Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003024	A. BUILDING: ______ B. WING ______	C 08/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRHAVEN CHRISTIAN RET CENTER	3470 NORTH ALPINE ROAD ROCKFORD, IL 61114

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S 000	Initial Comments Facility Reported Incident of 7/31/23/ IL163346	S 000		
S9999	Final Observations 1/2 Statment of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3) 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 resident to meet the total nursing and personal care needs of the resident. Section 300.1210 General Requirements for	S9999	**Attachment A** **Statement of Licensure Violations**	

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Nursing and Personal Care
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 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.

These regulations were not met as evidenced by:

Based on interview and record review the facility failed to have an ongoing assessment of a resident post fall, failed to ensure medical care and services were provided to a resident post fall in a timely manner for 1 of 3 residents (R2) reviewed for nursing care. This failure resulted a delay in care and pain control for a resident (R2) with multiple pelvic fractures.

The findings include:

R2's face sheet showed she was admitted to the facility on 2/3/23 with diagnoses to include pain in right hip, generalized anxiety disorder, restlessness and agitation, chronic atrial fibrillation, weakness, essential hypertension, chronic congestive heart failure, and mild cognitive impairment of uncertain or unknown etiology. R2's facility assessment dated 5/12/23 showed she had moderate cognitive impairment and required assistance of one staff for most cares. R2's facility fall risk assessment completed 5/17/23 showed she is a high risk for falls.

R2's care plan initiated 2/10/23 showed, "Falls: I

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am at risk for falling related to weakness and a history of falls. I use a wheeled walker and one staff supervision for ambulation." This same care plan showed a personal alarm was in place".

R2's Resident Accident/Incident report dated 7/23/23 showed, " Unwitnessed Event: 7/23/23 at 6:25 AM. Sitting in recliner in lounge area, stood up and fell on right side of body. Chair alarm sounded, Resident was already on floor- Right elbow skin tear, complains of right hip pain." The same Resident Accident/Incident report showed on the back of the form in different handwriting the nurse practitioner was called at 9:30 AM and contact with the nurse practitioner occurred at 10:45 AM (4 hours and 15 minutes after the incident occurred). This document also showed new orders to obtain an x-ray and maintain non-weight bearing status until xray results were received.

R2's nursing progress note dated 7/23/23 at 6:25 AM showed, "Agency nurse reports that resident fell this AM (morning) at 6:25 AM. As noted on the Incident Report sheet resident is complaining of right hip pain. No information charted by agency nurse. This nurse to make all phone calls and assess residents right leg."

R2's nursing progress note dated 7/23/23 at 9:30 AM showed, "Call placed to residents POA (Power of Attorney) to inform her that resident has had a fall this morning and is complaining of right hip pain. Will inform POA of any changes in her condition or plan of care.

R2's nursing progress note dated 7/23/23 at 9:50 AM showed, "Call placed to DON (Director of Nursing) to inform her of residents fall this morning. Message left on house voicemail but if

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there are any changes to residents condition, will call DON on phone. Waiting for reply from [nurse practitioner]. No answer so message left for return call due to fall and need for xray."

R2's nursing progress note dated 7/23/23 at 11:05 AM showed, "Return call from [Nurse Practitioner], order received for xray right hip two view STAT (as soon as possible) and for resident to be non weight bearing until results obtained. Call to [mobile xray], will be here in approximately 4 hours. Staff informed of non weight bearing status."

R2's nursing progress note dated 7/23/23 at 11:54 AM showed, "Resident states she is not hungry and wants to lay down. Transferred with two assist and hoyer lift. Frequent complaints of pain upon movement."

R2's nursing progress note dated 7/23/23 at 2:45 PM showed, "[Mobile xray company] here to take xray and results sent showing right hip fracture with dislocation. [Nurse Practitioner] called and order received to send resident to the hospital."

R2's nursing progress note dated 7/23/23 at 3:45 PM showed, "Resident transported to [acute care hospital] at 3:34 PM."

R2's July 2023 eMAR (electronic Medication Administration Record) showed R2 receives Tylenol 325 mg three times a day at 9:00 AM, 1:00 PM, and 8:00 PM. R2's eMAR showed R2's 9:00 AM dose of Tylenol was not administered until 11:02 AM (2 hours past the scheduled time and 4 hours and thirty minutes past R2's fall with complaints of pain).

R2's acute care hospital History and Physical

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dated 7/23/23 at 10:47 PM showed, "Her daughter is at bedside says that she is at baseline. She apparently attempted to get out of bed alone and fell at her nursing facility. This is not uncommon for her. Evaluation in the emergency department showed a right femoral subcapital neck fracture, right superior and inferior pubic rami fractures, suspicion for nondisplaced fracture of the right sacral ala, intermediate material in the ventral lower pelvis and prepubic region concerning for possible hemorrhage. Hemodynamically stable. Musculoskeletal: General: Deformity (Right Lower Extremity externally rotated) present. No swelling. Normal range of motion. CT Pelvis: Right femoral subcapital neck fracture. 2. Right superior and inferior pubic rami fractures. 3. Suspicious for nondisplaced fracture right sacral ala. 4. Intermediate material in the ventral lower pelvis and prepubic region obscuring margins of anterior urinary bladder and in part appearing to be within the space of Retzius. Although this may be hemorrhage related to the pubic ramus fracture, the volume is somewhat unexpected, the possibility of bladder injury cannot be excluded. 5. Recommend CTA of the pelvis and 5 minute delayed imaging of the entire pelvis to evaluate urinary bladder integrity."

R2's nursing progress note dated 7/24/23 at 9:56 AM showed, "The resident is scheduled for surgery for her right hip repair."

On 8/23/23 at 3:00 PM, V24 RN (Registered Nurse) said on 7/23/23 at about 6:30 AM, R2 had a fall in the common area near the nursing station. V24 said she believes the CNAs (Certified Nursing Assistants) had R2 up, dressed, and in the common area because she is a fall risk. V24 said she heard R2 fall and when

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she got to R2 she was laying on the floor. V24 said she told the CNAs she needed to do an assessment. V24 said she looked over R2 and saw a skin tear but did not notice anything wrong with R2's legs. V24 said it did not seem to her that anything was injured and she felt R2's hip area and it felt normal to her. V24 said they used 3 CNAs to get R2 up off the floor and into the chair. V24 said, "Honestly, I don't recall if she said she had pain. I filled out an incident report. I reported to the nurse that came on. I asked that nurse what else I was supposed to do and she said she would take care of it. I know she was a charge nurse. I don't remember her name. I didn't make any calls because the other nurse said she was going to take care of it. I gave report and I left. The resident seemed fine, she was sitting in the chair and that was it."

On 8/23/23 at 3:50 PM, V16 LPN (Licensed Practical Nurse) said R2's fall had happened right before she got there. V16 said the agency nurse said she had fallen and did not think she was hurt. V16 said the agency nurse (V24) started the incident report but did not make any of the notification calls. V16 said that morning R2 was in the wheelchair at breakfast and told V16 her leg was hurting. V16 said she talked to R2's POA (Power of Attorney) and she asked that R2 not be sent out for the xray but to the do the xray in house. V16 said when the xray technician was done doing the xray he looked at the xray screen and said 'I'm not a professional but I can see that's not aligned.' V16 said she knew something was not right. V16 said R2 was laid down in her bed for the xray and she stayed in bed the rest of V16's shift. V16 said she thinks she gave her some Tylenol because that is all she had orders for to treat pain. The surveyor asked V16 if R2 was given something in addition to her already

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scheduled dose of Tylenol for pain and V16 responded that she did not necessarily give R2 any of the medications herself but that she was the charge nurse that day so she asked the floor nurse to give R2 something for pain. V16 said she did not do pain assessments after breakfast and she did not assess R2 after breakfast because she was afraid to move her any more than necessary. V16 said R2 was verbalizing pain, saying "oh oh ow ow" with any movement. V16 said she made the first notification call to the Nurse Practitioner at about 9:30 AM. V16 said typically when the nurse does the incident report she would fill out both sides of the sheet and ensure the notifications were made but V24 only completed the first side. V16 said when she arrived for her shift R2 was in her wheelchair so she thought V24 had checked everything out. V16 said V24 told her that R2 had said her leg hurt but it was not until she went in and checked R2 out better when she realized she had not done her incident report, charting, or notifications. V16 said R2 reported pain to her and after breakfast is when she did an assessment.

On 8/24/23 at 9:28 AM, V20 CNA said she was the one who had transferred R2 into the recliner in the common area that morning. V20 said we heard [R2] fall. V20 said the nurse was at the desk and jumped up. V20 said the nurse said to get R2 up off the floor and into her wheelchair. V20 said she and two other CNAs got her up off the floor and set her into her wheelchair. V20 said R2 was not really complaining of a lot of pain at that time but that around breakfast time she was making noises and saying "oh ouch" and said she had pain in her thigh and hip. V20 said she told the nurse R2's thigh was hurting and she thinks she gave R2 her medicine around that time. V20 said they got R2 into bed for her xray using 2

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assist with a gait belt. V20 said R2 did not say anything during that transfer. V20 said R2 was laid down and she was fine.

On 8/24/23 at 10:00 AM, V21 CNA said she had been working night shift the day of R2's fall. V21 said R2 was in the common area sitting in the recliner with the feet up from about 5:00 AM so staff could keep a closer eye on her. V21 said about 6:15 AM or 6:30 AM she was at the whole other end of the hallway finishing her rounds when she saw R2 standing at the recliner holding the alarm box in her hands. V21 said R2 was taking stumbling steps forward and backward and was very unsteady. V21 said she yelled to R2 and ran toward her but could not get there in time. V21 said when she got to R2 she was moaning and groaning in pain. V21 said R2 landed right on the floor, she was in pain. V21 said R2 said one of the legs was hurting, her side, and her hip was hurting. V21 said there was an agency nurse working that day whom she does not remember her name. V21 said the nurse took R2's vitals and then had 3 CNAs lift R2 off the floor and back into the chair. V21 said she was present when the nurse was looking at R2 and R2 was in pain. V21 said she knew R2 was in pain because she was still groaning but it did not appear to be excruciating pain.

On 8/24/23 at 9:48 AM, V22 CNA said R2 is a fall risk, has alarms, a low bed, and she sits in the common area because she likes to stand up and try and transfer herself. V22 said it did not seem right away when she came in (6:30 AM) like R2 was in a lot of pain. V22 said then R2 started saying she was hurting. V22 said they laid R2 down before the xray company arrived and R2 said she was hurting and in pain.

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On 8/22/23 at 2:51 PM, V5 (Restorative Nurse) said she is part of the team that investigates falls. V5 said the nurse should be informed immediately of a resident fall and complete a head to toe assessment. The nurse will notify the physician of the assessment and obtain orders for care of the resident. V5 said she was unsure of the specifics of R2's fall. V5 said R2 had a short, tiny stature and required standby assistance and the use of a walker for ambulation. V5 reviewed R2's Resident Accident/Incident Report and said the form was completed by the nurse. V5 said the form showed the fall occurred in a common area at 6:25 AM. V5 said R2's small stature combined with the fall and complaints of hip pain would be concerning. V5 stated, "I would do a head-to-toe assessment immediately if she was complaining of hip pain after a fall. I would suspect a broken hip and would want the resident to receive the proper care by an orthopedic surgeon. The phone calls to R2's family and physician should have been done right away." V5 said R2's complaints of pain with movement would be concerning and were a sign of a possible hip fracture. V5 said she was not sure why the nurse delayed sending R2 to the emergency room for evaluation and treatment. V5 said Tylenol would not have provided sufficient pain control for a hip fracture.

On 8/24/23 at 3:00 PM, V27 NP (Nurse Practitioner) said she would expect to be notified as soon as possible after a fall. V27 said the nursing assessment would be used to determine what the orders would be. V27 said she would expect the resident to receive their scheduled medications on time for pain and if they were still reporting pain the nurses should be contacting them to get something else for pain.

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S9999	Continued From page 9 On 8/24/23 at 1:40 PM, V26 RN (Registered Nurse) said she worked 2:30 PM to 11:00 PM on 7/23/23. V26 said she is the one that sent R2 to the hospital. V26 said she sent R2 to the hospital after she notified the nurse practitioner of the xray results from the xray done earlier that day. V26 said she received in report from the previous nurse that R2 had fallen and was reporting pain. V26 said when a resident falls and reports pain they should contact the physician and family right away. On 8/24/23 at 4:02 PM, V3 DON (Director of Nursing) said she had received a call around 9:00 AM or 9:30 AM on 7/23/23 telling her R2 had experienced a fall and was having pain. V3 said she told V16 LPN to contact the daughter and the doctor. V3 said she expects nursing to do a complete assessment after a fall which should include a body assessment looking for skin tears, bleeding, lacerations, and bone deformity. V3 said the nurse should be looking for shortening or turning of the leg and hip. V3 said this should be a head to toe assessment checking for fractures or even dislocations. They should assess for pain or guarding. V3 said she does not know what the case was with R2 because of her confusion. V3 said she just knows when they were providing care they noticed R2 was in pain but she wasn't sure if she was in pain right after the fall. V3 said there should be documentation regarding the fall entered in the resident record in the progress notes. V3 said she believes there was confusion between the night nurse and the day shift nurse regarding who was completing the notification phone calls. V3 said if a resident reports pain they should be offered pain medications and if they continue to report pain the nurse should reach out to the provider regarding additional pain control. V3 said the nurse should sign off when pain	S9999		

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medication is received in the resident's MAR. V3 said the nurses should contact the provider if the resident's pain is not controlled. V3 said she remembers a conversation she had with V16 LPN so maybe she gave pain medication but did not sign it out. V3 said she expects the physician or nurse practitioner to be notified of falls right away or as soon as possible.

The facility's Pain Assessment Policy with revision date of 3/11/11 showed, "Purpose: To assess for the presence and level of pain, to distinguish between acute and chronic pain, assess for chronic, undetected or under-treated pain, and provide pain management to enhance the residents quality of life. Should the pain be of an acute nature, the physician shall be contacted concerning signs and symptoms displayed by the resident. Ongoing monitoring of pain management will occur so that lack of pain control can be communicated to the physician. Pain management will be assessed on admission, quarterly, with a significant change in the residents physical or mental condition or any time pain control is not controlling the resident's pain."

The facility's Fall Protocol with revision date of 3/13/14 showed, "Purpose: To coordinate appropriate facility response to a resident fall. Protocol: 1. No staff member shall assist a resident to rise from the discovered position until first assessed by a nurse. 2. Nursing assessment shall include: vital signs, visual observations looking for possible displacement or fractures, evaluation of resident's pain and any other physical or environmental concerns that may be present."

The facility's Policy/Procedure Emergency Care

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for Falls with Resulting Fractures with revision date of 10/21/03 showed, "A. Leave resident in the discovered position until a nurse assesses the resident. B. Assess resident for injuries: 1. Gently feel along extremity for possible displacement, edema, pain and tenderness. 2. Check for external/internal rotation or radiating pain is suspected hip fracture."

The facility's Notification of Changes Policy with revision date of 11/9/16 showed, "Policy: It is the policy of this facility that changes in a resident's condition or treatment are immediately shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate (hereafter designated as the physician) All pertinent information will be made available to the provider by the facility staff. Nurses and other care staff are educated to identify changes in a resident's status and define changes that require notification of the resident and/or their representative, and the resident's physician, to ensure best outcomes of care for the resident... The objective of the notification policy is to ensure that the facility staff makes appropriate notification to the physician and Non-Physician Practitioner and immediate notification to the resident and/or the resident representative when there is a change in the resident's condition, or an accident that may require physician intervention. The intend of the policy is to provide appropriate and timely information about changes relevant to the resident's condition... to the parties who will make decisions about care, treatment. 1. Requirements for notification of resident, the resident representative and their physician: 1) An accident involving the resident, which results in injury and has the potential for requiring physician intervention... Procedure: 1. The nurse will

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S9999	Continued From page 12 immediately notify the resident, resident's physician and the resident representative(s) for the following: a. An accident involving the resident, which results in injury and has the potential for requiring physician intervention: 3. Document the notification and record any new orders in the resident's medical record." (B) 2/2 300.610a) 300.1210b) 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 resident to meet the total nursing and personal care needs of the resident.	S9999		

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	IL6003024	A. BUILDING: ______ B. WING ______	C 08/29/2023

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Section 300.1210 General Requirements for Nursing and Personal Care
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 regulations were not met as evidenced by:

Based on interview and record review the facility failed to safely ambulate a resident with a history of falls. This failure resulted in R1 falling and sustaining a hip fracture and hematoma to the head. R1's hip fracture required surgical intervention and hospitalization. This applies to 1 of 3 residents (R1) reviewed for falls in the sample of 3.

The findings include:

The facility's Incident Report dated 7/31/23 showed R1 fell in the lounge area and sustained a right hip fracture and hematoma to the right side of her head. This document showed she was a standby assist with a wheeled walker. The staff assisted R1 to the bathroom. R1 lost her balance and she fell on her right side. R1 said she felt dizzy before falling. R1 complained of right leg pain after the fall and her blood pressure was high (166/104). The resident was sent to the emergency room for further evaluation. R1 was admitted to the hospital for a right femur fracture.

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R1's Face Sheet dated 8/22/23 showed diagnoses to include, but not limited to: Alzheimer's; left femur fracture (following a fall); pain; low blood pressure; generalized weakness; Parkinson's Disease; ; nutritional deficiency; rheumatoid arthritis; and anxiety.

R1's facility assessment dated 7/24/23 showed R1 had severe cognitive impairment; did not reject care; and required limited assistance of staff for toilet use.

R1's Fall Risk completed 4/27/23 showed R1 was "High Risk," related to intermittent confusion, poor recall, judgement, and safety awareness. This document showed R1 suffered from neuromuscular/functional conditions that can increase her risk for falls.

R1's Fall Care Plan reviewed 7/723 showed, "I am at risk for falls due to poor safety awareness, Parkinson's Disease and I have a history of falls. I am a stand pivot transfer with one staff assist. I use a walker for my mobility on the unit and a (wheelchair) for any distance. I have a yellow safety/fall star on my walker and above the door of my room for staff awareness of my fall/safety risk. I am working with therapy and Restorative Nursing for ambulation with my walker and one SBA (Standby Assist). I take medications that could affect my fall risk."

R1's ADL Function Status Care Plan reviewed 7/13/23 showed R1 was admitted to the facility following a fall in supportive care that resulted in a left hip fracture. R1 had balance deficits and needed staff to help stabilizer her and required standby assistance for locomotion on the unit.

R1's Progress Note dated 7/27/23 at 9:37 PM,

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showed R1 transferred with SBA-GB (Standby Assistance with a Gait Belt).

R1's Progress Note dated 7/31/23 at 1:25 AM, showed R1 was ambulating to the toilet with a walker and SBA x 2 (standby assistance of 2 staff). R1 lost her balance and fell over landing on her right side. R1 reported feeling dizzy prior to falling. R1 reported hitting her head and right hip. She had complaints of pain in these areas. R1 was transferred to the emergency room for evaluation.

R1's Progress Note dated 7/31/23 at 5:42 AM, showed R1 was admitted to the hospital with a closed, displaced right hip fracture.

R1's Resident Accident/Incident Report dated 7/31/23 showed R1 fell in the dining room at 12:40 AM. V7 (CNA) was ambulating R1 to the bathroom. R1 fell, landing on her right side. R1 sustained a hematoma to the right side of her head and was complaining of head and hip/leg pain. This document showed R1's BP was 166/104 (high). This document showed the "Cause/Probable cause of this event: Not using a gait belt."

R1's Hospital Records faxed 8/4/23 showed R1 had X-rays of her right hip/pelvis due to trauma, pain, injury, and a fall. The results showed R1 had an acute minimally displaced right femur (hip) fracture. R1's Admitting Note dated 7/31/23, showed R1 was reportedly walking with 2 staff members in the bathroom when she tripped over her feet, falling and hitting her head. She was complaining of pain mostly in right hip. R1's initial assessments were consistent with right hip fracture. The plan was to admit the resident for an orthopedic surgery evaluation. R1's Hospitalist

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Note dated 7/31/21 showed R1 had an acute closed hip fracture following a ground level, mechanical fall. This note showed R1 was lying in bed and appeared uncomfortable with complaints of increasing pain in her hip. R1's Internal Medicine Note dated 8/3/23 showed R1 was admitted with an acute closed right hip fracture and underwent hip replacement surgery on 7/31/23. This note showed R1's postoperative course was complicated by delirium, inability to participate in therapy, decreased oral intake and R1 was not showing significant improvement. This was discussed with R1's daughter and the decision was made to start hospice care. R1 was to be discharged with hospice care.

On 8/22/23 at 2:30 PM, V7 (Certified Nursing Assistant - CNA) said she was working the night R1 fell (7/31/23). R1 had been sleeping in a recliner in the lounge (common area). R1 kept trying to get up out of the recliner, which usually means she needs to go to the bathroom. V8 (CNA) assisted me with putting on R1's shoes. We started walking with R1 toward the bathroom, but V8 walked away to help another resident. R1 was walking with her walker and then she fell. V7 said R1 fell forward and to the right side. V7 stated, "It happened so fast. She did not have a gait belt on, so I couldn't catch her." R1 was complaining of hip pain. R1 said the CNAs are supposed to use gait belt when they walk with residents. The gait belt helps keep the resident steady and if they lose their balance, we can try to stabilize them.

On 8/22/23 at 2:51 PM, V5 (Restorative Nurse) said R1 had Parkinson's. R1 had a slow, shuffling, unsteady gait. V5 said R1 was supposed to have Standby Assistance with a Gait Belt (SBA w/ GB) for any ambulation. V5 stated, "I

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didn't see the cameras for her fall, but I think there was separation from R1 and the young male CNA (V8). The CNAs are provided a gait belt during orientation. They are told that it is part of their uniform and they should always have it. If they are ambulating a resident, then they should have the gait belt and hands on the resident at all times. The gait belt allows the CNA to keep the resident steady and prevents the resident from going horizontal (or falling).

On 8/23/23 at 3:35 PM, V11 (Agency RN) said she was the nurse the night R1 fell. V11 said she saw V7 (CNA) walking R1 to the toilet, but she did not see R1 fall. V11 said she can not recall if R1 had a gait belt on. V11 stated, "The CNAs are supposed to use gait belts with all transfers and ambulation. A gait belt would have allowed the CNAs to steady her and possibly prevent the fall." V11 said R1 was lying on the floor on her right side. V11 said R1 hit her head and right side. R1 was complaining of head and hip pain. V11 stated, "I only work there once a month, so I had one of the CNAs get [V12 - LPN] to help me. She has been the facility like 30 years, so I ask her when I need help. She came down and helped me complete the paperwork, make the phone calls, and she stayed with us until R1 went with the ambulance. She did some education with the CNAs (V7, V8) before she went back to her floor."

On 8/23/23 at 3:53 PM, V8 (CNA) stated, "I worked the night [R1] fell, but I wasn't ambulating her. She said she needed to go to the bathroom and I helped put on her shoes. That's all. [V7 (CNA)] is the one who walked R1. I didn't see R1 fall. I heard a noise and looked over and R1 was on the floor. She was lying flat on her face. She said she was in pain. After the nurse checked R1, I helped sit her up, but that's it. I don't remember

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R1 having a gait belt on her."

On 8/24/23 at 9:07 AM, V17 (Nurse Practitioner) said she does not see R1 regularly, but she was on call for the facility on 7/31/23. V17 said she reviewed her call logs. V17 said she received a call that R1 had fallen, had a head injury and was complaining of hip pain. V17 said an order was given to send R1 to the hospital for evaluation. V17 said a resident with Parkinson's will likely have a shuffling, unsteady gait. R1 should have been evaluated to see if she needed a gait belt for safety. V17 stated, "I would expect the facility to follow the recommendations to use a gait belt during ambulation." V17 said gait belts allow the staff to help stabilize residents and keep their hands on the resident. When a gait belt is used properly, it is possible it could prevent a fall or decrease the severity of the injuries. V17 said R1's fall was the likely cause of her injuries, including a right head hematoma and right hip fracture.

The facility's Self Ambulation/Gait Belt Policy dated 1/2008 showed, "During a transfer, assisting ambulation, or other care procedures, unless contraindicated for a medical condition, a gait belt is to be used for the safety of each resident. Procedure: 1. Gait belt is part of the standard uniform of the staff giving direct care... Each staff member should always have his or her gait belt on their person for easy access at all times. 3. During transfer or ambulation, etc. The gait belt is used to assist the resident without using their clothing, or arms to give assistance in balance or movement. It is the responsibility of all direct care giving staff to abide by this policy at all times."

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