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	IL6009567	A. BUILDING: _____ B. WING _____	C 12/03/2020

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S 000	Initial Comments Complaint Investigation #1069316/IL129016	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)6) 300.1220 b)3) 300.3240 a) 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	S9999	Attachment A Statement of Licensure Violations	

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care needs of the resident.
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.

Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These regulations are not met as evidenced by:

Based on interview and record review, the facility failed to prevent a fall resulting in a major injury

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and failed to update a resident's care plan with fall interventions for one of three residents (R1) reviewed for falls in the sample list of three. This failure resulted in R1 being admitted to the hospital with an acute subdural hemorrhage, subarachnoid hemorrhage, and facial fracture.

Findings include:

The facility's Fall Prevention Program policy, dated 3/2020, documents, "The Facility will assess hazards and risks, develop an individualized plan of care to address hazards and risks, implement individualized interventions, and revise the plan of care in order to minimize the risk for fall incidents and/or injuries to the resident." This policy also documents, "Complete a Fall Risk Evaluation upon admission, re-admission, with significant change, post fall, quarterly and annually."

R1's Physician Order Report, dated 11/1/20 through 11/30/20, documents diagnoses including Malignant Neoplasm of head, face and neck, Muscle weakness, Epilepsy and Abnormal Weight Loss. R1's Fall Risk Assessment, dated 10/18/19, documents R1 was a high risk for falls. R1's Care Plan, with a start date of 10/18/2019, documents R1 is at risk for falls due to a history of falls, poor memory, and previous stroke.

R1's electronic Nurse's Progress Notes document a fall on 8/7/20, and R1's electronic medical record documents fall events for 9/13/20, 10/31/20, and two events on 11/27/20.

R1's electronic medical record documents a fall on 8/7/20 at 4:30 PM, in R1's room. The fall investigation, dated 8/7/20, documents R1 fell in R1's room and received an abrasion and a skin

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tear. The immediate interventions documented on the fall investigation are applying direct pressure to the bleeding site, give first aid and for R1 to get some rest. R1's Care Plan, with a start date of 10/18/19, does not document a new intervention developed after this fall to help prevent further falls. R1's Nurse's Progress note, dated 8/9/20 at 5:00 AM, written by V15, Licensed Practical Nurse, documents R1 is non-compliant with call light use and has a right forehead hematoma and a skin tear on the right hand. This note documents the nurse informed R1 to use the call light for assistance but goes on to document that R1 was alert with confusion.

R1's electronic medical record documents the next fall as being on 9/13/20 at 2:30 PM. The fall investigation, dated 9/13/20, documents R1 fell in R1's room. This fall investigation documents R1 was unable to transfer on and off the toilet, bed, or chair safely, and R1 had an unsteady gait. This investigation also documents R1 tries to stand, transfer, or walk unassisted unsafely. This investigation documents no injuries from this fall, and documents the interventions of education for R1 to call for assistance and lock the wheelchair brakes. R1's Care Plan already documents these interventions of reminding R1 to lock the wheelchair brakes on 1/3/20, and reminding R1 to ask for assistance on 3/6/20 and on 12/19/19. There are no new interventions documented after this fall to help prevent further falls.

R1's Fall Risk assessment, dated 9/13/20, documents R1 as a moderate risk for falls. R1's MDS, dated 9/18/20, documents R1 required one person physical assistance for transfers and for toileting and has moderately impaired cognition. This MDS also documents that R1 was no longer walking.

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R1's Care Plan, dated 10/18/2019, documents R1 is at risk for falls due to a history of falls, poor memory, and previous stroke. This Care Plan does not document an intervention for the fall on 8/7/20. R1's Care Plan documents fall interventions put into place on 1/03/20 to stop and lock brakes applied to the wheelchair; 1/26/20 reminded to wear non skid socks; 3/6/20 remind (R1) to ask for assist and not to attempt transfers per self; 1/27/20 assist to bathroom upon rising, before meals and before bed; and 12/22/19 re-educated to seek assistance with all transfers. R1's Care Plan, dated 10/18/19, documents each of these interventions were looked at on 9/21/20. This Care Plan was not updated with any new interventions for the 9/13/20 fall.

R1's Care Plan, dated 10/18/19, documents an intervention dated 10/31/2020, to remind resident with each interaction to ask for assistance when needed. This intervention was already put into place on 3/6/20. Therefore, there were no new interventions for the 10/31/20 fall.

R1's electronic medical record documents the next fall as being on 10/31/20 at 4:30 AM. The fall investigation, dated 10/31/20, documents R1 fell in R1's room. This fall investigation documents R1 was unable to transfer on and off the toilet, bed, or chair safely, had poor standing balance and an unsteady gait. This investigation also documents R1 tries to stand, transfer or walk unassisted unsafely. This investigation documents no injuries from this fall and the same intervention of reminding R1 to call for assistance. R1's Care Plan documents the intervention added on 10/31/20, to remind R1 to ask for assistance with each interaction. This intervention was already on the care plan from

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S9999	Continued From page 5 3/6/20 and 12/22/19. There are no new interventions developed after this fall to help prevent further falls. R1's electronic medical record documents the next fall as being on 11/27/20 at 3:50 AM. The fall investigation, dated 11/27/20, documents R1 fell in R1's room. This fall investigation documents R1 has confusion, R1 is unable to transfer on and off the toilet, bed or chair safely, has a decline in functional status, has an unsteady gait and tries to stand, transfer or walk unassisted and unsafely. This investigation documents a minor injury of a raised area to the back of R1's head and treatment of sending R1 to the emergency room. R1's Nurse's Progress Note, dated 11/27/2020 at 6:52 AM, documents, "(R1) was on the floor between (R1) bed and nightstand at 3:50 AM this morning. When asked what (R1) was doing when (R1) fell, (R1) did not answer the question coherently. (R1's) baseline is alert and oriented to at least 2. (R1) was confused, mumbling, and seemed agitated. (R1's) blood pressure was high when vitals were taken. (R1) has a knot on the back of (R1's) head and cannot verbalize which part of (R1's) body hurts. (Emergency Medical Service) arrived at 4:18 AM and transported (R1) to the ER (emergency room). POA (Power of Attorney), DON (Director of Nursing), and responsible parties were notified." R1's Nurse's Progress notes documents R1 returned from Emergency Room at 10:45 AM on 11/27/20. This note documents R1's incontinent brief was changed and R1's bed was lowered. R1's Care Plan does not document any interventions developed after this fall to help prevent further falls. R1's hospital CT (computerized tomography) of head or brain without contrast, dated 11/27/20, documents no acute hemorrhage and no acute abnormality	S9999		

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S9999	Continued From page 6 evident. R1's electronic medical record documents the next fall as being on 11/27/20 at 11:00 AM. The fall investigation, dated 11/27/20 at 11:00 AM, documents R1 fell in R1's bathroom. This investigation documents R1 had confusion, a decline in functional status, an unsteady gait and tries to stand, transfer or walk unassisted unsafely. This investigation documents R1 had a major injury and was sent to the emergency room again. This investigation documents the parts of the body injured as the head, chin, right elbow, right knee and neck. R1's Nurse's Progress notes, dated 11/27/2020 at 11:00 AM, document that R1 was found lying on the floor next to the bathroom. R1's incontinent brief was soiled and injuries were noted to the right back side of R1's head and R1 was bleeding. R1 also had a laceration on the right side of R1's chin, a skin tear to the right elbow and an abrasion on the right knee and also a laceration to the right side of R1's neck. R1 was awake and talkative. R1 had swelling noted to the right eye and the ambulance was called. R1 was transferred to the Emergency Room again. R1's hospital CT of the head or brain without contrast, dated 11/27/20, documents this CT is done in comparison to the CT that was done earlier on 11/27/20 at 5:53 AM. The findings of this CT are an acute subdural hemorrhage in the left temporoparieatal region measuring approximately 7.3 cm (centimeters) x (by) 1.6 cm. There is also noted some parenchymal contusions in the left to fontal and temporal region. There is also subarachnoid hemorrhage noted. There is hemorrhage in the left tentorium as well as in the falx in the midline. There is a parenchymal hemorrhage in the left temporal	S9999		

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region measuring approximately 2.2 cm in size. There is also a nondisplaced fracture of the zygomatic arch on the right side.

On 12/3/20 at 11:08 AM, V7, Temporary Nursing Assistant (TNA), stated V7 worked with R1 a little when R1 was here. R1 would put on R1's call light and tell V7 R1 wanted V7 to run a rummage sale and that there was stuff under R1's trash can. V7 stated that was the last couple of days R1 was at the facility, V7 stated R1 was talking "out of his head". V7 stated on 11/27/20 when R1 came back to them from the hospital, V7 said that V7 cleaned R1 up because R1 had bowel movement in R1's incontinent brief. V7 stated V7 changed R1 and lowered R1's bed. V7 stated then V7 went to help another resident, and the nurse came to V7 and said R1 fell. V7 stated there was no mat on the floor when R1 was on the rehab section. V7 stated that R1 would use the call light when R1 needed help but R1 didn't use it this time. V7 stated that it was around lunch time on Friday (the 27th). V7 stated that R1 did have a bowel movement again. V7 stated that R1 must've had to go to the bathroom again after V7 changed R1 the first time. V7 stated maybe R1 was looking for R1's wheelchair because R1 usually has one in there, but this time there was none in R1's room.

On 12/3/20 at 11:15 AM, V8, Temporary Nursing Assistant (TNA), stated V8 would help R1 to the bathroom. V8 stated R1 used the call light to ask for assistance when V8 took care of R1. On 12/3/20 at 11:20 AM, V9, Certified Nursing Assistant (CNA), stated R1 would use the call light but was getting more confused towards the end.

On 12/3/20 at 11:47 AM, V3, Nurse Manager,

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S9999	Continued From page 8 stated R1 had a fall around 4:00 AM on 11/27/20, and was sent to the hospital and R1 returned around 10:45 AM and staff cleaned R1 up and changed R1's incontinent brief. V3 stated staff left R1's room to take care of another resident, and within minutes R1 had fallen again. V3 stated V3 thinks R1 was trying to go to the bathroom as R1's incontinent brief was soiled again. V3 stated V3 feels that it was R1's cancer that caused the fall. On 12/3/20 at 4:15 PM, V3 confirmed that there were no new interventions developed and documented to help prevent R1's falls. (A)	S9999		