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	IL6012322	A. BUILDING: _____ B. WING _____	C 10/20/2021

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S 000	Initial Comments Facility Reported Incident of October 1, 2021 IL139189	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 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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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 interview and record review, the facility failed to ensure an investigation for a resident's fall was investigated, failed to ensure resident's falls were thoroughly investigated, failed to identify the root cause of falls, and failed to ensure fall prevention interventions and post fall interventions were implemented. These failures affect 3 residents (R1, R2 and R3) reviewed for falls in the sample of three. These failures resulted in R1 falling twice resulting in a hip fracture and an injury to the lung that required a chest drainage tube to be placed.

Findings include:

1. R1's Fall Risk Data Collection assessment, dated 9/30/21, documents R1 is a high risk for falls.

R1's Minimum Data Set, dated 10/1/21, documents R1 requires extensive staff assistance for toileting and transferring.

R1's Occurrence Report documents R1 had a fall on 9/30/21 at 2:20pm. This report documents R1 was found sitting on the floor in the bathroom with R1's pants and briefs down around the bottom of

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S9999	Continued From page 2 R1's ankles. The conclusion documents R1 slid to the floor on buttocks, and documents the root cause of the fall as "due to resident action or internal risk factors" but no resident specific details/reason. There is no documentation why R1 was in the bathroom, when R1 was last toileted, or when R1 was last observed prior to the fall. R1's Occurrence Report documents R1 had a fall on 10/1/21 at 7:00am. This report documents R1 was found on the floor on R1's left side laying in front of the sink in R1's room, and internal rotation of the left leg was noted and a "full head to toe assessment" was performed, with no details of what the head to toe assessment consisted of/showed. This report does not document the last time R1 had been assisted to the toilet. The conclusion for this fall documents R1 was assisted off the floor and requested to be taken to the bathroom. R1 noted hip pain, and V6, Licensed Practical Nurse (LPN), came to re-assess R1 due to the hip pain. R1 requested to go to the dining room and was having trouble breathing. R1 was then taken to the nurse's station where staff applied oxygen and transferred R1 to the hospital. The root cause is documented as "due to resident action or internal risk factors" but does not identify a specific identified root cause related to the fall. This report documents fall interventions were in place at the time of the fall, but the investigation does not document what fall interventions were in place. This report also documents R1 was admitted to the hospital with a diagnosis of a Left Hip Fracture and Pneumothorax. R1's Hospitalist Admission History and Physical Exam, dated 10/1/21, documents R1's medical history including a history of Deep Vein	S9999		

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Thrombosis (DVT) and Pulmonary Embolism (PE) with R1 taking Eliquis (Anticoagulant) and Aspirin (NonSteroidal Anti-Inflammatory) medication, Temporal Arteritis which caused blindness and Anxiety. This report documents R1 presented to the hospital with Dyspnea and no breath sounds on the right side. A Computed Tomography (CT) of the chest revealed a moderate right Pneumothorax and a non-displaced Left Acetabular Fracture. This report documents R1 was admitted to the hospital for "Acute Hypoxemic Respiratory Failure secondary to Traumatic Right Pneumothorax after fall today."

On 10/19/21 at 2:10pm, V2, Director of Nursing (DON), stated R1 was in the bathroom trying to pull up R1's pants and lost R1's balance. R1 requires assist and refuses to use call light at times. There is no documentation of how R1 got in to the bathroom. Staff placed a sign in the bathroom to call, not fall, as a reminder, but staff are to be taking R1. V2 stated R1 had gone from R1's bed to the chair to the bathroom, but it is not documented and there is no supporting documentation. "That is just where (R1) goes." There is no documentation of where R1 was prior to the fall. There is no documentation of investigation into when R1 was last toileted. V2 stated the root cause was R1 is unaware of safety limitations and transfers without asking for assistance, but the investigation is incomplete.

V2 stated R1 was found on the floor on 10/1/21 at 7:00am. V2 stated staff reported R1 needed to go to the bathroom, so staff assisted R1 and that is when R1 reported the hip pain. R1 wanted to go to dining room. V2 stated when a head to toe assessment is completed, staff do a skin check, and check for range of motion and shortening, etc

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of leg and vital signs. V2 stated V2 didn't know for sure if R1 had always had the shortening of the left leg.

2. R2's Face Sheet, dated 10/19/21, documents R1's diagnoses including Alcoholic Hepatitis, Cognitive Communication Deficit, Muscle Weakness, Degeneration of Nervous System, Anemia, Hallucinations, Unspecified Psychosis, Anxiety and Chronic Pain Syndrome.

R2's Minimum Data Set (MDS), dated 9/13/21, documents R2 was dependent on staff for bed mobility and toileting. This MDS also documents R2 has a history of multiple falls.

R2's Fall Risk Data Collection assessment, dated 7/17/21, documents R2 is at a high risk for falls.

R2's Occurrence Reports document R2's fall incident investigations as follows:

8/28/21 at 10:01am- R2 attempted to stand up from the shower chair in the shower room. V12, Certified Nursing Assistant (CNA), reported R2 got up and the shower chair slid out from under R2. There is no documentation the facility evaluated the shower chair to ensure proper functioning. There is no documentation regarding if the shower chair was being used properly, such as positioning and use of brakes on shower chair. The root cause is documented as "due to resident action or internal risk factors" with no identification of specific root cause of why R2 fell.

8/28/21 at 9:15pm- R2 was found on the floor after an unidentified "family" adjoining R2's room heard R2 "hit the wall." R2 had a bruise to the left temple area of R2's head. This report documents R2 stated R2 was getting ready for work. This

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report documents R2 lost R2's balance and fell, but does not identify why R2 may have lost his balance and fell. There is no documentation of a post fall intervention placed in regards to this fall within the investigation.

R2's Occurrence Report, dated 8/29/21 at 1:12am, documents R2 was found laying on the floor. This investigation documents R2 rolled out of bed while trying to get up unassisted, but does not identify why R2 was attempting to get out of bed. There is no documentation of staff interviews related to this fall. There is no documentation in this investigation of a post fall intervention being placed for this fall.

R2's Occurrence Report, dated 8/29/21 at 6:25am, documents V9, Licensed Practical Nurse (LPN), "heard a loud thump" while at the nurse's station, and V9 went down the hall and found R2 lying in the hallway on R2's right side wearing only a brief. R2 was "moaning" and stated "(R2) just fell." There is no documentation in the investigation as to when R2 had last been toileted. This investigation also documents V14, Certified Nursing Assistant (CNA), reported R2 was lying on R2's left side on the ground and includes environmental conditions present including obstacles in path of isolation bins, bedside table, and that R2 has a recliner in R2's room along with a bedside table. This report documents R2 lost R2's balance while ambulating unassisted, and is unaware of R2's safety limitations. R2 is encouraged to use R2's call light and wait for assistance. There is no root cause identified as to why R2 had got up unassisted, or what may have actually caused R2 to fall.

R2's Occurrence Report, dated 9/6/21 at 7:15pm, documents R2's position when found as "right

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S9999	Continued From page 6 side witnessed fall." There is no documentation as to when R2 last received toileting, repositioning, or had food and fluids. There is no documentation of interviews with staff for this investigation. This report documents the conclusion of the investigation including R2 attempted to self transfer, but due to R2's weakness, R2 was unable to complete the transfer. There is no root cause identified as to why R2 attempted to self transfer. R2's Occurrence Report, dated 9/9/21, documents V15, R2's family, was visiting with R2 and left to get something to drink. V15 found R2 on the floor upon returning to R2's room. This report does not document when R2 had last been toileted, repositioned, or given food or fluids. This investigation documents R2 was last observed 9/9/21 at 4:08pm, but this was by R2's wife, and does not identify when R2 was last seen/observed by staff. The root cause is documented as "due to resident action or internal risk factors" with no identification of specific root cause of why R2 fell. R2's Progress Notes, dated 9/12/21 at 1:50pm, documents R2 "experienced a fall that was unwitnessed." This note documents R1's alarm was sounding but staff were unable to respond in time before R2 rolled off the bed. This note documents V2, Director of Nursing (DON), and V3, Assistant Director of Nursing (ADON), were notified and the facility was to start the process of moving R2 closer to the nurses station and to place a "louder alarm" on R2. There is no documentation R2 was moved closer to the nurse's station, or that a "louder alarm" was put in place for R2. There is no investigation documented for this fall.	S9999		

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S9999	Continued From page 7 On 10/19/21 at 4:00pm, V2, Director of Nursing (DON), stated R2 had Cirrhosis of the liver and would get agitated, and the facility had sent R2 out multiple times to try to get R2 help. In regards to R2's fall while in the shower with a shower chair in use, V2 stated V2 doesn't know if the shower chair was working properly or not, and the shower chair that had been used has been replaced. V2 stated V2 doesn't know if the shower chair wheels were locked because that was not investigated. V2 also stated V2 is unaware of which family had notified staff of R1's fall on 8/28/21 at 9:15pm, and V2 did not interview the family. V2 stated R2 was "getting up to get ready for work" and staff gave R2 a positioning pillow to help R2 from rolling out of bed, but there is no documentation R2 rolled out of bed, or documentation of interviews with staff regarding this fall on 8/28/21 at 9:15pm. 3. R3's Admission Record, dated 10/20/21, documents R3's diagnoses including Myasthenia Gravis, Metabolic Encephalopathy, Heart Failure, Chronic Atrial Fibrillation, History of Transient Ischemic Attack (TIA), Repeated Falls, Sick Sinus Syndrome, Ischemic Cardiomyopathy, Unsteadiness on Feet, Lack of Coordination and Cognitive Communication Deficit. R3's Minimum Data Set (MDS), dated 10/6/21, documents R3 requires extensive staff assistance for bed mobility, transfers and toileting. This MDS also documents R3 has a history of falls. R3's Fall Risk Data Collection assessment, dated 9/29/21, documents R3 is a risk for falls. R3's Occurrence Report documents R3 fell on 9/29/21 at 9:15am. This report/investigation documents R3 stated R3 was "trying to get into	S9999		

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bed when (R3's) feet started to slide", and R3 slipped down to R3's buttocks to the floor. There is no documentation in this investigation as to when R3 was assisted to the toilet, was visually observed, given fluids or food, repositioned or given medications. There is no documentation if R3's call light was within reach. This investigation documents R3 was wearing "poorly fitting shoes" and slipper socks. This investigation documents the root cause "due to resident action or internal risk factors", but does not document details regarding the root cause of R3's fall. There is no documentation of witness statements from staff working that day or responsible for R3's care that day.

R3's Occurrence Report documents R3 fell on 10/2/21 at 7:51pm. This report documents R3 had swelling/small localized bump to R3's right shin. R3 was found holding on to the "rail" in the bathroom when R3's knees started to buckle and R3's shin hit the wheelchair and V16, Licensed Practical Nurse (LPN) assisted R3 to the floor. R3 stated R3's "knees buckled." This report documents a conclusion including R3 reported R3 was trying to go to the bathroom and R3's knees buckled. R3 was encouraged to use R3's call light and wait for assistance, with a root cause "due to resident action or internal risk factors", with no specific root cause identified.

On 10/20/21 at 1:00pm, V2, Director of Nursing (DON), stated R3's fall investigations are incomplete and do not identify a root cause specific to each fall, due to details of each fall not being investigated.

The facility's Fall Prevention Policy (S.A.F.E.), dated February 2014, documents the definition as the S.A.F.E program promotes Safety

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S9999	Continued From page 9 Assessment, Fall prevention and Education of both staff and residents. This policy documents residents found to be at high risk for falls are placed on the S.A.F.E. program and specific interventions are implemented to meet individual needs. This policy documents following any falls, the facility staff completes an Occurrence Report. Details of the fall will be reported and potential causal factors identified and investigated. Interventions will be immediately implemented following each fall and the resident's care plan will be updated. All Occurrence Reports are reviewed at the daily meeting to ensure an intervention was immediately implemented, added to the plan of care and that the current intervention is appropriate. This policy also documents occurrences will be reviewed weekly at the facility's care management meeting to ensure the occurrence report is completely finished and closed and that interventions were implemented timely and to evaluate the outcome of the interventions. Revisions to the plan of care will be done if indicated. (A)	S9999		