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S 000	Initial Comments Complaint Investigation #2463664/IL172973	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1010i) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain	S9999		

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of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid procedures.

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 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

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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:

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 were not met as evidenced by:

Failures at this level required more than one deficient practice statement.

A. Based on observation, interview and record review the facility failed to implement fall interventions and provide a safe transfer for a severely cognitively impaired resident at risk for falls. The facility failed to follow therapy recommendations for R1's transfer and delayed treatment of R1's injuries and provide medical care timely after falls for (R4). Failing to follow

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therapy recommendations for R1's transfer resulted in R1 falling backwards and R1 hitting R1's head on the floor and R1 sustaining an Occipital Fracture, Left Hip Fracture, Subarachnoid Hemorrhage (traumatic), Traumatic Intraparenchymal Hemorrhage, and Traumatic Subdural Hematoma. R1 subsequently died on 5/16/24 while on Hospice care. These failures affect two (R1 & R4) of four residents reviewed for falls on the sample list of four residents.

Findings include:

1. R1's Electronic Medical Record (EMR) reviewed on 5/14/24 documents R1's new diagnosis of Left Humerus Fracture from 5/1/24 fall, Occipital Fracture, Left Hip Fracture, Subarachnoid Hemorrhage (traumatic), Traumatic Intraparenchymal Hemorrhage, and Traumatic Subdural Hematoma from 5/5/24 fall and past medical history of Atrial Fibrillation, Weakness, Need for Assistance with Personal Care, Dementia, History of Falling, Repeated Falls, Convulsions, Inflammatory Spondylopathy Lumbar Region, Trans Ischemic Attack (TIA) and Cerebral Infarction.

R1's Minimum Data Set (MDS) dated 4/5/24 documents R1 as severely cognitively impaired. This same MDS documents R1 as requiring supervision for transfers, bathing, mobility, eating, personal hygiene and walking.

R1's Care Plan intervention dated 11/10/21 instructs staff to place walker in front of R1 for visual cue and 4/21/23 intervention instructs staff to inform (R1) what you are doing and what is expected of her, apply gait belt, and give verbal/visual cues as needed for safe transfer

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technique. This same careplan does not include R1's transfer status.

R1's Physician Order Sheet (POS) dated May 2024 documents a physician order for Plavix (anti-platelet medication) 75 milligrams (mg) daily.

R1's Nurse Progress Note dated 5/1/24 at 4:47 AM documents "(R1) motion alarm sounding. (R1) had fallen in bathroom. (R1) Sitting on bilateral buttocks with both legs extended in front of body. (R1) stating that she had hit back of head on bathroom wall. When asked what (R1) was attempting to do stated "I was going to the bathroom, I have to go." Assisted from floor with two assist and gait belt. Bathroom cares provided. Ice pack applied to head. Emergency Services (EMS) called due to (R1) hitting head and taking Plavix. Initially denied pain, approximately five minutes later began complaining of pain to Left Upper Extremity (LUE)."

R1's X Ray report dated 5/1/24 documents "Reason for exam is Shoulder pain from a fall. Summary: Displaced Fracture Proximal Left Humerus."

R1's Physical Therapy Treatment Encounter dated 5/1/24 (after R1 returned from emergency room after 5/1/24 fall) documents R1 is not to use a walker and staff are to use a gait belt with transfers while keeping R1's Left Upper Extremity (LUE) immobilized and non-weight bearing due to R1's Left Humerus Fracture sustained in 5/1/24 fall.

R1's Nurse Progress Note dated 5/5/24 at 6:00 AM documents "(R1) was ambulating to the bathroom with walker with (V8) CNA when (R1)

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stopped responding to (V8) CNA and fell backwards. (V8) CNA was unable to catch (R1). (R1) noted to be in a post-ictal like state. (V8) CNA reported that resident did hit head. (R1) began to become more alert and endorsed pain in her left arm which is currently in a sling due to a humerus fracture. (R1) assisted up via staff and placed in bed."

R1's Nurse Progress Note dated 5/5/24 at 10:44 AM documents "(R1) sent out to emergency room. (V22) (Registered Nurse) RN told this nurse that (R1) had a fall last night and hit her head. (R1) unable to put weight on Left Leg and cries out in pain. (V8) CNA told this writer when (R1) fell (V8) CNA noticed (R1's) eyes rolling to the back of head and gagging. (R1) has altered mental status, decreased level of consciousness (LOC) and unable to keep eyes open and respond."

R1's Hospital Record dated 5/5/24-5/8/24 documents R1 transferred to this hospital's trauma unit via air transfer from community hospital due to a mechanism of fall. The record documents "(R1) is a 93 year old female with multiple prior falls who fell at facility again today (5/5) and subsequently developed progressive altered mental status (AMS) and is incomprehensible moaning at this time." This same report documents R1 showed tenderness to her Posterior Scalp and her pupils were pinpoint bilaterally. This same report documents R1's Computerized Tomography (CT) results as "Acute Sub Arachnoid Hematoma along the bilateral frontal lobes, five millimeter (mm) Left Convexity Acute Subdural Hematoma, three (millimeter) mm Rightward midline shift, Right Parietal Lobe chronic infarction and Nondepressed Left Occipital Bone Fracture."

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This same report documents "This is a significant brain injury and is not survivable in her condition. 93 year old woman status post fall now with multifocal Subarachnoid and Holohemispheric Left Subdural Hematoma. In the setting of age, significant prior stroke, and Dementia-this is a non-survivable injury."

R1's Final Incident Report to State Agency dated 5/5/24 documents R1 fell on 5/5/24 at 5:10 AM while being transferred by staff to the bathroom. (V8) CNA was ambulating with (R1) to the bathroom when (R1) stopped responding to V8 CNA, stared forward and did not blink. R1 fell backwards before (V8) could catch her. (R1) appeared to be in a post-ictal state, mentation slowly improved and staff assisted (R1) up and into bed. (R1) given pain medication. R1 obtained a 'Hemorrhage, Fractured Occipital Bone and Left Hip Fracture."

R1's Physician Progress Note dated 5/9/24 documents. "(R1) Readmitted on 05/08/2024 post fall at facility, hit her head and has skull fracture with Subdural bleed. Is pending Hospice admission for comfort cares."

On 5/14/24 at 3:00 PM R1 was laying in bed with eyes closed. R1's brows were furrowed and hands were laying on top of covers in a clenched position.

The Nurse Progress note dated 5/16/24 at 10:45 am documents R1 died at the facility.

On 5/14/24 at 10:48 AM V12 Certified Nurse Aide (CNA) stated V12 came on duty the early morning of 5/5/24 and heard 'commotion' from R1's room. V12 stated "I went to (R1's) room and saw (R1) laying on the floor with her feet towards

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the bathroom door and her head was towards the room door. (R1) was laying on her back. (R1's) eyes were going back and forth real fast. (V8) CNA told me that (V8) was taking (R1) to the bathroom and (R1) fell straight back and hit her head hard two or three times. (R1) did not have a gait belt on and I didn't see one in the room. (V2) Director of Nurses (DON) told us (V8, V12) to get R1 up and lay her on (R1's) bed so we did. (R1) wasn't walking very well. (R1) was still pretty out of it. (R1) was vomiting and I was afraid she was going to choke on her own vomit so I got her laid on her side on the bed. (R1) was coughing and choking. It was so scary. We (V8, V12) told (V2) about (R1) vomiting and gagging. (V2) had stepped out of the room to get the IPAD to call the telehealth doctor."

On 5/14/24 at 1:05 PM V2 Director of Nurses (DON) stated V8 Certified Nurse Aide (CNA) was walking R1 to the bathroom. V2 stated R1 quit responding when V8 opened the bathroom door. V2 stated V2 was told R1 had a blank stare and then fell backwards. V2 DON stated V2 was at the nurses station when R1 fell. V2 stated "When I saw (R1), she was laying on her back on the floor with her head towards the door and her feet towards the bathroom. (R1) was somewhat responsive but not as much as usual. (R1) was complaining of pain in her Left Arm. They (V8, V12) got (R1) back to bed. I gave (R1) a pain pill which she took orally. (R1) seemed very drowsy but was able to answer some basic questions. I had left the room to get the IPAD to call telehealth. When I returned with the IPAD, (R1) was laying in bed and looked like she was resting ok. I didn't see a gait belt laying around anywhere or on (R1). The telehealth doctor was able to see (R1) laying in bed with her eyes closed and gave orders to keep monitoring her

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and return the call if (R1's) mentation changes." V2 DON stated R1 had a post-ictal stare, only moved her hands and made a 'm-m-m' noise. V2 DON stated V2 did not see R1 vomit but did observe R1 'swallow hard' several times as if she was trying to swallow something. V2 stated V2 re-assessed R1 and found no changes in her mentation until the time V2 left that morning at 6:20 AM. V2 stated (V22 Registered Nurse (RN)) dayshift nurse was informed of R1's fall and change in condition. V2 DON stated at the time of her 5/1/24 fall R1 required supervision and a walker to ambulate.

On 5/16/24 at 11:35 AM V20 Licensed Practical Nurse (LPN) stated "I came into work on 5/5/24 at 10:00 AM. As soon as I got report from (V22) RN about (R1), I briefly assessed (R1) and knew that she needed to be sent to the emergency room. I didn't even do the full neuros (Neurological Assessment) because it was obvious something was really wrong.
I am not sure why (R1) was not sent out to begin with right after she fell but I wasn't going to let (R1) suffer any longer."

On 5/14/24 at 1:05 PM V8 Certified Nurse Aide (CNA) stated she went into R1's room (5/5/24) to find R1 sitting up in bed. V8 stated R1 sat up on the side of the bed and was 'a little woozy.' V8 stated V8 gave R1 a non-wheeled walker to use to walk to the bathroom. V8 did not use a gait belt during transfer or walking R1 to the bathroom. V8 CNA stated she was not aware that R1 had previously broken her arm but R1 was wearing a sling on her left arm. V8 CNA stated she instructed R1 to use the walker with her Right hand. V8 CNA stated just before reaching bathroom, R1 became unresponsive and had a blank stare. V8 CNA stated "There was

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something definitely wrong. (R1) had a thousand-mile stare. (R1) wouldn't respond to me. I was standing behind her and when she stopped, I walked in front of her to open the bathroom door. (R1) wasn't wearing a gait belt. That is when (R1) fell backward. (R1) didn't bend her knees or anything. (R1) fell like a tree. (R1) hit her head hard and it bounced off of the floor two to three times. The nurse (V2) Director of Nurses (DON) came into (R1's) room. (V2) told me to get her to bed so we (V8, V12) got her up and moved her to her bed. Then (V2) came back in with the IPAD for the doctor to see her." (IPAD described as an off-site video doctor exam).

On 5/14/24 at 11:25 AM V11 Director of Rehab Services stated V11 worked with R1 prior to her 5/1/24 fall and then again between her 5/1/24 fall and 5/5/24 fall. V11 stated R1 had a major decline in her cognition and physical abilities since her 5/1/24 fall, but 'especially after her 5/5/24 fall.' V11 stated prior to R1's fall on 5/1/24 she was able to walk with supervision about the facility. V11 stated after R1's fall on 5/1/24 where she obtained a Left Humerus Fracture R1 was wearing a sling on her Left Arm for immobilization. V11 stated when working with R1 after her 5/1/24 fall, V11 only provided physical therapy while R1 was laying in bed. V11 stated "It was just too painful for her to get up and move very much so we focused on strengthening and positioning while (R1) was in bed. If the staff were getting her up, they should have been using a gait belt and wheelchair." V11 stated R1 had very poor safety awareness but was 'very compliant and re-directable.'

On 5/15/24 at 3:40 PM V14 Medical Director stated R1 fell on 5/5 at the facility during a witnessed fall. V14 confirmed R1 was not

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transferred safely which contributed to R1's fall. V14 Medical Director stated anytime a resident has a witnessed fall and they 'hit hard' such as R1 did on 5/5, that resident should be automatically sent to the emergency room. V14 stated "You don't need a Physician order to send one of the residents to the emergency room for evaluation. That is left to the nurse's critical thinking skills." V14 stated the facility should have sent R1 to the emergency room immediately after the fall. V14 stated moving R1 could have worsened her injuries. V14 stated R1 sustained several major injuries which could affect her neurological status. V14 stated due to R1's previous fall on 5/1/24 where she had a Left Humerus Fracture, the staff should have known to use a gait belt on her and monitor her more closely.

On 5/15/24 at 3:00 PM V1 Administrator stated the facility should have called 911 emergency services for R1 at the time of her fall on 5/5/24. V1 Administrator stated "I am not a nurse but would definitely consider (R1's) fall on 5/5/24 an emergent situation. Telehealth is a service that is available to our nursing staff for after hours Physician notification but it is not meant for emergency situations as what happened with (R1)."

The facility policy titled 'Neurological Assessment' revised August 2008 documents a change in the level of consciousness constitutes the most significant or earliest sign of neurological deterioration. It must be accessible in in all situations. If there is a decline in the level of alertness, orientation, then the complete neurological assessment should be performed. When performing a neurological assessment, be sure to record the best response obtained. Documentation should be made in the nurse's

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notes or on a flow sheet, describing the required aspects, including bowel and bladder functioning. Always be complete, specific and compare the Right side of the body with the Left. Dangerous trends that need to be reported to the physician are: any pupillary reaction changes, especially with a decrease in level of consciousness, any decrease in level of consciousness from baseline assessment or from resident normalcy, any sensory or motor loss or decline, any marked changed in vital signs; other significant symptoms include nausea and vomiting, seizure activity, visually disturbances and headache. Neurological Assessments should be performed as follows for a 72 hour period, unless otherwise ordered by the attending physician: Every 15 minutes times four times, every one hour times four time, every two hours times eight times and every four hours until 72 hours is complete.

The undated facility policy titled 'Gait Belt Policy and Procedure' documents facility staff will utilize a gait belt around a resident's waist to help transfer the resident to the destination safely unless contraindicated by medical condition or use of mechanical lift.

2.) R4's undated Medical Diagnosis List documents R4's medical diagnoses as Diabetes Mellitus Type II, Chronic Congestive Heart Failure, Kidney Failure, Persistent Atrial Fibrillation, Muscle Weakness, Abnormalities of Gait and Mobility, Dementia, Unsteady on Feet and History of Falling.

R4's Minimum Data Set (MDS) dated 4/24/24 documents R4 as severely cognitively impaired. This same MDS documents R4 requires maximum assistance for toileting, bathing, dressing, personal hygiene and transfers.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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R4's Physician Order Sheet (POS) dated May 2024 documents a physician order starting 4/5/24 for Apixaban (anticoagulant) 2.5 milligrams (mg) daily.

R4's Fall Evaluation dated 5/5/24 documents R4 obtained a Laceration below R4's Left Eyebrow measuring 1.2 centimeters (cm) long by 0.5 cm wide by no measurable depth and a laceration to R4's Left Eyebrow measuring 1.5 cm by 0.8 cm by no measurable depth.

R4's undated Fall Investigation documents R4 had an unwitnessed fall on 5/5/24 at 1:45 AM. This same report documents R4 observed in R4's bed approximately one hour prior to fall and was last toileted at 10:00 PM on 5/4/24. This same report documents R4 requires the assistance of one person and a walker, is severely cognitively impaired, and was found lying on the floor in the doorway of R4's room face down. The report documents R4 had one shoe on and the other half on/half off and R4 obtained two lacerations to his Left Eye and the wound was cleansed and steri strip applied.

R4's Medication Administration Record (MAR) dated May 2024 documents R4 rated his pain at a three out of ten and was administered Acetaminophen 650 milligrams (mg) at 6:00 AM on 5/5/24.

R4's Physician Progress Note dated 5/5/24 (no time documented) documents physician orders for "Left Hip, Unilateral with Pelvis when performed, 2-3 views/Facial Bones, less than 3 views/Left Radiologic examination, femur; minimum 2 views, completed 5/6/24."

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	IL6007488	A. BUILDING: _____ B. WING _____	C 05/23/2024

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R4's Nurse Progress Note dated 5/5/24 at 9:00 PM documents R4 was sent to the emergency room due to "(R1) screaming 'somebody help me' due to Inguinal pain."

R4's Nurse Progress Note dated 5/6/24 at 10:47 AM documents "(R4's) order for Hip/Pelvis and Femur of Left side made via portable X-Ray".

On 5/15/24 at 11:45 AM R4 was laying in his bed. R4 stated "I don't remember exactly what happened but I know I fell. My eye (rubbing his Left eye) still hurts. I have problems holding my urine. If I have to go to the bathroom then I need to go as soon as I can get there."

On 5/15/24 at 2:30 PM V2 Director of Nurses (DON) stated the night (5/5/24) R4 had an unwitnessed fall R4 was trying to find someone to help him get to the bathroom. V2 DON stated "(R4) got up from bed and walked to the doorway of his room where he was found. (R4) had a goose egg and laceration on his Left eyebrow/forehead area. I provided first aid, the staff got him back up and helped him to the bathroom."

On 5/17/24 at 1:00 PM V1 Administrator stated any resident on an anticoagulant who has fallen and obtained a head injury should be sent to the emergency room. V1 stated "I am not sure why we (facility) waited to get the X-Rays done but we should have called for them that morning (R4) fell. (R4) could have had an internal injury that we couldn't see from the outside and we would never have known."

The facility policy titled 'Falls and Fall Risk, Managing' revised August 2008 documents the facility will identify interventions related to the

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resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant. Staff will identify and implement relevant interventions (e.g. hip padding or treatment of Osteoporosis, as applicable) to try to minimize serious consequences of falling. The staff, with the Physicians guidance, will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or Subdural Hematoma have been ruled out or resolved.

B. Based on interview and record review the facility failed to implement fall interventions for one (R2) of four residents reviewed for falls in a sample list of four residents.

Findings include:

R2's undated Medical Diagnosis List documents R2's medical diagnoses as Orthostatic Hypotension, Atrial Fibrillation, Heart Failure, Generalized Anxiety Disorder, Obsessive-Compulsive Disorder, Abnormalities of Gait and Mobility, Dementia with Agitation, Need for Assistance with Personal Care, Unsteady on Feet and Repeated Falls.

R2's Minimum Data Set (MDS) dated 4/24/24 documents R2 as severely cognitively impaired and requires maximum assistance for toileting and moderate assistance (helper lifts, holds or supports trunk or limbs, but provides less than half the effort) for toilet transferring.

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R2's Care Plan documents a fall intervention dated 4/16/2020 for staff to supervise transfers providing (R2) with verbal/visual cues as needed for safe transfer technique (i.e. push up from bed/chair to stand and reach back before sitting). Staff to provide physical assistance as needed while encouraging (R2's) highest level of functioning.

R2's Nurse Progress Note dated 4/24/24 at 12:30 PM documents "(R2) had fallen in bathroom and hit her head. (R2) complained of (c/o) pain in her head, neck, and lower back. (R2) sent to emergency room for evaluation."

R2's Post Fall Evaluation dated 4/24/24 documents R2 slipped while washing her hands in the bathroom

R2's Hospital Record dated 4/24/24 documents R2 was seen in the emergency room after having a nonsyncopal fall (slipped off the toilet) at facility and hit head. R2's hospital diagnosis documents "Likely closed head injury."

On 5/17/24 at 11:05 AM V35 stated "I wheeled (R2) back to her room from the dining room in her wheelchair. (R2) said she needed to use the bathroom so I assisted her to the toilet. I left (R2) alone in the bathroom to go get some towels. Then I heard (R2) hit the floor in her bathroom. (R2's) feet were tangled up in her wheelchair. (R2) was sitting against the wall of her bathroom on the floor with her arm leaning on the garbage can. (R2) hit the back of her head."

On 5/14/24 at 1:50 PM V16 Registered Nurse (RN)/Fall Nurse stated V35 CNA should not have left R2 in the bathroom unattended. V16 stated R2 had recent falls and required closer

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S9999	Continued From page 16 supervision. The facility assessment updated October 18, 2023 documents the facility will respond to requests for assistance to the bathroom/toilet promptly in order to maintain continence and promote resident dignity. (A)	S9999		