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| | IL6005938 | A. BUILDING: _____ B. WING _____ | C 11/22/2022 |

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| S 000 | Initial Comments<br><br>Complaint Investigations:<br>2269107/IL153337<br>2269036/IL153260<br>2269230/IL153476 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations<br>300.610a)<br>300.1210b)<br>300.1210c)<br>300.1210d)6)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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 | S9999 | Attachment A<br>Statement of Licensure Violations | |

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| S9999 | Continued From page 1<br>care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.<br><br>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.<br><br>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:<br><br>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.<br><br>These requirements are not met as evidenced by:<br><br>Based on observation, interview and record review the facility failed to supervise and assist a resident in a safe manner (R3), failed to investigate a fall, develop and implement post fall interventions, and update a residents fall prevention plan of care (R4, R2 and R1) for four of four resident reviewed for accidents on the total sample list of eight. This failure resulted in R3 rolling off the edge of an elevated bed, falling onto a hard floor surface resulting in a subdural hematoma (closed head injury) requiring hospitalization.<br><br>Findings include:<br><br>1. R3's medical record documents, "Date of fall: 11/8/22, time of fall: 5:50 AM, observed resident lying on right side with legs curled up close to | S9999 | | |

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body on the floor. Activity at time of fall:: Certified Nursing Assistant (V4) was providing incontinent care at time of event. Resident/Staff (if witnessed) description of fall:: CNA stated, " I was doing incontinent care on resident. (R4) was turned on (R4's) side and when I went to put a clean brief on (R4), the top of (R4's) body started to slide off the side of the bed." " I was unable to stop (R4) from sliding off the bed, (R4) hit her head during the fall." Resident was complaints of pain everywhere. Resident was sent to (local hospital) via ambulance. Root Cause: Resident has poor trunk strength and needs assist with positioning. Resident was turned on left side while CNA was changing her brief. Resident's upper torso began to slide off the bed. CNA was unable to prevent resident from sliding off the side of the bed. Resident may have slide to side of bed during cares."

R3's Post Fall Evaluation: 11-8-22 Detailed Description of Fall 4: was stated by CNA that res "rolled off side of bed" Summarize potential factors that could have contributed to the fall: resident might have been too close to side of bed.

R3's hospital records, dated 11/8/22, signed by V15 Emergency Room Physician, documents: "Chief Complaint: Fall. The accident occurred less than 1 hour ago. The fall occurred from a bed. (R3) fell from a height of 1 to 2 feet. (R3) landed on a hard floor. There was no blood loss. The point of impact was the head. The pain is present in the head. Associated symptoms include headaches. Clinical Impression: 1. Fall, initial encounter. 2. Closed head injury, initial encounter. Examination: CT head or brain without contrast, Indications: head trauma, Findings: A small area of extra-axial hemorrhage is demonstrated in the right temporoparietal

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| S9999 | Continued From page 3<br><br>region. Impression: Small acute extra-axial hematoma over the right temporoparietal region is demonstrated. This most likely represents a subdural hematoma. Called and discussed with (V16 Radiologist), states patient definitely has a subdural hematoma. Called (specialty hospital) for trauma transfer."<br><br>On 11/15/22 at 12:54 PM V4 Certified Nursing Assistant stated, "it was approximately 5:30 AM (11/8/22) I was in (R3's) room changing (R3's) incontinence brief to get (R3) ready for the day. We were visiting and having a conversation, (R3) was alert and oriented. (R3) was lying on (R3's) right side facing towards the window, the bed was elevated because I am a shorter gal, I was on the back side of the bed, between the bed and the door to the room, my stomach was pressed up against the bed frame, (R3's) back was towards me, as I was tucking the incontinence brief under (R3's) hip, (R3) rolled forward and rolled right out of the bed towards the window onto the floor. (R3) had an air mattress on the bed. There was no way for me to grab ahold of (R3) once (R3) started to roll off. I could not see how close I had (R3) positioned on the side of the bed."<br><br>On 11/15/22 at 6:40 PM V3 Registered Nurse stated, "around 5:50 AM (11/8/22) the CNA (V4) was in (R3's) room doing rounds and changing (R3), I was in the hallway and (V4) alerted me to come to (R3's) room, (R3) was lying on the floor on (R3's) right side close to (R3's) bed, (R3's) bed was elevated, (R3) was complaining of a headache and was found that (R3) had hit (R3's) head, sent (R3) to the Emergency Room. (V4) had stated (V4) had rolled (R3) over and (R3) was on the side of the bed and (R3) rolled off the bed onto the floor." | S9999 | | |

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| S9999 | Continued From page 4<br><br>On 11/16/22 at 11:10 am V11 Corporate Nurse Consultant stated, "(R3) was rolled over in bed by the CNA (V4), the CNA pushed down on the mattress to place a pad under (R3) and (R3) was too close to the edge of the bed and rolled of the bed. CNA was educated to not roll residents away but towards herself when changing them."<br><br>The Facility's Investigation Final report form documents: "Nurse observed resident on the floor next to bed. It appeared (R3) rolled out of bed, and did strike (R3's) head. Due to change in cognition and current orders of Plavix resident was transferred via ambulance to the local Emergency Room. Resident was diagnosed with subdural hematoma. Investigation initiated and in progress. CNA was providing incontinent care at the time of the event. Resident was assisted to turn on side and began placing brief under (R3) and the resident started to roll off the bed. Employee was unable to stop the resident from rolling off the bed. (R3) has poor trunk stability and was laying too close to the edge of the mattress."<br><br>2. R4's medical record documents, "9/2/2022 at 5:20 PM, Resident slid out of chair on to the floor in sports bar. Fall was witnessed by activity staff."<br><br>R4's medical record did not contain a post fall assessment or updates to R4's fall prevention plan of care, after R4's fall on 9/2/2022.<br><br>R4's care plan, with an initiation date of 11/23/2021, documents "at risk for falls related to diagnosis: Parkinson's, Incontinence, Degenerative Joint Disease, Memory Loss, Osteoarthritis. History of falls." | S9999 | | |

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| S9999 | Continued From page 5 | S9999 | | |

R4's Minimum Data Set assessment, dated 10/27/22 R4 requires extensive assistance of two staff members for toilet use.

R4's medical record documents on 11/3/2022 at 3:42 PM, Resident was taken to the bathroom, aide went to check on another resident and when she came back resident was lying on the floor in her room next to the bathroom door. Root Cause: Resident has poor safety awareness, and while CNA was assisting another resident, resident attempted to stand up per self and pull up her pants. Resident lost her balance while doing so and slid to the floor. Staff were educated to not leave the resident unattended in restroom.

On 11/16/22 at 1:15 PM, V14 CNA stated, "on 11/3/22 I took (R4) to the bathroom, I told (R4) I was going to go down and change someone else, I got out from changing another resident, (R4) was already out of the bathroom and was sitting on floor. V11 told me not to leave (R4) unattended in the bathroom."

On 11/16/22 at 1:00 PM V11 Corporate Nurse Consultant stated, "(R4's) post fall investigation was not fully completed by nurse after (R4's) fall on 9/2/22, new interventions were not developed. (R4's) fall on 11/3/22 the (V14) left (R4) unattended in bathroom (R4) stood up and fell, the CNA was educated not to leave resident unattended in bathroom, (R4's) Parkinsons disease is advancing."

3. R2's medical record documents, on 11/3/2022 at 3:00 AM, Walked by residents room heard a

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|---|---|---|---|---|
| S9999 | Continued From page 6 | S9999 | | |

noise, looked in residents room saw (R2) on the floor beside bed lying on left side with left leg partially underneath her, complained of left hip pain. Further exam a lump on her left forehead. Area discolored and slightly bleeding. Transported resident to (local hospital). Root Cause: Resident fell because attempted to get out of bed. Intervention will be body pillow.

R2's medical record documents R2 readmitted to the facility from the hospital on 11/14/22.

R2's fall prevention care plan did not document new interventions of "body pillow"

On 11/15/22 at 2:00 PM and 11/16/22 at 10:35 AM R2 was lying in bed with eyes closed, bed in low position, over the bed table by the bed with call light on top and within reach. R2 had no body pillow in bed or located in R2's room.

On 11/16/22 at 10:40 AM V11 Corporate Nurse Consultant stated, the intervention for R2's fall on 11/3/22 is a body pillow. V11 confirmed the body pillow should be on R2's fall prevention care plan and used while in bed.

4. R1's Side Rail Use Assessment form completed by V13 dated 9-26-22 documents, "side rails do not appear to be indicated for R1 at this time. Interventions: lower the bed to the floor and mat on floor."

On 11/16/22 at 9:40 AM V13 Certified Occupational Therapy Assistant stated, "(R1's) family had requested (R1) to have siderails, I completed a side rail evaluation on (R1). (R1) was not a candidate, and other recommendation

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| S9999 | Continued From page 7<br>for bed in low position and mat beside the bed were implemented."<br><br>R1's care plans document: "Focus: At risk for falls related to decreased mobility, weakness, initiated: 9/24/22. Interventions/Task: Minimize risk for falls for resident. 11/11/2022 fall, MD to evaluate resident at hospital and provide orders upon return. Staff to encourage resident's son to not bring in foods that are fried or spicy due to cholelithiasis. Educate resident to ask for assist with transfers. Encourage to change position slowly. Encourage to wait for assist when call light is on. Place call light in reach and remind to use for assist." "Focus: I am at risk for falling related to history of falls, poor standing balance, Diagnosis: CerbroVascular Accident with left weakness, anemia, pain in knee, Osteoarthritis, initiated: 10/11/22. Interventions/task: (10/12/22-fall) body pillow, Educate me in safety awareness and to call when I need assistance. Keep call light in reach at all times, Keep personal items and frequently used items within reach, Monitor me for any signs/symptoms or complaints of pain/discomfort, notify my nurse to administer pain medication if ordered and update physician on any unresolved discomfort noted."<br><br>R1's fall risk/prevention care plans did not document prevention measures to "Keep R1's bed in low position or mat beside the bed."<br><br>On 11/16/22 at 9:25 AM V11 Corporate Nurse Consultant stated, "keeping (R1's) bed in low position and a mat by the bed should be on (R1's) care plan and on the Kardex. V11stated, "for some reason R1 has two fall care plans." V11 confirmed fall prevention measures of keeping R1's bed in a low position and a mat beside R1's bed was not on R1's care plan or on R1's Kardex. | S9999 | | |

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| S9999 | Continued From page 8<br><br>The facility policy, with a revision date of 12/1/2020, titled "Fall Prevention Program" documents, "Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Policy Explanation and Compliance Guidelines: 6- Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. a- Interventions will be monitored for effectiveness. b- The plan of care will be revised as needed. 7. When any resident experiences a fall, the facility will: a- assess the resident, b- complete a post fall assessment, c- notify the physician and family, d- review the residents care plan and update as indicated, e- document all assessments and actions."<br><br>(A) | S9999 | | |