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S 000	Initial Comments Complaint Investigation 2346253/IL162558	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610 a) 300.1210 b) 3001210 d)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. d) Pursuant to subsection (a), general	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 observation, interview, and record review, the facility failed to provide adequate supervision and monitoring to prevent falls for 1 of 3 residents (R5) reviewed for falls in the sample of 9. This failure resulted in R5 having 3 falls during first week of her stay in the facility and sustaining a non-operable re-fracture of her left hip. Findings include: R5's Face Sheet documents she was initially admitted to the facility on 7/14/23, with diagnoses of Unspecified Dementia, Other Specified Disorders of Bone Density and Structure, Hypothyroidism, Depression, Vertigo, Atherosclerotic Heart Disease, Diverticulitis, Chronic Kidney Disease, Stage 3, and Personal History of Cardiac Arrest. R5's Physician Order Summary Report lists her diagnosis as Fracture of Unspecified Part of Neck of Left Femur, Initial Encounter for Closed Fracture.	S9999		

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R5's Referral Information to facility, dated 7/13/23, includes hospital reports document R5 was admitted to the hospital on 7/3/23 after a fall in her memory care facility that resulted in a closed hip fracture. The referral information included documentation R5 sustained a subdural hematoma on 7/8/23 while in the hospital when she fell after she attempted to stand but was off balance and fell to the ground and was found on the floor. The referral information included the hospital's "Assessment/Plan" that listed her diagnoses to include: Acute Subdural Hematoma: Patient had a fall on 7/8/23, CT (Computed Tomography) head shows subdural hematoma, neurosurgery consulted, repeat CT head stable, appreciate neurosurgery recommendations, fall precautions, monitor neurochecks.

R5's Minimum Data Set (MDS), dated 7/19/23, documents she is severely cognitively impaired, has behaviors including inattention and disorganized thinking, and requires assist with Activities of Daily Living (ADLs) including bed mobility, transfers, walking in room, dressing, eating and toileting. According to this MDS, R5 is not steady when moving from a seated to a standing position, when moving on and off toilet, and with surface-to-surface transfers (transfer between bed and chair or wheelchair) and is only able to stabilize with staff assist.

R5's Care Plan, dated 7/14/23, documents, "The resident is at risk for falls." The interventions for this care plan include: "Be sure (R5's) call light is within reach and encourage the resident to use it for assistance as needed; Ensure floor mat is place beside bed when resident is in bed; Ensure floor mat is picked up when resident is not in bed; Ensure personal items are within reach; Ensure that (R5) is wearing appropriate footwear when

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ambulating or mobilizing in wheelchair (w/c); Gripper socks; Keep bed in lowest position when in bed; Physical Therapy/Occupational Therapy (PT/OT) evaluate and treat as ordered or as needed (prn); Resident moved to memory care unit for centralized care (closer supervision)-initiated 7/28/23; Staff to assist resident to toilet after meals and more frequently related to (r/t) urgency; Staff to encourage participation in activities of her choice when restless in bed."

R5's Fall Risk Data Collection, dated 7/14/23, documents the score of 28 indicating she is at high risk of falls. Fall Risk Data Collection documents, dated 7/15/23 and 7/20/23, document R5 continued to be at high risk of falls.

The facility's document Occurrence Type: Falls, dated 2/1/23 through 8/1/23, documents R5 had two falls on 7/15/23 and a third fall on 7/20/23.

R5's Fall Report dated 7/15/23 at 1:15 PM, documents, " At 1:15 PM writer was alerted by CNA that resident was on the floor. Writer entered resident's room and found resident sitting on her buttocks with left leg extended forward and right leg bent. Resident was found at the foot of her bed, gripper socks were on both feet, area was well lit, and no obstacles were in the pathway. Writer assessed the resident; vs (vital signs) 118/60, 68, 97.8, 97%, A&O x1 (alert and oriented to person) baseline. Resident voiced complaint of (c/o) pain and discomfort. Writer instructed CNA to stay with resident and instructed both CNA and resident to avoid moving. Writer left room to notify appropriate personnel. Writer notified resident's daughter and called 911 for transport to hospital for eval at 1:31 PM. Resident left the facility with 2 ambulance

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attendants, POLST, Notice of Transfer, and bed hold policy. Writer gave report to (local hospital.)" This fall report documents a recommendation to be implemented after the fall: "Staff to encourage participation in activities of her choice when restless in bed."

R5's Progress Note, dated 7/15/23 at 4:53 PM, documents, " Resident report received via ER (Emergency Room) nurse. Resident had ct (Computed Tomography) head, neck bilat hips, all resulted negative. Nurse reports (indwelling urinary catheter) inserted, and urine specimen obtained and sent to lab resulted in dx (diagnosis) of UTI (urinary tract infection). Positive blood, nitrates ketones and WBCs (white blood cells). Resident to be sent back via ambulance stretcher and with prescription for Macrobid. 1st dose to be given prior to return to facility. (Indwelling Urinary Catheter) will be dc'd (discontinued) prior to transport. Report given to resident's nurse. All questions answered."

R5's Hospital Discharge Instructions, dated 7/15/23 at 4:22 PM, documents, "Tylenol, Ibuprophen as needed; Assistance with any movement and close observation."

R5's second Fall report, dated 7/15/23 at 6:55 PM, documents, "Writer called to resident's room by CNA. Upon entering resident's room, resident noted to be lying on the floor in front of resident's bathroom. Resident lying on her right side with her head lying toward the door and feet towards the wall. Resident c/o right shoulder pain and is lying on her right arm. Resident c/o left hip pain and low back pain. Resident is not moved from position, CNA stayed with resident while nurse called 911. Resident had non-skid socks on. Floor clean, room quiet. 911 called at 7:01 PM. (R5's

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daughter/responsible party) called, HIPPA compliant voicemail left to return call to facility. Report called to (local ER) and (ER staff) informed the writer would need to speak with the MD (Medical Doctor). MD, unable to understand name due to accent, spoke with writer and informed writer that resident had already been sent to the ER prior and he gave orders for resident to be 1:1 and he did not understand how she fell again. Writer explained to MD that resident is confused and gets up without assistance. MD asked why she was being sent back to ER. Writer informed MD that due to resident c/o pain to right shoulder, left hip and back pain writer cannot move resident from the position to risk further injury if anything fractured. MD advised writer to call the Administrator and let her know that resident needs to be 1:1 to prevent resident from falling and being sent back and forth to the ER. Writer informed MD that Administrator would be informed of his concerns. (Local ambulance) called to inform they were on another call dropping them off at the hospital and would be to facility after completing that call. 7:17 PM Administrator informed of incident and conversation with MD. Writer informed to call family to see if family could sit with resident. No return call from responsible party, (emergency contact #2) called and explained concern and need for family to sit with resident due to falls. (Emergency contact #2) informed writer that if family was able to sit with her 24/7, they would not have placed in facility, but she understands and will speak to (Healthcare Power of Attorney/HCPOA). 7:36 PM (local ambulance) arrived, resident transferred to (local hospital ER) via stretcher. Bed hold policy sent with paperwork. (HCPOA) returned call to facility and spoke with writer stating she believes if the pain medication and /or Ativan was more frequent that

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every 8 hours she believes resident would not be attempting to get up and having falls. Writer informed (HCPOA) that on call MD would be called to see if he can increase the frequency and writer would call her back. On call MD paged and returned call at 7:47 PM. New order Norco 5/325 milligrams (mg) every 4 hours for pain but Ativan order would remain the same. Writer called HCPOA and informed of new orders. On-call nurse notified." The fall report documents the recommendation after the fall: "1:1 provided for safety of resident. Staff to assist resident to toilet after meals and more frequently related to urgency."

R5's fall investigation of her second fall on 7:15 PM included documentation that 1:1 monitoring was initiated at 1:00 AM on 7/16/23 with every 1-hour monitoring done by staff until 7/17/23 at 5:00 AM.

R5's Hospital Discharge Orders, dated 7/15/23 at 11:58 PM, documents, "Continue home medicine; Close observation; and Contact her orthopedic for follow-up."

R5's third fall report, dated 7/20/23 at 10:48 PM, documents, "Writer in hallway at med cart on 200-hall. A loud noise was heard and a voice from 200 hall. Writer went to investigate and noted resident laying on the floor in her room with commode tipped over near her feet. Resident's head was pointing south with head up against dresser. Room was quiet and floor dry except some urine that had spilled from commode. Room was dim lit. Resident was wearing no skid socks. Call light was on bed rail in reach from where resident had been sleeping in bed. Call light was not on. Resident unable to give a statement of what happened due to cognition with

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dementia. Personal belongings were in reach of where resident had been laying in bed. Resident c/o pain to left temple and hematoma noted. Resident c/o left hip pain. Resident has known healing left hip fracture (fx). Decision made to not move resident and contact MD."

R5's Hospital Records, dated 7/23/23 at 6:05 AM, documents, under Impression/Plan: "New left peri-implant proximal femoral fracture, history of falls, history of dementia, Alzheimer's type. Plan: Orthopedics consulted-no operative plans at this time."

On 8/2/23 at 8:43 AM, V11, Certified Nursing Assistant (CNA), and V25, CNA, provided incontinent care to R5 in her bed. R5 had a scar on her left hip that had a few superficial scabs on the healed incision line. R5 complained of pain and discomfort when her pants were taken off and when she was rolled side to side for care. R5 stated she did not know why her hip was hurting like that. R5's room was at the very end of her hall, farthest away from the nurse's station.

On 8/3/23 at 3:45 PM V1, Administrator, stated she was not given all the information about R5's previous falls when the referral was sent to the facility before she was admitted. V1 stated V30, Business Office Manager, and V31, Admissions Coordinator, reviewed the information for her admission. V1 stated she heard about the additional fall R5 had while in the hospital after the fact, but when she was admitted, R5 was placed in the room that was closest to the nurse's station. V1 stated there were no female beds available in the dementia unit. V1 stated if she had been aware of R5's fall in the hospital, she would have looked at putting her on one of the halls that had more staffing available for closer

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monitoring. V1 stated the facility cannot typically do 1:1 monitoring with a resident, so they called her family when the doctor said he wanted 1:1, but the family refused to come in and sit with her. V1 stated staff had just been in R5's room on 7/15/23 15 minutes before she fell.

On 8/4/23 at 12:01 PM, V1 stated staff did not call and inform her R5 had fallen on 7/15/23 until she had her second fall on that same day and the emergency room doctor did not want her sent back to the emergency room. V1 stated she came to the facility, but by then, the ER doctor was agreeable for R5 to be transported to the ER for evaluation. V1 stated it was after R5's second fall on 7/15/23 that she found out the ER doctor had ordered her to be monitored 1:1 after she returned from ER after her first fall. V1 stated she directed the staff to call her family to see if they would come in and sit 1:1 with R5, but they refused stating it was facility's job to do 1:1 and that was why she was here. V1 stated R5's 1:1 was only done for a couple of days because after that she was doing better, and she was kept at the nurse's station for closer observation. V1 stated to her recollection, the order for 1:1s was not an on-going order. V1 stated after they stopped the 1:1's, R5 was kept in public places, there was a mattress in place on the floor when she was in bed, and they were doing frequent checks on R5. V1 stated she would expect frequent checks to mean the staff checked on R5 at least every 1 to 2 hours and whenever they walked by her room. V1 stated they also had R5 going to activities. V1 stated since her last fall on 7/20/23, R5 does not try to get up and walk any more.

On 8/4/23 at 1:38 PM, V32, CNA, during phone interview, stated she has worked with R5 a few

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times. She stated she worked with her on 7/20/23 when R5 fell. V32 stated she was in another resident's room down the hall helping her with the bed pan when R5 fell. V32 stated R5 had been sleeping most of the night before she fell. V32 stated she had been trying to check on R5 about every 15 minutes because she still tried to get up by herself, but R5 was not trying to get up as much because she was in pain. V32 stated she did not see R5 fall but from the way R5 was laying close to the commode, and the commode was tipped over, she assumed R5 was going to the bathroom when she fell. V32 stated the nurse was also checking on R5 frequently when she (V32) was in other residents' rooms. V32 stated it was impossible to 1:1s with R5 because there is not enough staff; if you are 1:1 with R5, no one else would get their care. V32 stated she did the best she could. V32 stated she has worked with R5 since she has been moved to the dementia unit and stated R5 continues to try to get up on her own sometimes. She stated just this past Saturday she caught R5 standing up trying to get to the bathroom on her own.

On 8/4/23 at 1:55 PM, V33, Registered Nurse (RN) ,stated she is an agency nurse who worked at the facility on 7/15/23 and 7/16/23. She stated she received the call from the ER nurse after R5's first fall when she was returning to the facility. V33 stated she is an ER nurse herself and remembers she asked the questions regarding labs and x-rays, but does not remember the nurse telling her R5 should be on 1:1s when she returned. V33 stated she was working with V14, Licensed Practical Nurse/LPN, who would have received R5's discharge paperwork from the hospital. V33 stated R5 would have come back just when the nurse was finishing her medication pass and getting ready to change shifts, so

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something may have been missed. V33 stated she worked again the next day (Sunday) 7/16/23, and she went out to the shed herself to find R5 a (reclining wheelchair). V33 stated she kept R5 up at the nurse's station with her, and R5 was frequently trying to stand up and walk. She stated R5 was very feisty and was not easily redirected by staff. V33 stated there was not enough staff to do 1:1's. She stated now she understands about 1:1's because she compared trying to monitor R5 to trying to monitor a six-month-old and stated, "You would have to be right by her all the time."

On 8/4/23 at 2:50 PM, V1 stated, "If I had known the emergency room doctor had ordered for R5 to be monitored on 1:1s I would have gotten someone to come in and do 1:1s or I would have done them myself."

On 8/8/23 at 11:24 AM, V1 provided a copy of the facility's Fall Policy, which was revised 9/17/19. The fall policy referred to the "Fall Program". V1 stated she has no idea what the fall program was before she got here, and stated the Fall Program now is outlined in the untitled document, dated 8/4/23, which she presented along with the Fall Policy which outlined a review of recent falls and a plan to educate staff on the Fall Prevention System. Per this document, V24, Regional Nurse, reviewed falls for the past 3 months and determined the Fall Prevention System was not fully in place. V1 stated she knows they went around and put leaves on residents' doors who were determined to be at risk for falls.

The facility's policy, Fall Policy, revised 9/17/19 documents, "The purpose of the Fall Management Program is to develop, implement, monitor and evaluate an interdisciplinary team falls prevention approach and manage strategies

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S9999	Continued From page 11 and interventions that foster resident independence and quality of life. The Fall Management Program promotes safety, prevention and education of both staff and residents. Policy: The facility shall ensure that a Fall Management Program will be maintained to reduce the incidence of falls and risk of injury to the resident and promote independence and safety." Per the policy, residents found to be at high risk for falls are place on the Fall Program, and interventions are implemented to meet individual needs. (A)	S9999		