STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015168	A. BUILDING: _____ B. WING _____	C 10/21/2021

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S 000	Initial Comments Facility Reported Incident (FRI) of 09/22/2021-IL138713	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3)6) 300.1220b)2) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3)Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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: 2)Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. These requirements were not met evidenced by:	S9999		

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S9999	Continued From page 2 Based on interviews and record reviews, the facility failed to conduct a thorough assessment and monitoring of a resident after fall incident for one (R2) of three residents reviewed for accidents and supervision. This deficiency resulted in R2 sustaining a left hip fracture which caused subsequent emergent transfer to the hospital where R2 required surgical intervention. Findings include: R2 is a 72 year old admitted in the facility on 07/21/21 with diagnoses of Dementia with Lewy Bodies; Parkinson's Disease; Pain in Left Hip and Displaced Intertrochanteric Fracture of Left Femur, Subsequent Encounter For Closed Fracture With Routine Healing. According to progress notes dated 09/18/21, R2 was observed sitting on the floor inside room.. Alert and verbally responsive but confused and forgetful. R2 denies hitting head, no change in level of consciousness and no complaints of pain. There were no injuries noted at the time of fall. On 10/19/21 at 11:40 AM, V4 (Registered Nurse, RN) was interviewed regarding R2's fall on 09/18/21. V4 verbalized, "That time, V6 (Certified Nurse Assistant, CNA) did rounds and found (R2) sitting on the floor. When I went to room, I did a head to toe assessment and there were no injuries or pain at the time. (R2) was able to walk back to bed. I notified V5 (Physician) regarding the fall through voicemail, awaiting for a call back. He did not call back on my shift. The next day I was working, V8 (Nurse to the Practitioner, NP) was notified that she (R2) had a fall and complained of pain on the right leg. So I told him (V8) to do a STAT (immediately) X-ray of the right lower extremities."	S9999		

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S9999	Continued From page 3 R2's X-ray report dated 09/18/21 documented the following results: Right Tibia and Fibula: Findings - there is no evidence of fracture or dislocation. Right Femur: Findings - There is no evidence of fracture or dislocation. According to V13 (RN) during interview on 10/19/21 at 12:50 PM, when she came back to work on 09/21/21, R2 was still complaining of pain , on left hip. Progress notes dated 09/21/21 indicated that in the morning at 9:00 AM, R2 complained of twitching and pain in the left leg, difficulty moving the left leg and tension in the left leg muscle; with shortening of the left leg. V5 was notified with order for R2 to be sent to the hospital for evaluation. V11 (Power of Attorney) was also notified but refused to bring R2 to hospital. Instead, (R2) has to be seen by therapy first for evaluation. However, after talking to V12 (NP), V11 agreed to take R2 to an outpatient orthopedic clinic the following day. Progress notes dated 09/22/21, time stamped 8:30 AM, documented that R2 left facility with V11 for an orthopedic appointment. Progress notes dated 09/22/21, time stamped 10:35 AM, V11 called facility to inform that R2 had a fracture on the left hip and will be admitted in the hospital for surgical intervention. R2's Hospital records dated 09/26/21 documented: Primary/Discharge diagnosis - Left hip fracture Procedures or Surgeries done - Left hip ORIF (Open Reduction and Internal Fixation)	S9999		

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S9999	Continued From page 4	S9999		

On 10/19/21 at 2:35 PM, V8 was interviewed regarding R2's fall and X-ray order. V8 replied, "On R2, I don't remember ordering for a right femur, fibula and tibia X-rays. I don't remember ordering that."

V2 (Director of Nursing) was also asked regarding R2. V2 stated, "She had a fall on 09/18/21. She was assessed, no injuries, no pain. V4 was the nurse on duty on 09/17/21 night shift and on 09/18/21 morning shift. There were no other complaints of pain from her (R2). At that time, I asked V4 why she ordered a right femur/tibia and fibula X-rays. She said that R2 complained of pain on the right side that morning and she notified V8 who did order for an X-ray on that right side. There was no fracture seen."

Further review on R2's progress notes from 09/18/21 to 09/22/21 showed no documented assessment regarding R2 complaining of pain on her right side or leg post fall incident. According to neurological (neuro) evaluation sheet, R2 expressed pain on 09/18/21 at 10:40 AM but there was no specific location of pain indicated. Also, the neuro sheet documented that on 09/19/21, all observation on pain recorded as NO until 09/22/21 when R2 went for an orthopedic appointment, no notation to the fact that she (R2) complained of pain on 09/21/21 on her left leg.

V2 (DON) was inquired of regarding follow-up assessment and monitoring conducted on R2 after the fall incident. V2 replied, "There was no assessment documented regarding her (R2) complaining of pain on her right side. There was no 72 hours monitoring assessment post fall on her (R2). She (R2) is supposed to have been assessed for 72 hours post fall because you will

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S9999	Continued From page 5 never know if there is injury that you don't see right away. The 72 hours post monitoring charting should be in the progress notes but the only charting was resting comfortably in bed. Every incident should have 72 hours post fall monitoring charting. (R2) had a fall on 09/18/21 and should have been monitored until 09/21/21. But on 09/21/21, was already complaining of pain. V4 did not actually document that (R2) had pain on the right lower extremities, I don't know why. (R2) should have been assessed and it should be documented. R2 went to the orthopedic appointment, the clinic called stating R2 was beling sent directly to the hospital with a left hip fracture. X-ray orders are based on what nurse assessed on residents after a fall incident. Nurse has to do a full assessment and monitoring after fall incidents. All assessment documentation should be in the electronic medical chart." R2's neuro evaluation sheet is not a part of her electronic medical records. During interview with V5 (Physician) on 10/19/21 at 4:49 PM, he stated that he was the one who ordered the X-ray on the right hip. V5 stated, "When (R2) had the fall last time, I was notified. They did not say that she had an injury. I was informed that it was just a fall and not complaining of any pain. I ordered an X-ray. I ordered a right hip X-ray. I based it on the side she had fallen. I was just notified that she had a fall on that right side. Since she has Dementia and a poor historian, I ordered a right hip X-ray. I ordered right only because I would not want her (R2) to be exposed to radiation that much unless she is complaining of pain. She was apparently asymptomatic that is why I ordered X-ray on her right side where she fell off."	S9999		

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S9999	Continued From page 6 Per facility's post fall huddle documentation worksheet, R2 was found sitting at the back of bedroom door during fall incident. V6 verbalized, "On 09/18/21, around 4:00 AM, I did my rounds. Everybody in bed. Around 4:55 AM, I heard a noise, my instinct was to go with another resident who usually walks and walks. But she was on bed. Everybody was in bed on that hallway. I ran to the other hallway, I noticed that R2's door was closed and hard to open. I tried and put my head inside and that's when I saw R2 sitting on the floor behind the door. I called V4, we went inside together. She (V4) made an assessment on R2, no injuries. R2 said she had no pain, we walked from door to bed with the use of walker. R2 was able to walk at the time with no problem. " Facility's incident report dated 09/22/21 also documented that R2 was observed sitting on the floor by the door in room and no injury noted at the time of incident. There was no documentation indicating that R2 fell on right side. Also, there were no follow-up documentation regarding post fall assessments charted within the 72 hours on R2's electronic medical records. The neurological evaluation sheet documented that on 09/08/21 at 4:55 AM until 09/19/21 at 1 PM, it was recorded that R2's left lower extremities can still be moved. On 09/19/21 at 4 PM, it was recorded that her (R2) left lower extremities as no movement until 9/22/21. There were no follow up reports regarding the assessment. On 10/20/21 at 10:15 AM, V12 (NP) was asked regarding fall monitoring on residents at risk. V12 stated, "Staff need to do an immediate assessment, head to toe - looking for injuries; check neuro status, vital signs, notify me of	S9999		

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S9999	Continued From page 7 incident, they have to do post fall assessments and monitoring regardless if it is in the facility policy or not, and have to notify me of any significant changes in the assessment. Initially, resident may not feel any pain due to adrenaline shock, so I need to know after the initial shock is resolved. There could be a possibility that injuries may present several days after fall." V5 was also asked regarding his expectations of staff regarding fall reports, stated, "I expect them to call me immediately and tell me about the nature of the fall and the specific details of the incident, what side exactly resident fell on, how long they stayed on that position or if resident is complaining of pain." Facility's policy titled "Falls" date revised March 2018 documented in part but not limited to the following: After a fall: 6. Observe for delayed complications of a fall for approximately forty-eight (48) hours after an observed or suspected fall, and will document findings in the medical record. 7. Document any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility; and any changes in level of responsiveness/consciousness and overall function. Note the presence or absence of significant findings. Reporting 2. Report other information in accordance with facility policy and professional standards of practice.	S9999		

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