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<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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**Statement of Licensure Violations**:

- 300.610a)
- 300.1210b)
- 300.1210c(2)(3)
- 300.1210d(6)
- 300.3220f)
- 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
**Summary Statement of Deficiencies**

Each deficiency must be preceded by full regulatory or LSC identifying information.

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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:

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

2) All treatments and procedures shall be administered as ordered by the physician.

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.

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 300.3220 Medical Care
Continued From page 2

f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)

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)

These Regulations were not met as evidenced by:

Based on interview and record review the facility failed to ensure physician ordered X-rays were obtained for one (R1) resident reviewed for falls. This failure resulted in continued pain for R1 and a four day delayed treatment of R1's left hip and left wrist fractures which required hospitalization.

Findings include:

The facility Fall Prevention policy and procedure, revised 11/10/18, documents "Immediately after any resident fall the unit nurse will assess the resident and provide any care or treatment needed for the resident."

The A.I.M. for Wellness form for R1, dated 6/2/22 at 2:15 am, documents R1 fell going to the bathroom without using her wheeled walker and complained of pain to her left forearm and back. This form documents R1's PCP (Primary Care Physician) was notified and X-rays were
### SUMMARY STATEMENT OF DEFICIENCIES

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requested for R1's left forearm and back.

The Nurses Note for R1, dated 6/2/22 at 10:00 am, documents R1 refusing to stand or walk due to complaints of pain. R1's PCP was notified due to resident now complaining of left hip and left foot pain.

The Nurses Note for R1, dated 6/3/22 at 12:00 pm, documents "New order received for X-rays post fall."

The POS (Physician Order Sheet) for R1, dated 6/3/22, documents a Physician Order for X-rays of R1's left forearm, back, left hip and left foot due to post fall pain and limited mobility.

The Nurses Note for R1, dated 6/6/22 at 1:00 pm, four days after R1's fall, documents "(diagnostic service) coming today to complete X-rays."

The (diagnostic service) X-ray results dated 6/6/22 document results of left hip X-ray as "Left femoral neck fracture" and left forearm X-ray as "Distal transverse radial fracture."

The Nurses Note for R1, dated 6/6/22 at 9:05 pm, documents "Results from X-ray came back shows left arm and left hip fracture." (R1) sent to local hospital by ambulance.

The Nurses Note for R1, dated 6/7/22 at 2:15 am, documents follow up entry as R1 being transferred from local hospital to another local hospital for surgical intervention.

The PRN (as needed) MAR (medication administration record) for R1, dated 6/2/22 through 6/6/22 documents R1 received two Tylenol 500 mg (milligrams) tabs every morning.
Continued From page 4

for complaints of generalized pain. There was no pain assessment documented and no other pain medications were ordered or administered during this time frame.

On 6/10/22 at 9:02 am V10 (R1's) Family Member stated she received a call in the middle of the night on 6/2/22 that R1 had fallen, and they were going to get some X-rays then days later the facility called again telling V10 that they were sending (R1) to the hospital for a broken hip and then the hospital did surgery yesterday (6/09/22). V10 stated she doesn't know what took the facility so long to get the X-rays.

On 6/10/22 at 8:32 am, V18 Paramedic stated he was called to the facility to transport (R1) to the (local hospital). V18 stated when he got to the facility and got report he was told R1 had fallen on 6/2/22 and the facility X-rays on 6/6/22 said (R1) had fractures to her hip and wrist. V18 stated the facility had the order for the X-rays on 6/3/22 and waited four days and R1's MAR only showed Tylenol had been given for pain. V18 stated "It was very obvious to me that her wrist was broke and (R1) was in pain. It should have been obvious to the facility as well." V18 stated R1 moaned when she was moved onto the stretcher. V18 stated "There is no excuse that they should have waited four days to get the X-rays."

On 6/10/22 at 12:13 pm, V13 LPN stated she was R1's Nurse on 6/2/22 on night shift and was called down to R1's room because R1 had fallen in the bathroom. R1 was lying on the floor and complained about left arm and back pain. (R1) didn't have any visible signs of injury, there was no swelling or bruising and (R1) was able to move her arms and legs. V13 stated she wanted
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to send R1 to the hospital because she was crying in pain but when she called V2 DON, V2 told her to notify the doctor and get X-rays in house. V13 stated she faxed V14 (R1's) PCP to notify of R1's fall and requested X-rays. V13 stated when she came into work on 6/3/22 night shift R1 was still complaining about pain. The second shift Nurse reported to (V13 LPN) that R1 was now complaining of left hip and foot pain and the second shift Nurse had called to get more X-rays. V13 LPN stated she did not work the weekend but when she came in to work on 6/6/22 the diagnostic service had been at the facility and she was waiting for the X-ray results. V13 stated the results came in sometime between 8:00 pm and 9:00 pm and R1 had a left hip and left wrist fracture. V13 stated R1 sent R1 to (local hospital) for treatment.

On 6/10/22 at 3:36 pm, V16 CNA stated she was working on 6/2/22 when R1 fell and was called down to the B hall bathroom to help V17 CNA and V13 LPN. V16 stated R1 is supposed to use her walker but didn't and fell. V16 stated R1 was hysterical, anxious, and crying at first and was complaining about her left wrist and back hurting. "(R1) kept saying her wrist hurt." V16 stated R1's left wrist was a little red but didn't have any swelling and V13 LPN checked her and didn't feel anything out of the normal. V16 CNA stated after V13 LPN finished assessing R1 V16 CNA and V17 CNA assisted R1 up off the floor and V13 LPN pushed a wheelchair behind her because R1 wasn't able to stand. "(R1) kept saying it hurt and wouldn't bear weight so (R1) just sat in the wheelchair or in her recliner. V16 stated V3 LPN/ADON worked over the weekend as one of the Nurses and she reported to her that R1 couldn't bear weight and was in pain but does not know what was done.
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On 6/10/22 at 9:18 am, V11 LPN stated she worked Thursday 6/2/22 from 6:00 am to 6:00 pm and was told in report that R1 had fallen and was complaining of pain and they were waiting for orders from V14 (R1's) PCP for X-rays. V11 stated she noticed a bump on R1's left forearm but nothing else and gave R1 Tylenol as per R1's usual request in the morning and that was all R1 received on 6/2/22 for pain. V11 stated she did call V14 (R1's) PCP (Primary Care Physician) prior to leaving her shift because R1 started complaining about foot and hip pain. V11 stated when she left that day she had not received an order back from V14. V11 LPN stated when she returned to work on 6/3/22 she found the orders for the X-rays had been received and she processed the orders and reported off to V5 Agency RN and told (V5) everything was done except calling (diagnostic service) to come and do the x-rays. V11 LPN stated she gave V5 Agency RN the 24 hour book that contained the (diagnostic service) phone number and reminded V5 Agency RN not to forget to call.

On 6/9/22 at 1:40 pm, V5 Agency RN stated when she came into work on 6/2/22 at 10:00 am, V11 LPN had already processed the X-ray orders for R1 and had notified the (diagnostic service) to come and do the X-rays. V5 stated no one told her to call the diagnostic service to come and do the X-rays. V5 stated she did not call the (diagnostic service).

On 6/10/22 at 4:12 pm, V3 LPN/ADON stated she did work the floor as a Nurse over the weekend and was (R1's) Nurse. V3 stated R1 was up in a wheelchair to the dining room for meals and fed herself. V3 stated she did not check for R1's X-ray results and stated "It didn't trigger in me to
**Continued From page 7**

check them because she hadn't complained of any pain." V3 stated she never saw R1's body or skin because R1 had a sweater on and none of the staff said anything to her about R1 complaining or having concerns.

On 6/9/22 at 10:35 am V4 Agency RN stated she worked on 6/2/22 and 6/3/22 but was not R1's Nurse. V4 stated R1 is usually up walking around but on those two days R1 was sitting in a wheelchair. V4 stated when she returned to work on 6/6/22 R1 was still sitting in a wheelchair and (V4) assumed the X-rays for R1 had already been done. V4 stated she does not know how R1 was able to sit up in a wheelchair with a left femur fracture and left wrist fracture.

On 6/9/22 at 1:48 pm, V6 CNA stated before R1's fall R1 could get up with supervision and would use her walker to walk, but after R1 fell it would take two to three of us to her up in a wheelchair or put her in her recliner. V6 stated R1 did complain of a lot of pain and finally got X-rays on 6/8/22 and R1 was sent to the hospital.

On 6/9/22 at 1:51 pm, V7 CNA stated when she came into work on 6/2/22 at 6:00 am, she was told that R1 had fallen during the night and was in a lot of pain. V7 stated R1 complained of pain during her shift and didn't want to stand up.

On 6/9/22 at 1:56 pm, V8 CNA stated she heard R1 complain of pain on 6/2/22 and (R1) was not walking anymore, and R1 was sitting in a wheelchair.

On 6/9/22 at 2:15 pm, V9 CNA stated she just recently started working at the facility but remembers helping other CNA's to transfer R1 and R1 was complaining of pain.
On 6/9/22 at 12:00 pm, V2 DON (Director of Nursing) stated R1 fell on 6/2/22 on third shift and V13 LPN (Licensed Practical Nurse) assessed her and R1 was complaining of left forearm and back pain but there were no visible injuries. V2 stated V13 LPN notified V14 (R1's) PCP (Primary Care Physician's) and requested X-ray orders. V2 stated later in the day R1 started complaining about different pain and V11 LPN notified V14 (R1's) PCP and requested further X-rays. V2 stated the diagnostic service the facility uses was supposed to be called but wasn't. V2 stated V5 Agency RN was supposed to call but didn't. V2 stated she found out on Monday 6/6/22 that the X-rays weren't done for R1, and she had V11 LPN call and have the diagnostic service come out to do them. V2 stated the X-rays showed fractures to R1's left hip and left wrist and was sent to the (local hospital) for treatment.

On 6/10/22 at 11:21 am, V12 HR (Human Resources) Manager for the diagnostic services the facility uses stated they received orders from the facility for X-rays of R1's left hip with pelvis, left forearm, left foot, and spine on 6/6/22 at 1:06 pm, the X-rays were completed on 6/6/22 around 4:45 pm, and the results were faxed to the facility on 6/6/22 at 8:51 pm, and called to the facility at 9:07 pm and results were verbally given to V13 RN. V12 HR Manager for diagnostic service stated they did not receive any orders from the facility for R1 prior to 6/6/22.

On 6/10/22 at 12:55 pm, V15 RN stated she is V14 (R1's) PCP Nurse and V14 PCP received a fax from the facility on Thursday 6/2/22 at two something in the morning that R1 had fallen and was complaining of left forearm and back pain and the facility requested X-rays. V15 stated later...
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in the day at 1:00 pm, V14 PCP received another request for additional X-rays because R1 started complaining of left hip and foot pain and at 5:07 pm. V14 PCP gave the facility the order for the X-rays. V15 RN stated on Monday 6/6/22 we received the X-ray results from the facility showing R1 had fractures and V14 PCP sent a message back asking for the cause of the four-day delay in obtaining X-rays and has still not received a response from the facility.

(A)