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LITTLE SISTERS OF THE POOR	2325 NORTH LAKEWOOD AVENUE CHICAGO, IL 60614

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S 000	Initial Comments Facility Reported Incident of 9/11/21/IL138166 - F689G Facility Reported Incident of 9/15/21/IL138697 - F689G	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 measures shall include, at a minimum, the following procedures: 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, Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)	S9999		

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S9999	Continued From page 2 These Regulations were not met as evidenced by: Based on observation, interview and record review the facility failed to implement measures to supervise and maintain a safe environment to prevent falls for 2 residents (R1 and R2) reviewed for falls and safety. This failure affected R1 and R2 who had an unwitnessed fall. The facility failure resulted in R1 sustaining a right forearm transverse fracture of the distal radius and ulna and right hip intertrochanteric fracture with varus deformity; and R2 sustaining a right femur fracture. Findings include: 1. R1's medical record face sheet documents the date of initial admission as August 7, 2019. On 9/11/21 R1 had an unwitnessed fall. The Facility Incident Report for R1 dated 9/11/21 at 3:16 am shows the following: R1 was found on the floor next to R1's bed. R1 did not use the call light for assistance, and complained of pain to the right wrist. Ice pack and pain medication administered and V17 (Physician) and V24 (Family) notified at 3:43am. V17 ordered for X-ray to be done. R1's local diagnostic service report on 9/11/2021 at 14:36 (2:36pm) documents Study Description R SHOULDER HUMERUS TO WRIST, RT HIP findings: Right Forearm X-ray: examination reveals soft tissue swelling with transverse fracture of the distal radius with slight dorsal angulation distal fracture fragment. Impression Right Forearm: Fracture of the distal radius. Right Wrist X-Rays Findings: Right Wrist: Examination reveals soft tissue swelling with a transverse	S9999		

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slightly impacted fracture of the distal radius and dorsal angulation of the distal fracture fragment. There is also a transverse slightly impacted fracture of the distal ulna with no significant displacement. Impression Right Wrist: Transverse fractures of the distal radius and ulna. Right Hip X-Ray Findings Right Hip: Examination reveals an impacted intertrochanteric fracture with marked varus deformity and no significant displacement. Impression Right Hip: Impacted intertrochanteric fracture with varus deformity.

R1's medical record showed that R1 was placed on a comfort measure care program with Do Not Attempt Resuscitation (DNR) signed and dated 9/10/21. R1 expired at the facility on 9/15/21 with family at bedside.

Order Summary Report for R1 documents: wrap R upper extremity to maintain immobilization due to fracture as needed for fracture Order Status: Active, Order Date: 9/11/2021, Start Date: 9/11/2021; Morphine Sulfate (Concentrate) Solution 20MG/ML Give 0.5 milliliter sublingually every 2 hours for pain related to fracture Order Status: Active, Order Date 9/11/2021, Start Date: 9/11/2021; Morphine Sulfate (Concentrate) Solution 20 MG/ML Give 0.5 milliliter sublingually every hour for pain related to fractures

On 10/04/21 at 12:21pm, V2 DON (Director of Nurse's) stated, R1 was not sent to the hospital because R1's family member who was the POA did not want R1 to be going in and out of the hospital. V2 stated R1 is on comfort measures only.

On 10/05/21 at 11:38am, V4 (Restorative Nurse) made the following statement concerning R1 and ADL's performance with transfers, safety and

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supervision. R1 passed away on 9/15/21 after fall incident. V4 explained that R1 needed supervision with transfer and ambulation due to decrease in gait and agitation. V4 stated R1 believed that the staff were stealing from (R1) so (R1) would block the room door with her (R1's) ambulating device not letting staff into R1's room.

R1's facility assessment tool section G for ADL's (Activity of daily Living) assistance dated August 31, 2021. R1 was coded 2/2 for transfer showing that R1 needs limited assistance with one-person physical assistance and walking in the room and corridor as 3/2 indicating that R1 needed extensive with one-person physical assistance. Dressing: R1 was coded 3/2 and personal hygiene 3/2 showing that R1 needed extensive assistance with one-person physical assistance. BIMS coded as 04 (four).

On 10/5/21 at 12:06pm V4 (Restorative Nurse) stated the fall care plan should be updated immediately (referring to R1's fall on 9/11/2021). The revision date on R1's care plan for the fall on 9/11/21 was 9/14/21 (referring to Goal). V4 further stated, "The lateness is due to not being in the facility." "I was not here (referring facility). When I came back I updated the care plan."

R1's fall care plan document: date initiated 11/11/19 and previous to fall on 9/11/21, care plan documents R1 had a fall on 11/18/19 and 2/23/21.

R1's fall care plan shows goal: R1 will be free of minor injury through the review date. Date initiated 11/11/2019, Revision on 9/14/2021, Target Date 9/11/2021. Intervention 9/11/2021: Check on R1 frequently, she is on bed rest, reposition as needed, keep her clean and

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comfortable, date initiated 11/11/2019, revision on 9/15/2021. The fall care plan for R1 documents the fall care plan was not revised immediately.

On 10/05/21 at 1:40pm, V17(physician) stated I've been taking care of (R1) since (R1) moved here (referring to the facility). At first R1's daughter was concerned about the Heart Failure diagnosis and was tired of R1 going in and out of the hospital. (V17) stated R1's medication was adjusted to where R1's status was great. V17 further explained that R1 was supposed to be on dialysis, but the family was worried and concerned about R1 going on dialysis. V17 stated that R1 ended up falling on 9/11/21 and broke (R1's) hip, ulna and everything went down from there. Daughter was going on a trip and family was ok with R1 being on comfort measures. When the surveyor asked about the reason for not sending R1 to the hospital for evaluation and treatment, V17 stated in part the goal was for R1 not to suffer. R1 got up on (R1's) own and apparently fell during the night. V17 attributed the fall to having Dementia. V17 stated, "Most of the residents with dementia will get up at night. They don't realize their limitation because of the diminished brain capacity. Then asked what measures are supposed to be put in place to prevent falls. V17 replied, most of the residents with dementia have to have cues and supervision. In an ideal work situation they should have one to one supervision, frequent rounding (referring to round checks). Most places (referring to facilities) use these to prevent falls because they may be ok one minute and the next fall.

On 10/06/21 at 11:38am, V20 CNA (Certified Nurse's Aide) stated, on that day (referring to 9/11/21 incident) R1 was in bed sleeping, and we (referring to V21) used to take turns to monitor

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S9999	Continued From page 6 R1. V20 stated, R1 wants to get up and do things on her own. R1 was agitated. We (V20 and V21) were with R1 on 1:1 monitoring. V21 who was in charge of monitoring was going on lunch break. V20 explained that in-between the monitoring, (V20) went to use the bathroom. R1 was sleeping at the time. V20 stated, as I (V20) was coming back, I saw V21 coming back too. We (V20 and V21) heard a bang sound. As we were trying find out where the sound was coming from, we saw (R1) sitting on the floor in the room. When the surveyor asked who was supervising R1 at the time, V20 stated, "No one because R1 was sleeping." On 10/06/21 at 11:43am, V21 (CNA) explained (referring to 9/11/21 incident), R1 was in the room in bed. We (referring to V21 and V20) were monitoring R1. When the surveyor asked about how the monitoring is done, V21 replied by staying in the room with R1. We (V21 and V20) make rounds, one stays in the room and one rounds. There is a recliner in R1's room and we (V21 and V20) were doing one on one monitoring with R1. V21 stated, I went on break and when I was coming back to R1's room, I heard a thud. The sound was very clear and loud. V21 stated, I rushed to R1's room. R1 was sitting on the floor. V21 explained that at first glance it seemed, R1 was sitting on the floor. V21 stated, it appeared that R1 slid off the bed. The other CNA (Referring to V20) stayed with R1 and I went to get the nurse (V22). We did not move R1 or touch her (R1). V21 stated, I went to get the nurse (V22) because the nurse (V22) was working on both 1 south and second floor south. The surveyor asked V21 who was supervising R1 at the time of the fall. V21 replied, I think what happened was that the other CNA (referring to	S9999		

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V20) had gone to use the bathroom. V21 stated it was an unfortunate tragedy. When asked, what is the facility protocol when a resident is on one to one monitoring. V21 replied, we stay in the room with the resident and find a relief if we need to step out of the room. V21 further explained that R1 was in excruciating pain. Four of us (Referring to V20, V21, V22 and V24) put R1 back in bed with a sheet (Linen). V22 suggested we roll up the sheet to support the chest so that way we would not put any weight under the arms (two staff supporting the upper extremities and two staff supporting the lower extremities).

On 10/06/21 at 12:30pm, when the surveyor asked V2 about the facility policy and procedure regarding one to one supervision. V2 replied that the facility does not have any policy on one to one, the staff just use their judgement.

2. R2's admission record documents the date of initial admission as November 24, 2015 with the following diagnoses but not limited to: Displaced fracture of lateral condyle of right femur, initial encounter per closed fracture, fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing, bipolar disorder, major depressive disorder, unspecified dementia with behavior disturbance and generalized anxiety disorder.

Progress note dated 9/15/2021 at 22:14 (10:14pm), Type: Health Status documents: NOD called local hospital. Per ED R2 will be admitted with right femur fracture.

MDS Progress note dated 9/22/2021 at 14:30 (2:30pm), Type: Health Status documents in part: Main Hospital Discharge Dx (Primary dx): Closed

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S9999	Continued From page 8 Bicondylar Fracture of distal femur, R initial encounter. That is the fx at R leg up near knee. On 10/04/21 at 12:21pm, V1 (Administrator) stated, according to the facility investigation, V23 CNA (Certified Nurse's Aide) used poor judgement in leaving R2 alone to go and seek another staff's help in transferring R2 from the wheel chair to bed. V1 stated V23 could have used the call light to get the staff's attention. V1 stated, review of the facility camera showed V23 going in and out of the room multiple times. On 10/04/21 at 12:21pm, V2 DON (Director of Nurse's) confirmed what V1 said and added that V23 is no longer working at the facility. V2 stated V23 has been terminated for using a poor judgement that resulted in R2's fall, causing R2 to have a fracture of the femur. V2 stated, according to the facility investigation, R2 was left undressed, with no shoes or socks on and V23 could have used the call light to call for assistance. On 10/04/21 at 3:44pm, V19 RN (Registered Nurse) stated, (referring to 9/15/21fall incident) V23 came to get (V19) for assistance in transferring R2 to bed. Upon getting to the room, R2 was found on the floor laying on her (R2) left side of the body and holding her (R2) elbow. V19 stated that during the assessment, R2 could not tell what (R2)'s name was and her (R2) eyes were not blinking. V19 stated, upon touching the lower extremities R2 expressed feeling of pain. V19 stated the emergency paramedics were called and R2 was sent to the hospital. V19 further stated, R2 has unsteady gait but was able to propel herself (R2) in the wheel chair. V19 stated R2 needs a stand lift device. V19 stated, upon entering R2's room the wheel chair was by R2's head unlocked.	S9999		

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According to the facility incident investigation report dated September 21, 2021 documented the following under findings: there were no witnesses to the fall of 9/15/21. R2 fell out of the wheelchair onto her bedroom floor. Report documented that the wheelchair was locked; but not at the time of staff returning to R2's room. It was determined that, V23 assigned to R2 used poor judgement for R2 who was at high risk for falls. V23 could have pulled the call light for assistance.

R2's fall risk assessment dated 8/25/2021, documents R2 is at moderate risk with a score of 9. Disoriented and requires use of assistive devices.

R2's facility assessment tool dated August 23, 2021 section G for ADL's (Activity of daily Living) assistance shows the following: R2 was coded 3/3 for transfer showing that R2 needed extensive assistance with two persons physical assistance, walk in the room and corridor as 8/8 indicating that this activity did not occur. Dressing R2 was coded 3/2 and personal hygiene 3/2 showing that R2 needed extensive assistance with one person physical assistance. BIMS coded as 0 (Zero).

R2's plan of care for fall (High Risk Precaution) initiated 06/21/2018 documents R2 is high risk for falls related to poor safety awareness secondary to impair cognitive/dementia. Interventions include but not limited to: Ensuring R2 is wearing appropriate foot wear/nonskid socks when ambulating and providing R2 with a safe environment.

On 10/05/21 at 11:28am, V4 stated (referring to 9/15/21), "R1 should not have been left alone,

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because R2 needs two person assist before the fall due to dementia and impaired locomotion." V4 explained, when V23 CNA (Certified Nurse Aide) was interviewed, V23 stated she left R2 in bed to get help and when V23 came back to the room R2 was found on the floor. V4 further stated, V23 should have used the call light to alert the other staff for help.

The facility policy presented on Risk Management Team documented that the risk management also relates to supervision/adequate supervision. Adequate supervision is determined by assessing the appropriate level and number of staff required.

The facility policy on Resident's call on how to answer pointed out that the signal call system is a quick means of contact between residents and staff. To ensure that the resident's needs are met.

The facility policy on Falls Prevention with dated 5/2006 pointed out that the purpose of the program is to reduce the risk of falls and injury. Procedure includes but not limited to making sure that the locks on the wheel chair is functional, ensure that adaptive equipment is within reach.

The facility policy titled Comfort Care End of Life Measures dated 7/2005 presented documented under purpose that the goal of providing comfort care includes but not limited to ensuring the provision of appropriate care for those whose disease is not responsive to curative treatment

(A)