenced by:

Based on interviews and record reviews, the facility failed to provide adequate supervision for 1 confused resident [R1] who is a high fall risk out of 3 [R1, R2, R3] residents reviewed for falls. This failure resulted in R1 being found on the bathroom floor bleeding to the back of the head. R1 was transferred to the hospital and R1 received laceration repair with staples.

Findings Include:

R1's clinical record indicates in part the following: R1 is a 84-year-old admitted to the facility on 2/6/24 with admitting medical diagnosis include but not limited to- right closed femur fracture, abnormal gait and mobility, weakness, cerebral infarction, aphasia following cerebral infarction, traumatic hemorrhage cerebral without the loss of consciousness, muscle wasting and atrophy, dementia with mood disturbance, mood affective disorder, fall on/from stairs, essential hypertension, and osteo-arthritis. R1's Minimum Data Set Brief Interview for Mental Status [BIMS] score [04] indicates R1 is severely cognitively impaired.

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R1's After Care Visit Summary form hospital emergency department dated 3/9/24, documents in part:
-Diagnosis of injury to head, initial encounter
-Laceration repair with staples

R1's Care Plan documents in part-R1's fall risk behaviors are manifested by her attempts of self-toileting, and self-transfers from bed/wheelchair unassisted and poor safety awareness.

R1's progress notes documented in part:

V8 [Registered Nurse] Note: 2/14/24 at 5:41AM-R1 is requiring one on one assistance throughout the night to monitor for attempting to get out of bed. R1 is a high fall risk. PRN Xanax given and ineffective.

V9 [Restorative Aide] Note: 02/14/2024 at 11:48 AM -R1 participated in transfer exercises today. Aide applied a gait belt prior to transfer exercises to ensure resident's safety. R1 stood three times with the assistance of two restorative aides. R1 needed extensive assistance to reach a standing position then was able to stand for 5-10 seconds before asking to sit down.

V12 [Licensed Practical Nurse] Note: 2/21/24 at 4:08 PM-R1 alert requires redirection and 1:1 at times combative during patient care pain management effective at this time requires assist x 2 staff to complete ADL's and transfers.

V10- [Social Service Director] Note: 02/23/2024 at 01:42 am- R1 scored a 5/15 BIMS which indicates that she is severely impaired for her cognition and needs consistent cueing and

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redirection during daily ADL care. R1 also needs close monitoring due to fall risk and poor safety awareness.

V7 [Registered Nurse] Note: 3/9/24 at 10:07PM: 9PM V7 was called into R1's room because R1 was not in bed. R1 was found inside her bathroom with the door closed and the lights off. R1's head was underneath the bathroom sink and feet were up against the door. There was blood between R1's head and the toilet and on the right side of the sink. R1 was facing the toilet laying on her right side. There was blood on the back of R1's head. Upon further inspection, there was also blood on the opposite side of the wall to the bathroom and on the floor by R1's closet. R1 had about half inch laceration to the back of R1's head which had dried blood around it. There was only dried blood on the back of R1's head.

On 4/6/24 at 9:55AM V3 [R1's Family Member] stated, "Two years ago, R1 had a stroke that affected her mobility and speech. The end of January 2024, R1 fell at home in our basement, fractured her hip and had surgery for hip repair. R1 was admitted to the facility for rehab services at the beginning of February. R1 completed therapy, but now lives here. I can't take R1 home until she can walk without falling. I am not able to monitor R1 continuously at home, I felt her being here would be safer for R1. I come and visit with R1 every day, I arrive after breakfast, but stay until 7PM, which is her bedtime. On 3/9/24, not to soon after I left the facility I received a phone call, the nurse told me R1 got out of bed and looked outside her bedroom door in the hallway, then went into her bathroom, fell, and hit her head. R1 was bleeding from her head and was sent to the emergency room and received some stapes to the back of her head. R1 probably was at the

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door looking for assistance to go to the bathroom, but she is not able to communicate her needs since her stroke. She cannot talk but understands what you are saying to her and knows what she needs but has a hard time telling me or staff what she needs. R1 needs constant supervision since her stroke and last fall at home. R1 does not know how to use her call light, to call for assistance. I come every day to sit with my wife and monitor her closely and to give the staff a break. After R1 fell the last time, the facility placed a monitoring device in R1's room to help prevent another fall. I'll show you how it works." Surveyor observed V3 lay down on R1's bed and got up. Once V3 got out of the bed the speaker came on and said to please wait for assistance, and nursing staff came into the room.

On 4/6/24 at 10:18 AM, V4 [Agency Certified Nurse Assistant] stated, "I been working here through an agency for a month. I am familiar with R1. R1 is alert to self, however she needs constant supervision. When R1's family member is not here, I need to bring R1 out of her room into activities. R1 tries to stand up and walk all the time, even during activities. There are times when I try to hold onto R1 so she does not fall, R1 would try to hit me, so staff must be careful. When R1 is sleeping the staff take turns sitting in the chair outside her door to monitor R1 closely since her last fall."

On 4/6/24 at 10:33 AM, V5 [Agency Licensed Practical Nurse] stated, "I been working here for eight months through an agency. I am familiar with R1. She is alert to self, not able to communicate verbally her needs, but I try figure out what she needs. R1 does not have a communication board. Due to R1 not placing on her call light for assistance, and not able to

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verbalize her needs, the nursing staff provides close constant monitoring. R1 repetitively tries to stand up by scooting to the edge of her wheelchair and pulling on other furniture to try and stand up. I give frequent verbal ques not to stand and try to figure out what R1 needs or want. Some of R1's fall interventions are, R1 has the fall alert system in her room. It is a sensor that monitor's R1's movements when exiting the bed or chair. The alarm goes off on this phone the nurses carry and the tablets that the certified nursing assistance carry 30 to 65 seconds before the resident stands. This has been in place since her latest fall. Also, low bed, and floor mats on each side of her bed."

On 4/6/24 at 1:01 PM V1 [Administrator] stated, "R1's after care visit indicate there was a CT of the head without contrast. The hospital did not send any further paperwork in regard to the results of the CT scan of R1's head."

On 4/6/24 at 1:18 PM, V1 stated, "The Director of Nursing [V2] is out of town on vacation and is unavailable. However, I reached out to V2, and he said the hospital did not send the results and he [V2] did not contact the hospital for R1's CT scan of the head results. I called the hospital, and the medical record department is closed today."

On 4/6/24 at 2:52 PM, V12 [Licensed Practical Nurse] stated, "During R1's admission to the facility R1 was alert x3, verbal and able to express her needs, there were times R1 had periods of confusion. R1 was admitted to the Medicare unit for rehab services. The staff rotated and sat outside her door to always monitor R1 closely, because R1 would not use her call light for assistance. R1 did not fall on the Medicare unit, she fell on the long-term care unit.

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I have not worked with R1 since her move to the other unit.

On 4/6/24 at 2:55PM, V6 [Certified Nurse Assistant] stated, "I am familiar with R1. She is alert to self, confused and combative towards staff. R1 is a high fall risk. I have never seen R1 walk. R1 needs frequent reminders, she will scoot to the edge of the wheelchair and while in bed, she would move her legs while in bed trying to get out. On 3/9/24, I checked on R1 around 6PM, and R1 was dry. Around 8:40 PM, I was making rounds and I went into R1's room and noticed she was not in her bed and the bathroom door was closed. I went out to the nurse station and asked coworkers if anyone knew where R1 was at. Everyone said they did not know where R1 was at. I went back to R1's room and tried to open the bathroom door, but the door could not open. I pushed the door in a little more and saw R1 laying on the bathroom door, I yelled out R1 was on the floor. I asked R1 to slide her foot off the door, and she did. R1 was positioned under the sink, and blood was on the floor. V7 [Registered Nurse] came into the bathroom and assessed R1, and 911 was called. R1 is not able use her call light, needed two-person assist for transfers and toileting. Some fall interventions for R1 were low bed, call light in reach, floor mat on each side of the bed. After her last fall, now she has the fall monitoring censor in her room. The system detects R1 having movement from one position, the alarm will go off on my tablet and will talk out loud to R1 to remind her not to get up and help is on the way."

On 4/6/24 at 3:10 PM, V7 [Registered Nurse] stated, "R1 was admitted post fall surgery on her hip. R1 is alert x 1-2, at times she's very confused and combative. R1 has diagnosis of dementia.

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She cannot voice her needs, we must monitor R1 closely, she is high fall risk. On 3/9/24, when I started my shift, R1 was in her room with V3 [R1's Family Member]. Around 730PM, V3 left the facility, I remember seeing him leave. I was in the hallway passing medication. A few minutes later V3 called me on the phone and said that he left R1's bed up, it was not in the lowest position. I was in a room with another resident and forgot to go check on R1. I completed passing medications, I had already given R1 her medication earlier when V3 was here. Around 9pm, V6 asked me if I knew where R1 was at, because she was not in the room. V6 and I went back to R1's room, and V6 told me that R1 was on the bathroom floor. R1 was laying on the floor with her head under the sink and her feet were next to the door. The bathroom lights were off, and she was facing the toilet. There was blood on the floor, the blood was dry and there was a smear of blood on the bedroom wall across from hallway and some more blood near the hallway door at the bottom near the floor door of her closet. R1 could have fallen in the bedroom on the floor near the closet and again in the bathroom or crawled on the bathroom, I am not sure. During my assessment of R1, there was a nice size of a round dried spot of blood on the back of her head. The blood was dried in her hair, I could not see where the blood came from. The area looked like it was starting to scab over. I looked over all R1's extremities, and she was able to move them. The charge nurse came to see R1 and called 911, due to her head injury and R1 takes a blood thinner. R1 returned back to the facility with several staples. Now, R1 has the fall senor monitoring system, and it has been helping us monitor R1 more closely."

On 4/6/24 at 3:40 PM, V1 stated, "In R1's

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conclusion of the fall, we looked at video tape and saw V3 left and closed the bedroom door. In two minutes, she poked her head out looking in the hallway. I think she fell soon as V3 left due to blood. V3 called back and said he left the bed up. I don't know if that was the cause of the fall. I don't think the fall could have been prevented because she fell within minutes of, V3 leaving. V3 told staff she was in bed when he left. Even if V7 went to check on R1, after V3 called her, I believe R1 had already fallen. R1 receives close monitoring and supervision, with the new fall system sensor, she has not fallen."

On 4/7/24 at 10:12 AM, V11 [R1's Physician] stated, "R1 is alert and very confused. R1 needs close supervision and monitoring. Prior to R1's fall I was receiving frequent phone calls regarding R1 being agitated. I started R1 on several medication with the consent of V3, and they seem to be helping R1. The facility staff does a great job monitoring R1, however no one can sit with R1 24 hours 7days per week. I don't think R1's fall was avoidable because she is impulsive. Since the fall and medications, R1 has been calmer, and less agitated."

Policy documented in part: Fall Management dated 3/3/19. -The purpose for identification of fall risk factors and interventions that may be used to manage and decrease the number of falls, therefore preventing resident injury. -Upon admission, review hospital discharge records, transfer sheets, other data regarding the resident's history of, or risk factors related to falls. -Fall history in the past three months, ambulation, gait, and balance.

(B)

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