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	IL6008825	A. BUILDING: _____ B. WING _____	C 08/28/2023

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WARREN BARR SOUTH LOOP	1725 SOUTH WABASH CHICAGO, IL 60616

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S 000	Initial Comments COMPLAINT INVESTIGATION: 2385929/IL162159 2385840/IL162060	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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. 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 observation, interview and record review, the facility failed to supervise one cognitively impaired resident (R2) who is at high risk for falls and has a history of repeated falls; failed to update the fall risk care plan; and failed to implement fall prevention interventions as care planned for one resident (R2) of three residents (R2, R3, R8) reviewed for falls. As a result of these failures, R2 fell with R2 sustaining a right posterior occiput (head) laceration, one centimeter, which required emergency transfer to the hospital for 2 staples of the laceration repair. Findings include: R2's Admission Record documents, in part, diagnoses of anoxic brain injury, metabolic	S9999		

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encephalopathy, hypertension, type 2 diabetes mellitus, muscle wasting and atrophy, dysphagia, lack of coordination, abnormal posture, reduced mobility gastrostomy status, and weakness.

R2's Minimum Data Set (MDS), dated 6/20/23, documents, in part, a Brief Interview for Mental Status (BIMS) score of 10 which indicates the R2 has moderate cognitive impairment. R2's MDS, dated 7/17/23, documents, in part, one fall with major injury, and a staff assessment for mental status coded as moderately impaired by "cues/supervision required."

On 8/21/23 at 12:00 pm, R2's room door observed closed with R2 alone in R2's room with the television (TV) on with a high pitched, constant noise from the test pattern on the TV. R2 observed awake, alert, nonverbal and in bed with a bed alarm in place (green light on with a wire connected to bed sensor pad under R2's buttocks).

On 8/21/23 at 12:02 pm, V13 (Fall Coordinator/Licensed Practical Nurse, LPN) stated that the purpose of the bed alarm is that it alerts staff if the resident is getting out of bed unassisted. V13 stated that R2 has unsteady gait and is a fall risk. When asked if staff outside R2's closed room door would be able to hear the bed alarm with the high-pitched TV noise, V13 stated, "Yes, usually we can hear the alarm with the door closed." V13 provided oral care for R2, then left R2's room. This surveyor asked R2 about the fall incident, on 7/17/23, when R2 fell out of the wheelchair and had to go to the hospital for emergency care, R2 nodded R2's head up and down indicating yes. When asked about more details of this fall incident, R2 nodded R2's head side to side indicating no.

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In R2's General Progress Note, dated 7/17/23 at 11:00 pm, V26 (Agency LPN) documents, in part, "(R2) activated chair alarm. (V26) quickly responded to (R2) but could not break (R2's) fall. (R2) was noted lying on right side. 911 called. Head to toe assessment was completed with open area to back of head. Small amount of blood noted."

V26's signed "Employee/Resident Statement," dated 7/17/23 at 9:15 pm, documents, in part, that R2 had a fall at the nurse's station and that V26 did not witness R2's fall. V26 documents that V26 responded to R2 who was "on the floor in right side position." V26 documented that V26 was in another resident's room when R2's fall happened. V26 documents that the last time that V26 saw R2 was at 9:00 pm.

On 8/22/23 at 3:08 pm, V26 (Agency LPN) stated that as an agency nurse, V26 works at multiple facilities. When asked if V26 remembers R2, V26 stated that V26 sees many different residents on a daily basis and cannot remember R2. This surveyor read verbatim V26's authored progress note in R2's electronic medical record (EMR) from 7/17/23 at 11:00 pm, and V26 stated that V26 does not remember R2 or R2's fall incident on 7/17/23. When asked, in general, what are fall precaution interventions for a resident who has had multiple falls, confusion and poor safety awareness, V26 stated that there must be supervision. V26 stated that if the resident is alert, then V26 would bring the resident out to a common area, and that staff would have to "keep an eye on the patient."

R2's emergency department hospital records, document, in part, that R2 sustained a right

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occipital region 1 centimeter laceration from a mechanical fall. R2's procedure of laceration repair with 2 staples was performed by V42 (Hospital Physician) on 7/18/23 at 2:45 am.

On 8/23/23 at 11:01 am, V13 (Fall Coordinator/LPN) stated that V13 is responsible for performing the fall risk assessment for resident to determine if they are at low or high risk; will add interventions to the residents' care plan for the fall risk residents; will make sure that the fall interventions are appropriate to each fall incident; and the care planned fall interventions are in place. V13 stated that V13 is notified of all fall incidents that occur in the facility. V13 stated that with each fall incident, staff interviews (witness statements via paper forms) are conducted to figure out why a fall occurred. V13 stated that V13 will take data from the resident and staff interviews to determine a course of action to prevent a future fall incident. V13 stated that V13 was notified of R2's unwitnessed fall (7/14/23) from the bed to the floor. V13 stated that with the 7/14/23 fall incident, R2 was care planned for the intervention of floor mats to the sides of the bed. V13 stated that on 7/17/23, approximately 20 minutes after R2's fall incident at 9:15 pm, V2 (DON) notified V13 of R2's fall with injury. V13 stated that V13 then phoned the nurse's station after speaking to V2 and talked directly to V26 (Agency LPN) who was caring for R2. V13 stated that V26 reported to V13 that R2 was sitting up in R2's wheelchair at the nurse's station so V26 could see R2 and that R2 kept standing up unassisted. V13 stated that V26 reported that V26 was in another resident's room when R2 fell at the nurse's station. V13 stated that witness statements were collected from staff about R2's fall incident on 7/17/23. When asked what were R2's fall interventions prior to the

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S9999	Continued From page 5 7/17/23 fall, V13 stated for staff to keep R2 at the nurse's station, room close to the nurse's station, purposeful rounding, call light in reach, floor mats and bed/chair alarm. When asked the reasoning for keeping R2 at the nurse's station, V13 stated, "It's the hub of the floor. Activities going on. Staff coming in and out. And when staff aren't working in rooms, that's where they go." When asked about positioning R2 in a wheelchair at the nurse's station, V13 stated that it's in "eyesight" and that a nurse or any staff can see R2 as well. When asked what fall intervention was care planned for after R2's 7/14/23 fall, V13 stated that it was floor mats. This surveyor showed V13 the fall risk care plan for R2 asking V13 where the fall mats intervention is, and V13 viewed the care plan (initiated date 7/6/23). V13 stated that there is another care plan for R2 and printed a duplicate care plan (initiated date 7/6/23) from R2's EMR with no intervention listed for R2. V13 stated, "That's it. There's nothing more." V13 stated that V13 performs an investigation of each fall incident to determine the root cause and will add new interventions to the resident's care plan after each fall incident to "prevent that type of fall from occurring again." R2's Care Plan, date initiated 7/6/23, documents, in part, that R2 is at high risk for falls related to cognitive impairment, gait problems, poor safety awareness, muscle weakness, recent fall in last 2-6 months, recent fall in last month and traumatic brain injury with interventions as follows: "Keep (R2) in common areas when (R2) is not sleeping or sleepy (7/5/23);" "I (R2) would like staff to move me close to the nurses station for closer observation (6/28/23);" and "I (R2) have periods of forgetfulness. I would like staff to frequently reorient me to my surroundings (6/28/23)." R2's Care Plan (7/6/23) does not	S9999		

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include floor mats. Also, this surveyor observed R2 awake and alert on 8/21/23 at 12:00 pm inside R2's room with a closed door and high-pitched TV noise which is not a common area as care planned for.

Employee/Resident Statements, dated 7/17/23 at 9:15 pm for R2's fall in front of the nurse's station, were collected from V26, V34 (CNA), V35 (Agency CNA), and V43 (CNA). V35 and V43 documented that they did not witness R2's fall and that they were performing resident care for other residents. V34 documented that V34 did not witness R2's fall and that V34 was on a bathroom break.

On 7/14/23 at 5:13 am, V29 (LPN) documented, in part, in R2's incident note, that at approximately 4:10 am, V29 noted noise from within R2's room, went to inquire and found R2 in a sitting position on the side of the bed towards the door. R2's Fall Risk Evaluation (performed with R2's fall incident), dated 7/14/23, documents, a score of 13 which indicates that R2 is high risk for falls.

R2's incident report, dated 6/28/23 at 1:40 pm, documents an unwitnessed fall incident for R2. R2's Fall Risk Evaluation (performed with R2's fall incident), dated 6/26/23, documents, a score of 16 which indicates that R2 is high risk for falls. R2's progress note, dated 5/16/23 at 9:51 pm, indicates an unwitnessed fall incident for R2.

On 8/21/23 at 2:15 pm, when asked about R2's fall history, V2 (Director of Nursing, DON) stated that R2 had a previous fall in the facility, was unsure of how many previous falls, but stated that R2 did not have a fall incident previously with an injury. V2 stated that on 7/17/23, R2 was sitting

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across from the nurse's station in the wheelchair and had been brought out in the common area to be monitored. V2 stated that frequent monitoring is important especially since R2 had a previous fall incident.

On 8/24/23 at 3:50 pm, V33 (Attending Physician) stated, "Every time there is a fall, the nurses will call me. I give them instructions. I was not there for R2's falls so I sent (R2) out for evaluation. I talk to the nurses. They do follow my recommendations of fall precautions." When asked about R2's fall on 7/17/23 with injury, V33 stated, "I was notified on 7/17/23 of the fall, and I ordered for (R2) to be sent out to the hospital." When asked what is V33 expecting of nursing staff in following fall precautions, V33 stated, "To make sure there is close monitoring. Especially a resident with multiple falls, have close monitoring and frequent rounds. Make sure the bed rails are in proper position, so the resident won't get out of bed or when transferring to a wheelchair to make sure that that don't have a fall. It's a nursing expectation." This surveyor informed V33 that R2's fall with injury on 7/17/23 was when R2 was in a wheelchair in the common area at the nurse's station. When asked what type of supervision should nursing staff provide R2 while at R2's at the nurse's station, who has poor safety awareness, confusion and frequent falls, V33 stated, "To keep their eyes on (R2). In the communal area, (R2) should be close the nurse's station and somebody should be with (R2). Eyes closely on (R2)." When asked if nursing staff are not following these fall precautions, like direct supervision, for R2 who fell and experienced a laceration to the back of head that required 2 staples for closure, could this cause harm to R2, and V33 stated, "Yes. R2 frequently falling could cause a laceration. Nurses need to pay attention

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to residents, so they don't fall. A laceration should not occur. Nurses have to be more aware of falls and provide early intervention."

Facility policy dated 7/17/23 and titled "Fall Occurrence," documents, in part, "Policy Statement: It is the policy of the facility to ensure that residents are assessed for risk of falls, that interventions are put in place, and interventions are reevaluated and revised as necessary. Procedure: ... 2. Those identified as high risk for falls will be provided fall interventions ... 3. If a resident had fallen, the resident is automatically considered as high risk for falls ... 7. Ultimately, the Falls Coordinator may change the interventions provided by the nurse if the Falls Coordinator's investigation identifies a more appropriate interventions for the individual fall. 8. The Falls Coordinator will add the intervention in the resident's care plan."

Facility policy dated 7/27/23 and titled "Care Plan," documents, in part, "Policy Statement: It is the policy of the facility to ensure that all care plans including base line care plans are in conjunction with the federal regulations ... Procedures: ... 5. These will be periodically reviewed and revised by a team of qualified person after each assessment."

Facility job description titled "LPN Floor Nurse" and dated 12/1/19, documents in part, "Reports to: Director of Nursing & Assistant Director of Nursing. Summary/Objective: In keeping with our organization's goal of improving the lives of the Guests we serve, the Licensed Practical Nurse (L.P.N.) plays a critical role in providing superior customer service and nursing care to all Guests and guests. The L.P.N. provides supervision of staff and will safeguard the health, safety and

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S9999	Continued From page 9 welfare of all Guests/guests under their care by following applicable laws, regulations, and established nursing policies and procedures. Essential Functions: Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. 1. Provides quality nursing care to Guests in an environment that promotes their rights, dignity and freedom of choice. 2. Provides supervision to C.N. A's and all subordinate staff which includes checking their work to ascertain that assignments have been completed ... 9. Responsible for all nursing care of assigned Guests while on duty ... 14. Must be knowledgeable of individual care plans and support the care planning process by reporting specific information and observations of the Guest's needs, preferences and report any behavioral changes ... 18. Follow established safety precautions when performing tasks and using equipment and supplies ... 21. Ensure each Guest receives person centered care." Facility job description titled "Certified Nursing Assistant" and dated 5/20/22, documents, in part, "Reports to: Floor Nurse, Unit Manager and Staffing Coordinator. Summary/Objective: In keeping with our organization's goal of improving the lives of the Guests we serve, the Certified Nursing Assistant (C.N.A.) plays a critical role in providing superior customer service and nursing care to all Guests. The C.N.A. safeguards the health, safety and welfare of all Guests under their care by following applicable laws, regulations, and established nursing policies and procedures. Essential Functions Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. 1. Provides quality nursing care to Guests in an environment that promotes	S9999		

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S9999	Continued From page 10 their rights, dignity and freedom of choice ... 11. Follow established safety precautions when performing tasks and using equipment and supplies ... 15. Ensure each Guest receives person centered care." (B)	S9999		