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	IL6005938	A. BUILDING: _____ B. WING _____	C 09/30/2022

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S 000	Initial Comments Investigation of Facility Reported Incident of 9/19/22/IL151730	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)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	S9999		

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S9999	Continued From page 1 resident to meet the total nursing and personal 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. These requirements are not met as evidenced by: Based on record review, observation and interview the facility failed to ensure fall careplan interventions were implemented and failed to ensure an audible safety alarm was functioning for one (R1) resident out of three residents reviewed for falls in a sample list of three residents. This failure resulted in a fall with harm due to R1 sustaining a extra-axial hemorrhage, bruising and laceration requiring four sutures to upper Right Forehead. Findings include: The facility policy titled 'Incidents, Accidents and Supervision' implemented 1/1/2020 documents the following: Policy: the resident environment remains as free of accidental hazards as possible and each resident receives adequate supervision and assistive devices to prevent accidents. This	S9999		

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S9999	Continued From page 2 includes: Monitoring for effectiveness and modifying interventions as necessary. Supervision is a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents." R1's Undated Face Sheet documents medical diagnoses of Left Extra-Axial Hemorrhage, Left Temporal Laceration requiring Sutures, and History of Falling, Syncope and Collapse, Hearing Loss, Bilateral Glaucoma and Difficulty in Walking, R1's Minimum Data Set (MDS) dated 7/5/22 documents moderate cognitive disability level. This same MDS documents R1 as requiring extensive assistance of one person for bed mobility, transfers, walking in room, walking in corridor, dressing, toileting, personal hygiene and supervision for eating. R1's Care Plan fall intervention dated 4/28/22 documents R1 is to have bed alarm. This same Care Plan documents a fall intervention dated 7/16/22 which documents R1 is to be laid down in bed after breakfast. R1's Physician Order Sheet (POS) dated September 1-30, 2022 documents a physician order starting 9/20/22 to monitor Right side of head laceration for any signs and symptoms of infection example redness, swelling, warmth, drainage and notify Physician of any changes. This same POS documents physician orders for Aspirin chewable 81 milligram (mg) daily ordered 10/5/21 and discontinued 9/22/22, Clopidogrel Bisulfate (Plavix) 75 milligrams (mg) daily started 8/22/22 for Acute Myocardial Infarction and discontinued 9/22/22 and Sutures to be removed seven to ten days from day of fall 9/19/22.	S9999		

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S9999	Continued From page 3 Remove sutures Tuesday 9/27/22. R1's Physician Progress Note dated 7/14/22 documents "(R1)'s hearing loss does contribute to falls as (R1) does not hear bed alarm." R1's Fall Risk Assessment dated 9/19/22 documents a score of 60 which indicates R1 is at high risk for falling. R1's Nurse Progress Notes dated 9/19/22 at 3:52 PM documents "(R1) was sent to emergency room this morning for fall , hit head , right side Hematoma. Hospital did Computerized Tomography (CT) scan , results of bleeding in Subdural Hematoma , four sutures to laceration. Remove in 7-10 days. Remove Tuesday 9-27." R1's Fall Investigation Report dated 9/19/22 documents 'Predisposing Environmental Factors' includes fall alarm. This same report documents "(V7) Certified Nurse Aide (CNA) notified (V3) LPN that (R1) was on the floor. Upon entering (R1) room, (R1) was extended, back leaned on the bed. (R1) hit head on the Right side, bleeding and swollen Right side Hematoma. Resident description: "I was trying to get in bed." R1's Post Incident Interview Questions dated 9/19/22 documents immediate intervention taken to prevent another fall was 'need new bed and chair alarm'. R1's Resident Post Fall Review dated 9/19/22 documents 'how can we prevent from falling in the future as "bed alarm, chair alarm". This same report documents the last time a staff member assisted (R1) was 'before breakfast'. This same report documents (R1) stated "I was going to	S9999		

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S9999	Continued From page 4 bed" when asked why (R1) thinks (R1) fell. R1's Post Fall Observation dated 9/19/22 documents R1 as confused, transferring from wheelchair to bed after breakfast which resulted in Right Hematoma due to hitting head. This same Report documents R1's fall alarm was present but did not go off (did not sound). This same Report documents R1 is confused and does not ask for assistance with transferring. R1's Final Incident Report to Illinois Department of Public Health (IDPH) dated 9/23/22 documents "(R1) was discovered on the floor in room with legs extended and back resting on the bedframe. (R1) told staff (R1) was trying to get in the bed. (R1) noted to have a head injury, as visible swelling was noted to the Right Temporal area with external bleeding from a small laceration. (R1) was sent to the emergency room and a Computerized Tomography (CT) scan was done. (R1) was diagnosed with a small intracranial bleed. (R1) was returned to the facility with orders to hold Aspirin 81 milligrams (MG) and Clopidogrel Bisulfate (Plavix) 75 mg for two weeks and monitor. (R1) does not remember to ask for assistance. (R1) has a Brief Interview for Mental Status (BIMS) score of 7 out of 15 possible points indicating moderate cognitive impairment and is extremely hard of hearing." R1's Emergency Room progress note dated 9/19/22 documents "Head- (R1) has a 2.5 centimeter (cm) laceration of the Right Forehead. Four sutures placed to Right Forehead." This same progress note documents Chief complaint as "fall". R1's Computerized Tomography (CT) of Head or Brain Without Contrast dated 9/19/22 documents	S9999		

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"Findings: a scalp Hematoma is present. There is small extracranial high density seen within the left frontal parietal region compatible with extra-axial hemorrhage. No mass effect or midline shift is seen. Chronic Subdural hygromas are present bilaterally right greater than left. Impression: Acute extra-axial hemorrhage demonstrated on the left. This is felt to be superimposed on a small chronic Subdural hygroma."

On 9/29/22 at 1:25 PM R1 was laying in bed with call light in reach. Large softball sized area around R1's Right Eye and Right Forehead area were yellowed and gray. R1' s suture line on upper Right Forehead was dry, scabbed with no sutures in place.

On 9/29/22 at 1:40 PM V5 Certified Nurse Aide (CNA) stated residents' fall interventions are kept in a binder at the nurses station. V5 CNA asked other floor staff where fall intervention binder was. Other floor staff stated there is no fall intervention binder and all the fall interventions could be located through the electronic charting program used by the CNA's. V5 CNA walked to the wall kiosk where electronic charting could be completed. V5 used electronic search engine to learn how to sign in to electronic charting software. V5 CNA then signed in to electronic software charting and clicked in several different areas before finding R1's fall safety interventions. V5 CNA stated "I sure didn't know they were there." V5 CNA stated V5 regularly cares for R1.

On 9/29/22 at 3:50 PM V3 Licensed Practical Nurse (LPN) stated "the day (R1) fell and hit (R1)'s head, I did not hear (R1)'s alarm sounding. The staff came and told me (R1) fell so I went straight to (R1)'s room. When I entered (R1)'s

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room (R1) was in a sitting position with legs extended in front of bed. (R1)'s back was leaning against bed and (R1) was facing door to room. (R1)'s head was bleeding so we (staff) took (R1)'s vitals and sent (R1) to the emergency room for evaluation of (R1)'s head injury. Sometimes when (R1) lays on the alarm or sits on the alarm for long periods the alarm does not sound immediately when (R1) repositions or transfers. Sometimes the alarm takes 15-30 seconds before it sounds. I saw the chair alarm in the wheelchair but it was not sounding. (R1) was fully dressed since (R1) had been down to the dining room for breakfast prior to (R1)'s fall. (R1)'s bed was not made."

On 9/30/22 at 8:35 AM V8 Certified Nurse Aide (CNA) stated "I was passing hall trays with (V7) CNA the morning (R1) fell and hit (R1)'s head. (R1) was eating breakfast in the dining room and brought himself back to the room. We (V7, V8) did not know (R1) was in (R1)'s room because we (V7, V8) was assigned to pass hall trays. (V13) CNA was assigned to stay on the hall but (V13) was giving someone a shower. So there was no one watching (R1). That is how (R1) got back to (R1)'s room without us knowing. When I walked past (R1)'s room I heard (R1) hollering 'help' so I went in to check on (R1). (R1) was sitting up with legs extended out. (R1)'s back was against the bed and (R1) was facing towards the room door. (R1)'s wheelchair was sitting next to bed with cushion and wheelchair alarm in place. (R1)'s wheelchair did not seem disturbed. (R1)'s incontinence pad on bed was hanging off of bed. I think (R1) had brought himself back from breakfast, transferred himself from wheelchair to bed and then tried to get out of bed to use the bathroom and fell. It looked like (R1) had scooted himself off of the bed and hit (R1)'s head

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on the dresser. That is what it looked like to me. (R1)'s alarm was not sounding. (R1)'s wheelchair alarm was sitting in wheelchair and turned off. I do not know if (R1) turned off the alarm himself or someone forgot to turn it on. (R1) does turn off (R1)'s alarm sometimes that is why we (staff) have to watch (R1) closely. I guess it doesn't matter, either way it wasn't sounding. (R1) must have been there for some time because (R1) had time to get back from the dining room and transfer self."

On 9/30/22 at 9:30 AM V10 Physician stated "(R1) is advanced age and cognitively impaired. It is difficult for (R1) to understand the implications of him falling. (R1) has a tendency to get up by himself. The facility needs to make sure (R1)'s fall risk precautions are being implemented. Not ensuring fall interventions are being implemented could cause residents in general and especially (R1) significant problems or trauma. (R1) did obtain an acute small extra-axial Hematoma over a chronic Subdural hygroma. (R1) does have some atrophy which allows extra space for this small bleed and Hematoma to occur. So, basically because of the atrophy, the acute bleed and Hematoma has extra room to occupy. It is hard to tell how (R1)'s Hematoma will behave due to the atrophy. It could progress to intracranial mass effect causing herniation and significant increase in mortality. At this point, (R1) has not had any further significant neurological problems but also because of the space created by the atrophied brain the symptoms will most likely not show for weeks to months. At that point, those neurological symptoms could lead to increased mortality for (R1). (R1) was on Aspirin and Plavix at the time of (R1)'s fall which could lead to increased bleeding which is what happened with (R1)'s fall

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S9999	Continued From page 8 on 9/19/22." On 9/30/22 at 11:30 AM V2 Director of Nurses (DON) stated "(R1) is a high fall risk resident who will shut off the fall alarms sometimes. We (facility) knew this prior to (R1)'s 9/19/22 fall. We (facility) are responsible for (R1)'s safety since (R1) is cognitively impaired and we (facility) know (R1) is such a high fall risk. I have educated the staff multiple times regarding falls prior to (R1)'s fall on 9/19/22. They (staff) just do not listen apparently. It is the responsibility of the staff to ensure the bed and chair alarms are functioning properly and turned on at all times even when (R1) shuts the alarm off, the staff should make sure it is turned back on. The staff know that (R1) needs closely supervised. If some of the CNA's are passing hall trays then the CNA assigned to (R1) should have been monitoring (R1) until the ones passing the trays were available to monitor also." (A)	S9999		