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	IL6012579	A. BUILDING: _____ B. WING _____	C 01/20/2021

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S 000	Initial Comments Complaint Investigation #2160237/IL130132	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)6) 300.1220 b)3) 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.
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.

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.

These regulations are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to assess for, identify, and implement appropriate fall prevention interventions specific to the individual needs for

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S9999	Continued From page 2 R1 and R4, both with a known history of falls. Following a fall, R1 was admitted to a hospital for an acute intertrochanteric left femur fracture with severe varus angulation. Following a fall, R4 was admitted to a hospital for a laceration to right side of head and a Subarachnoid hemorrhage. R1 and R4 are two of four residents reviewed for falls in the sample list of four. Findings include: 1.) R1's undated Face Sheet documents R1's diagnoses as Craniectomy, Displaced Intertrochanteric Fracture of Left Femur, Hypo-osmolality and Hyponatremia, Vitamin D deficiency, unspecified, personal history of irradiation, Other specified disorders of bone density and structure, unspecified site, right foot, Tachycardia, unspecified, Osteophyte, unspecified joint, cervical region, Unspecified fracture of left pubis, sequela (History of), Syncope and collapse, Paroxysmal atrial fibrillation, and Orthostatic Hypotension. R1's Admission Observation, dated 12/31/2020 (admit date), documents R1 having memory problems, fallen in the last month, balance problems, symptoms experienced with activity such as dizziness, unsteady gait, and weakness. The facility's Fall Risk Assessment Tool, dated 12/31/2020, documents a moderate fall risk for R1. A facility report titled Incident Follow-up Report, undated, includes the following documentation on R1: during R1's hospital stay, R1 had a decrease in Lisinopril (antihypertensive) related to syncope episodes times 3, based on incident investigation it appears R1 fell (1/3/21) as a result of increased weakness related to Craniotomy and Orthostatic	S9999		

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Hypotension, and poor safety awareness. The report also documents R1 got up from bed to close R1's door and fell (1/3/21) and the nurse noted R1's left lower extremity (LLE) to be rotated inward and R1 stated R1 was having pain to the LLE and unable to bear weight; R1 was noted to be displaying signs of syncope; Power of Attorney was notified and stated R1 had been having episodes of Orthostatic Hypotension; R1 transported to a hospital and was admitted for a closed left hip fracture.

R1's Adult Hospital Admission History and Physical notes, dated 1/3/2021 at 11:05 PM, documents 72 year old female just discharged to skilled nursing on 12/31/2020, had a fall overnight and sustained a femoral intertrochanter femur fracture, (R1's) daughter acts as main historian and states (R1) is very frail, during (R1's) last hospital course, (R1) had Hyponatremia, Hypokalemia, and Hypomagnesemia. These notes also document orthopedic surgery was consulted in the Emergency Department (ED), will be admitting patient (R1), patient (R1) cleared for surgery, however, due to comorbidities, she (R1) is a moderate to high risk for perioperative complications.

R1's ED provider notes, dated 1/3/2021 at 11:14 AM, documents presenting to the ED for evaluation of a fall that occurred on 1/3/2021, resident (R1) states she was walking with her cane when she got out of balance and slipped on her side. R1's hospital records, dated 1/4/2021, Hip 2 views unilateral left x-ray documents findings which include: fall, left leg shortened and rotated, an acute intertrochanteric left femur fracture with severe varus angulation. R1's Adult Hematology Oncology Consult, dated 1/7/2021 at 8:48 AM, documents R1 admits to "not eating on

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S9999	Continued From page 4 a regular basis and stated her legs have felt weak since her brain surgery on 12/22/20 and they buckle and that is why she fell and broke her hip". R1's Discharge Plan *Final Report*, hospital summary, dated 12/31/2020, documents, "I also have these medical conditions: COPD (chronic obstructive pulmonary disease), High Blood Pressure, Emphysema, Mitral Valve Prolapse, Squamous Cell Carcinoma, Atrial Fibrillation, Syncope, Orthostatic Hypotension". On 1/13/2021 at 11:36 AM, V2, Director of Nursing (DON), stated V2 was not aware of R1's Orthostatic Hypotension diagnosis until V2 spoke with R1's daughter on 1/3/2021. V2 stated Orthostatic Hypotension was not passed on in report that day. V2 stated from R1's care plan, we monitor for fall risk and apply interventions as needed. V2 stated, "I do not have documentation of what was being done with resident (R1) due to increased fall risk status". V2 also stated, "We knew to monitor her (R1) for fall risk, that just means keep an eye on her (R1) more frequently". V2 was asked if fall interventions were appropriate to prevent the resident (R1) from falling. V2 stated "I (V2) don't know how to answer that because they (interventions) did not prevent a fall". On 1/14/2021 at 5:16 PM, V2, DON, stated V2 was aware R1 did not have the greatest safety awareness and R1 did have syncope episodes before coming to the facility and syncope could happen again. V2 also stated we address safety issues on a basic care plan such as: monitor if increased fall risk, help to assess risk for falls, and monitor skin. On 1/14/2021, at 3:03 PM, V1, Administrator, stated R1 had a baseline care plan initiated upon R1's admission that states that R1 is to have	S9999		

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S9999	Continued From page 5 "initial needs met"; goal is to address/meet residents needs/wants until comprehensive care plan is established; approach is to monitor for fall risk; and apply interventions as needed to reduce resident's risk for falls. There is no documentation in R1's medical record regarding fall preventions specific to R1's diagnoses such as Syncope and Orthostatic Hypotension, nor fall preventions from R1's Admission Observation that document R1 as having memory problems, previous fall(s), balance problems, dizziness, unsteady gait, and weakness. 2.) R4's undated Face Sheet, documents diagnoses as: Unspecified fracture of lower end of left femur, subsequent encounter for closed fracture with routine healing Non-traumatic subarachnoid hemorrhage, Unspecified protein-calorie malnutrition, Vitamin D deficiency, unspecified, Other reduced mobility, Altered mental status, unspecified, Visual hallucinations-Charles Bonnet syndrome, Urge incontinence, Unspecified lack of coordination, Muscle weakness (generalized), Dementia in other diseases classified elsewhere without behavioral disturbance, Unilateral primary osteoarthritis, unspecified knee, Spondylosis without myelopathy or radiculopathy, cervical region, Unspecified fracture of lower end of left femur, initial encounter for closed fracture, Presence of right artificial hip joint. R4's Care Plan, dated 6/27/2019, documents "resident at risk for falls r/t (related to) history of falls, history of vertigo, vision deficits, mobility deficits, pain arthritis, status-post fracture left femur, anemia, hearing deficits; 6/28/2019: impaired communication with deficits with receptive communication, has periods of confusion, forgetfulness and disorganized	S9999		

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thinking". This same Care Plan documents approaches for R4 as: administer medications as ordered by physician and monitor for adverse effects which may effect gait, balance, endurance, cognitive status report changes to doctor as needed; Nursing Approach Start Date: 6/27/2019: assist with activities of daily living (ADL'S) to the extent required to promote safety; Certified Nursing Assistant (CNA), Direct Care Staff, Nursing Approach Start Date: 06/27/2019: be sure call light is within reach and encourage R4 to use call light for assistance as needed, R4 does not always use R4's call light related to occasional confusion, check R4's status at the appropriate intervals that will address R4's needs, keep bed in the lowest position that is safe for the resident while in it, provide activities that minimize the potential for falls while providing diversion and distraction, remain in shower/bathroom with R4.

R4's Care Plan, dated 8/26/2020, documents "potential for complications, injury related to anticoagulant or antiplatelet medications. R4's Minimum Data Set (MDS), dated 11/9/2020, documents R4 requires extensive assistance for bed mobility and total dependence for transfers and locomotion on unit. R4's Care Plan does not document R4's highest fall risk areas nor what preventative measures to be implemented specific to R4 for falls.

The facility's undated Incident Report Follow-up documents R4's 1/10/2021 incident as follows: 101-year-old female has a medical history that includes Dementia, Altered Mental Status, Visual Hallucinations due to Charles Bonnet Syndrome, poor vision and hard of hearing. R4 is a mechanical lift due to history of bilateral lower extremity fractures. This document also states R4 fell as a result of a visual hallucination as R4 was

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S9999	Continued From page 7 trying to pick up a credit card that R4 saw, from the floor; nurse (V6) was alerted and found R4 face down on the floor with a large amount of blood on the floor; no credit cards or other items noted on the floor; nursing assessment performed identified hematoma to left forehead, skin tear on left forearm measuring 3 x 1 centimeters (cm), second skin tear to left forearm measuring 5 x 1cm, and laceration to right scalp. This report also documents post interview with nursing staff revealed that in the day leading up to R4's fall, R4 had been experiencing an increase in hallucinations. There is no documentation of these hallucinations pre-fall, documented in R4's medical record. Also documented in this report, R4 remains at a hospital for observation due to Subarachnoid Hemorrhage, six staples to scalp laceration and steri-strips to skin tears on left arm. R4's Hospital Encounter, dated 1/10/2021, documents 3-4 cm laceration to right side of head and large hematoma on front of forehead noting the clinical impression as a Subarachnoid hemorrhage. R4's Consult Note - Neurosurgery, dated 1/11/2021, documents Subarachnoid Hemorrhage extending along the posterior sylvian fissure, oral anticoagulant use, remain from anticoagulant for the next five days, if there is expansion of the hemorrhage, may need to remain off indefinitely. On 1/19/2021, at 11:38 AM, V6, Licensed Practical Nurse (LPN), stated "I (V6) am the nurse that usually takes care of R4; R4 has visual issues, her (R4) vision is not good, R4 gets confused, and R4 sees things that aren't there." V6 also stated R4 stated R4 was "seeing little girls" in R4's room a few days before the fall. V6 stated R4 has gotten weaker since COVID-19	S9999		

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diagnosis, R4 gets tired sitting up in R4's wheelchair, R4's head falls down during meals and R4 is not eating a lot. V6 stated, "R4 should not have been left alone in R4's wheelchair, we don't leave her (R4) sitting in her (R4) wheelchair, she's (R4) old and she's (R4) tired." V6 stated a nurse, a certified nurse assistant (CNA), activities, or therapy can transport R4 but not others because they are not familiar with her (R4) care plan. V6 stated V7, Restorative Aide, would not have had a matrix (care plan that CNA's use) that day because V7 was assisting with feeding and CNA's get the matrix when they come to work in the morning. V6 stated fall preventions should have been that R4 be transferred out of her (R4) wheelchair.

On 1/19/2021, at 1:00 PM, V7, Restorative Aide, stated V7 fills in on the floor sometimes as a CNA. V7 stated V7 would not have left R4 alone in R4's room in R4's wheelchair if V7 knew R4 had been hallucinating. V7 stated V7 only picks up a matrix (care plan for CNA's) when V7 is working on the floor as a CNA. V7 also stated V7 was not aware of R4's decreased safety awareness.

The facility's Safety and Fall Prevention Policy, dated reviewed December 2020, documents each resident will be assessed using the designated fall risk assessment tool upon admission to identify the resident's highest fall risk areas, and based on these areas, preventative measures will be implemented specific to resident individual needs.

(A)