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S 000	Initial Comments Investigation of Facility Reported Incident of 4/11/22/IL146414	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 a) 300.1210 b)4)5) 300.1210 d)3)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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest	S9999	Attachment A Statement of Licensure Violations	

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practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.

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.

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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

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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.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review the facility failed to develop and implement fall interventions to prevent falls and injury for three of three residents (R1, R2, R3) reviewed for falls in the sample list of three. This failure resulted in two falls for R1 who sustained a Proximal closed fracture of Left Humerus and Intramedullary Component Crosses Proximal Femur Fracture, and R1 being admitted to the hospital.

Findings include:

The facility's Fall Assessment and Management policy with a revised date of 4/2019 documents, "It is the policy of this facility to assess each resident's fall risk on admission, quarterly, and with each fall. This will help facilitate an interdisciplinary approach for care planning to appropriately monitor, assess and ultimately reduce injury risk. Factors related to the risk will be addressed and care planned. Procedure: 1. Fall Risk and Planning Assessment A. Upon admission/readmission, a Fall Assessment will be

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completed based on the initial admission nursing assessment and the resident's history. B. Each resident will be assessed using the Minimum Data Set (MDS) upon admission, quarterly and with any significant change assessment. C. The potential for falls will be care planned when appropriate, based on the results of the Fall Risk Assessment. The interdisciplinary care plan will be person centered to reflect the specific needs and risk factors of the resident."

The facility's Personal Alarms policy dated 12/1/05 documents, "Objective: 1. A means of alerting resident and/or staff of a potentially harmful situation. Policy: 1. Personal alarms are used in this facility to alert the resident and/or staff when the resident is in danger of potentially harming himself/herself or others. If the resident is alert and oriented this alarm is used as a cue to remind the resident of a potential injury. Confused residents may not understand this alarm. In these instances, the personal alarm is used to alert the staff of the possibility of potential injury and to expedite their response." "3. The cognitive status is reflected on the MDS, and individual approaches are added to the care plan. The (medical-patient information system) (where used) also reflects the use of a personal alarm."

The facility's Resident Assessment and Care Planning policy with a revised date of 11/2017 documents, "The facility shall develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs, as well as preferences for care and goals. This comprehensive care plan is person centered and may be the continuation of the baseline care plan established within 48 hours of admission."

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S9999	Continued From page 4 1. R1's Order Summary Report dated 5/9/22 documents diagnoses including Chronic Pain, Cervicalgia, Legal Blindness, Presence of Left Artificial Knee Joint, Age Related Osteoporosis, Sjogren Syndrome, Macular Degeneration, Fusion of Spine Cervical Region, Primary Generalized Osteo Arthritis, Metatarsalgia Left Foot, Rheumatoid Arthritis, Encephalopathy, Displaced Comminuted Fracture of Shaft of Humerus Left Arm and Displaced Intertrochanteric Fracture of left Femur. R1's Admission Minimum Data Set (MDS) dated 1/28/22 documents R1 had moderately impaired cognition, required limited assistance of one staff member physical assistance for bed mobility, transfers, walking and toileting. R1's balance was not steady but able to stabilize without staff assistance. R1 had impairment of one lower extremity on one side and used a walker and wheelchair. The Care Area Assessment Summary (CAAs) documents that falls were a triggered area and should have been addressed in the care plan. R1's Care Plan dated 1/11/22 only documents R1 was re-admitting to long term care placement and Social Services was to monitor adjustment back to long term placement. There is no further Care Plan on this date. R1's MDS dated 2/2/22 documents R1's transfer status had declined to extensive assistance of one staff physical assist. There was still no Care Plan or interventions developed and initiated at that time for falls or any other area. R1's Fall Risk Assessment dated 1/22/22 documents R1 was at a moderate risk for falling.	S9999		

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R1's Fall Risk Assessment dated 4/9/22 documents R1 was at a high risk for falling. There was still no Care Plan or interventions developed at this time to help prevent falls or injuries from falls.

R1's Fall Occurrence Report dated 4/11/22 at 4:15 AM, documents R1 was found sitting on the floor by the bed by a CNA (Certified Nursing Assistant). R1 was only oriented x (times) 1 and was readmitted to the facility on 4/9/22 after hospital stay for Hyponatremia and Altered Mental Status. This report documents that R1 had a bed alarm, but the alarm was not sounding when R1 was found on the floor. This report documents that staff continued the low bed for R1 and they were to ensure that the alarm was working.

R1's Fall Occurrence Report dated 4/11/22 at 5:30 AM, documents that a CNA heard a noise and went into R1's room and found R1 sitting on the floor at the foot of the bed. This report documents R1 was confused and stated R1 was looking for R1's keys to pick up R1's children. R1 complained of pain to buttocks and left hip/thigh area. R1 was sent to the hospital. This report documents that R1's bed alarm was again not sounding. This report documents that R1 returned from the hospital with a diagnosis of Proximal Closed Fracture of Left Humerus and had a sling in place. R1 still complained of hip pain and was seen in the facility by the Nurse Practitioner (NP) and the NP sent R1 to the hospital again for more x-rays. This report documents R1 returned with diagnosis of Intramedullary Component Crosses Proximal Femur Fracture. This report documents the bed alarm was replaced and a perimeter mattress was placed on R1's bed.

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R1 still did not have a Care Plan in place with interventions documented to help prevent falls and injuries.

On 5/9/22 at 10:39 AM, R1's bed alarm pressure mat cord was not plugged in to the alarm box. There was also a severed cord laying on the floor under R1's bed.

On 5/9/22 at 11:42 AM, V3 (Agency Registered Nurse/RN) confirmed the pressure pad alarm cord was not plugged into the alarm box. V3 stated it appears to have gotten pulled out. V3 confirmed that the severed cord was R1's call light cord. V3 pressed on R1's call light pressure pad and it did not sound or light up outside of the room. V3 was unsure how long the bed alarm or the call light were not functioning.

On 5/11/22 at 9:05 AM, V4 (Agency RN) confirmed V4 was the nurse taking care of R1 the morning that R1 had both falls on 4/11/22. V4 stated that it looked like R1 slid out of bed. V4 stated that they checked the bed alarm to see if it was functioning because it was not sounding. V4 stated after this fall that V4 made sure the bed was in the lowest position, that R1 had nonskid socks on and that the bed alarm was functioning. V4 stated that about an hour later R1 fell again. V4 stated that V5 (Certified Nursing Assistant/CNA) found R1 on the floor. V4 stated that R1 recently returned from the hospital and had increased confusion. V4 stated R1 complained of leg and hip pain after the second fall so V4 sent R1 to the hospital. V4 stated that R1 came back, and the hospital said that R1 had a broken arm. V4 stated R1 did not complain of any arm pain only hip and leg pain.

On 5/11/22 at 12:15 PM, V13 (Nurse Consultant)

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confirmed that R1 only had one page of a care plan initiated on 1/11/22 for re-admission. V13 confirmed that was all that they had for a Care Plan for R1 until 4/15/22 after the falls with fractures.

R1's hospital radiology report dated 4/11/22 at 7:19 AM documents x-ray of Humerus Left, and impression from x-ray documents, "Comminuted fracture of left humeral neck extending into the head."

R1's hospital radiology report dated 4/12/22 at 2:35 AM, documents an x-ray of the pelvis and femur left side. This report documents the history as "(R1) fell yesterday, worsening left leg/hip pain." This report documents the impression as "nondisplaced intertrochanteric fracture of left femur."

On 5/11/22 at 2:03 PM, V11 (R1's Physician) and V12 (R1's Nurse Practitioner) confirmed R1's fall from the bed would have caused the fractures. V11 stated that R1 had very soft bones from long term steroid use for R1's Rheumatoid Arthritis. V11 stated that when R1 went to the hospital after the second fall the hospital only completed an x-ray of R1's shoulder. V11 stated that they did not x-ray the hip or leg. V12 stated that V12 saw R1 after R1 returned from the hospital and R1 still complained of leg/hip pain so V12 stated V12 sent R1 to a different hospital for x-rays of the left hip and left leg. V11 stated that this hospital completed a CT (Computerized Tomography) of the entire left leg. V11 stated that R1 previously had a knee replacement on the left leg that now shows a fracture in the femur. V12 stated that R1 had a pressure bed alarm in place prior to these two falls but after the second fall they placed a concave mattress on R1's bed. V11 stated that

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with R1's soft bones R1 would have probably had a fracture no matter what kind of fall. V11 stated that the hospital stated that R1 had extremely osteoporotic bones.

On 5/11/22 at 2:18 PM, V5 (CNA) stated that V5 remembers R1's falls on 4/11/22. V5 stated that R1 was very confused that morning. V5 stated that it looked like R1 just slid out of bed with the first fall. V5 stated that the bed alarm was not sounding even though R1 was on the floor. V5 stated that they got R1 back in bed and checked R1's vital signs. V5 stated that V5 had other resident's that V5 had to take care of so V5 went to do that. V5 stated V5 heard a crash noise. V5 stated that it appeared that R1 climbed over the foot of R1's bed and came to a rest on R1's bottom on the floor at the foot of the bed. V5 stated that R1's bed alarm was not sounding again with this fall. V5 stated that they replaced the entire alarm, including the pressure pad and the alarm box. V5 stated that after the first fall they checked the alarm and tried to reorient R1 as to where R1 was. V5 confirmed they did not initiate anything new at that time.

On 5/11/22 at 3:20 PM, V1 (Administrator) confirmed there was no documented interventions in place to help prevent falls and injuries for R1 prior to R1's falls with fractures.

2.) R2's Order Summary Report dated 5/9/22 documents diagnoses including Epileptic Syndromes with Complex Partial Seizures, Alzheimer's Disease, Dementia in other Diseases Classified Elsewhere with Behavioral Disturbance, Difficulty Walking and Unsteadiness on Feet.

R2's MDS dated 1/6/22 documents R2 has

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severe cognitive impairment, requires extensive assistance from one staff for bed mobility and transfers and limited assistance from one staff for walking in R2's room and toileting. This MDS documents R2's is not steady and can only stabilize with staff assistance for surface-to-surface transitions.

R2's Care Plan dated 7/18/19 documents R2 has had falls related to weakness, unsteadiness and new onset of seizures and has a history of falls. This Care Plan documents an intervention dated 2/22/21 that R2 has a bed alarm at night to remind R2's self to call for help when room is dark.

R2's Fall Risk Assessment dated 1/17/22 documents R2 is at high risk for falling.

R2's Fall Occurrence Report dated 2/15/22 at 12:00 PM, documents that R2 was found on the floor in R2's room sitting on R2's buttocks with back leaning against the wall. This report documents no injuries. This report documents R2's chair alarm, that was not documented on the Care Plan as an intervention, was not sounding.

R2's Fall Occurrence Report dated 3/5/22 at 11:50 PM, documents R2 was found on the floor in the hallway behind a recliner that R2 had been sitting in. This report documents that the chair alarm was not sounding and that the CNA did not turn the chair pressure alarm on.

R2's Care Plan does not document a new intervention to help prevent falls and injury after this fall on 3/5/22.

On 5/9/22 at 10:47 AM, V6 (CNA) was in the bathroom with R2. After finishing in the bathroom

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S9999	Continued From page 10 with R2, V6 turned on R2's pressure pad alarm in R2's wheelchair. On 5/11/22 at 12:15 PM, V13 (Nurse Consultant) confirmed there is no new intervention on R2's Care Plan after the 3/5/22 fall. 3.) R3's Order Summary Report dated 5/9/22 documents diagnoses including Hypomagnesemia, Hypokalemia, Unspecified Symptoms and Signs Involving Cognitive Functions and Awareness and Delusional Disorders. R3's MDS dated 2/17/22 documents R3 is severely cognitively impaired, requires extensive assistance of two staff for bed mobility and transfers, extensive assistance of one staff for toileting and R3 did not ambulate. R3's Care Plan dated 8/16/19 documents R3 had an actual fall related to weakness and activity intolerance due to Atrial Fibrillation, use of diuretic, poor safety awareness, believes self-able to ambulate and psychotropic medication. There are several interventions listed for 2019 and 2020. There are no interventions listed for 2022 until 4/21/22, a month after R3 fell on 3/19/22. R3's Fall Occurrence Report dated 3/19/22 at 7:00 PM, documents R3 was found on the floor, laying on R3's back beside the bed. The pressure pad alarm in the bed was not sounding. No interventions were developed or implemented after this fall. There were interventions added to the Care Plan on 4/21/22. On 5/11/22 at 3:20 PM, V1 (Administrator) confirmed there was no new intervention	S9999		

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S9999	Continued From page 11 developed or implemented after R3's fall on 3/19/22 until 4/21/22. "A"	S9999		