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	IL6004725	A. BUILDING: _____ B. WING _____	C 10/20/2023

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S 000	Initial Comments Facility Reported Incident of September 10, 2023/IL164334 Facility Reported Incident of September 14, 2023/IL164981	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 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 a) Comprehensive Resident Care Plan. A	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 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. (Section 3-202.2a of the Act) 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. 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	S9999		

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nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These Requirements were not met evidenced by:

Based on interview and record review, the facility failed to prevent a fall by not implementing appropriate fall interventions for a dependent confused resident (R4) with a language barrier and history of falling. The facility also failed to follow fall prevention intervention to prevent a fall incident, to ensure that the appropriate side rails were used, and to ensure that the use of side rails was evaluated first before utilizing to a resident (R5) who was confused and at high risk for falls. These failures affected 2 (R4, R5) out of 3 residents reviewed for accidents and incidents. R4 had an unwitnessed fall incident. R4 was observed by facility staff on the floor by R4's bed and sustained a fracture of left hip transverse proximal femoral basicervical fracture with medial impaction. R5 had an unwitnessed fall incident. R5 was observed by facility staff lying flat beside R5's bed and sustained a subdural hematoma.

Findings Include:

1.) R4's clinical records show R4 was admitted in the facility on 9/12/23 with listed diagnoses not limited to Spinal Stenosis, Congestive Heart Failure, Radiculopathy, and Congestive Heart Failure.

R4's fall incident note dated 9/13/23 at 1:15 AM written by V30 (Registered Nurse) reads in part: R4 was observed in the bathroom sitting down with no visible injury noted.

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R4's fall incident note dated 9/14/23 at 9:15 AM written by V5 (Registered Nurse) reads in part: R4 was observed on the floor on R4's left side of R4's bed. R4 was alert and oriented x 1-2, no new pain, and no visible injuries noted. R4 was unable to provide description of what happened.

R4's progress notes written by V24 (Nurse Practitioner) dated 9/14/23 at 11:00 AM reads in part: [R4] seen at the bedside, lying in bed. Reported pain to left thigh, which started today. Per nurse, [R4] had an unwitnessed fall this morning. [R4] was found lying on [R4's] left side next to bed. This note also indicates that R4 speaks Serbian.

R4's hospital records dated 9/14/23 shows an X-ray was done on R4's left femur/hip with result that reads "left hip transverse proximal femoral basicervical fracture with medical impaction".

R4's Minimum Data Set (MDS) dated 9/14/23 shows R4 needed a Serbian interpreter to communicate with a doctor or health care staff. It also shows R4's cognitive status was not assessed and R4 required extensive one person assist for bed mobility, transfer, and toileting.

R4's Fall Risk Evaluation dated 9/12/23 and 9/13/23 show R4 was at low risk for falls. R4's fall care plan initiated on 9/13/23 shows R4 was at high risk for falls related to status post fall, history of fall, worsening back pain, functional decline, and decreased balance and activity tolerance.

On 10/17/23 at 11:33 AM, V5 (Registered Nurse) stated that on 9/14/23 at around 9:00 AM, V5 was passing medications and heard R4's bed alarm was going off. V5 stated V5 went inside R4's

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room and found R4 on the floor lying on R4's left side by R4's bed. V5 stated that R4's head was by the foot of R4's bed. V5 stated that R4's call light was not on and R4 did not speak English. V5 stated that V5 could not understand what R4 was saying and the only person that talks to R4 with the same language was V33 (R4's Son). V5 stated that R4 could not tell V5 what happened. V5 stated that that was the first time V5 had taken care of R4. V5 stated that R4 was high risk for falls and had fallen the day before. V5 stated that R4 was confused and did not know how to use the call light. V5 stated that V24 (Nurse Practitioner) saw R4 after the fall on 9/14/23 and ordered for R4 to be sent out to the hospital for complaint of left thigh pain.

On 10/18/23 at 12:45 PM, an interview conducted with V17 (Certified Nursing Assistant). V17 stated that on 9/14/23 at around 8:30 AM, V17 went to R4's room with the breakfast tray. V17 stated V17 woke up R4 but refused to be changed and refused breakfast. V17 stated, "[R4] was shooing me. I could not understand [R4]. [R4] did not speak English. [R4] was very confused. [R4] didn't go back to sleep. [R4] just stayed in bed and was very confused. [R4] did not push the button. [R4] didn't know how to use the call light. [R4] was very confused. [R4] won't let me do anything for [R4]. Like I said [R4] was shooing me so I left, and I went to the next patient. [R4] did not want to eat. I left the food set on [R4's] table covered up." V17 further stated that V17 was not aware that [R4] was high risk for falls. V17 stated, "[R4] came the day before on our floor, but [R4] was not my patient. Then the next morning [R4] was assigned to me. Nobody told me if [R4] had fallen before. I am not sure if [R4] was high risk for falls. Nobody told me if [R4's] at risk. I don't think the nurse knew either. I'm not sure if [R4]

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had the star on [R4's] door. [R4] was new to the floor. If I knew [R4] was a high fall risk, I would make sure to check on [R4] often, but when I saw [R4] before [R4] fell, [R4] had her call light and all [R4's] personal belongings close to [R4]. [R4] had the bed alarm. The nurse heard the bed alarm and the nurse found [R4] on the floor." V17 stated R4 didn't know how to use the call light due to R4 was very confused.

At 2:33 PM, an interview conducted with V2 (Director of Nursing). V2 stated that the staff should know if their residents are high risk for falls. V2 stated that it's in the resident's care plan if they are high risk for fall and the residents have a star by their name on the door. V2 stated that the Nurses and Certified Nursing Assistants (CNAs) should be doing frequent rounding and should always anticipate the resident's needs especially for confused residents that the staff have to make sure that their needs are anticipated. V2 stated that the staff should ask if they need to go to the toilet, check if incontinent, and ask what they need. V2 stated that if a resident has a language barrier that there should be a communication board at bedside or use staff that can interpret.

On 10/19/23 at 10:56 AM, a second interview conducted with V5 (Registered Nurse). V5 stated that R4 did not speak English at all and V5 thinks R4 spoke Serbian. V5 stated that V33 (R4's son) would usually translate for R4. V5 stated that there was no staff that works in the facility that could speak Serbian. V5 stated that R4 was able understand basic hand gestures. V5 stated that there was no communication board in R4's room.

At 12:23 PM, an interview conducted with V24 (Nurse Practitioner). V24 stated, "That was my

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first time meeting [R4]. The nurse [V5] reported to me that [R4] had unwitnessed fall. The nurse told me [R4] was found lying on [R4] left side by [R4's] bed. As far I could see [R4] had no injuries when I assessed [R4] but at that time [R4] was holding on to [R4's] left thigh and [R4] was having facial grimacing. [R4] spoke Serbian. I tried as best as I could to communicate with [R4]. I could tell [R4] was in a lot pain. [R4] was trying to tell me that it hurts a lot. I instructed the nurse to give [R4] some Tylenol and to send [R4] right away to the ED (Emergency Department)."

2.) R5's clinical records show R5 was admitted in the facility on 9/9/23 with listed diagnoses not limited to Dementia without behavioral disturbance, Essential Hypertension, History of Falling, Cerebral Infarction, and Congestive Heart Failure.

R5's fall incident note dated 9/10/23 written by V7 (Licensed Practical Nurse) reads in part: [R5] was observed laying flat by bed by CNA (Certified Nursing Assistant). [R5] was responsive to name and touch, able to verbalize needs to staff. When asked, [R5] has stated that [R5] has a fall.

The facility's incident report for R5 that was sent to the State Agency (SA) on 9/15/23 shows that on 9/10/23 at 4:00 AM, staff observed R5 lying flat beside R5's bed and when asked, R5 has stated that R5 fell. R5 was assessed with an opened skin on back of head and V23 (R5's Physician) was notified. R5 was sent to the acute hospital.

R5's hospital records dated 9/10/23 shows R5 was presented to the Emergency Room (ER) after experiencing an unwitnessed fall and was found to have subdural hematoma.

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R5's Minimum Data Set (MDS) dated 9/10/23 shows R5 had moderately impaired cognition and required extensive one staff assistance with bed mobility, transfer, and toileting.

R5's fall care plan initiated on 9/9/23 shows R5 is at risk for falls related to current medication use, poor safety awareness, unsteady gait, and disease process. One fall intervention reads in part: "Side rails to prevent rolling out of bed".

R5's electronic health record (EHR) does not show a side rail assessment was completed before R5's fall on 9/10/23. No side rail assessment found in R5's clinical records that would indicate the four side rails used were suited to R5's needs and condition. The only side rail assessment was completed and signed on 9/22/23 with an effective date of 9/12/23 and it shows R5 needed two half side rails. R5's progress notes dated 9/9/23 to 9/10/23 show no documentation of R5's side rail evaluation.

On 10/17/23 at 12:50 PM, an interview conducted with V2 (Director Nursing). V2 stated that R5 was admitted on 9/9/23 and R5's Fall Risk Assessment score was 5 meaning low risk. V2 stated that 0-7 is low risk for falls. V2 stated that R5 came to the facility with history of fall with occasional confusion. V2 stated that R5 was a new resident and on 9/10/23, V18 (Certified Nursing Assistant) found R5 on the floor early in the morning. V2 stated that V7 (Licensed Practical Nurse) did an assessment and R5 had open skin on the back of R5's head. V2 stated R5 was sent to the hospital and the Computed Tomography (CT) scan result showed R5 sustained subdural hematoma.

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On 10/18/23 at 9:43 AM, a phone interview conducted with V7 (Licensed Practical Nurse). V7 stated that a CNA (V7 does not remember the name) found R5 on the floor around early in the morning on 9/10/23. V7 stated that the CNA called V7 that R5 was found lying on the floor. V7 does not remember if R5's call light was on. V7 stated that V7 assessed R5 right away and saw a "crack" on the side of R5's head. V7 stated that R5 had confusion. V7 stated that R5 could not recall how R5 fell. V7 stated that R5 already had multiple falls before coming to the facility and was unstable. V7 stated R5 would always try to move around but R5 was not supposed to. V7 stated V7 last saw R5 at around 2:00 AM and R5 was sleeping. V7 stated V7 does not remember if R5 knew how to use the call light.

At 10:21 AM, a phone interview conducted with V18 (Certified Nursing Assistant). V18 stated that V18 worked night shift on 9/9/23 and found R5 on the floor close to 4:00 AM the next morning. V18 stated that when V18 found R5 on the floor, R5 said that R5 wanted to get up. V18 stated that V18 thinks R5 was trying to get up on his own. V18 stated that all four side rails were up when R5 was in bed and before R5 fell. V18 stated R5 did not have a bed alarm. V18 stated R5 did not yell for help. V18 stated, "[R5] was a little bit restless that night. I talked to [R5] and told [R5] to relax. [R5] was confused. I think that was [R5's] first night in the facility. I think [R5] was trying to get up. Maybe that's why [R5] fell. [R5] was at risk for falling that's why [R5] was on a low bed and had all four side rails up."

At 11:41 AM, V2 (Director Nursing) stated that before R5 fell, R5's fall interventions were to keep call light within reach, skilled therapy, restorative, and side rails up to prevent [R5] from rolling out

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of bed. V2 stated that it should only be two half side rails up not four. V2 stated, "We do have bed with four side rails, but they should only be using two half side rails for [R5]. If all four side rails are up it's considered full. We don't use full side rails to the residents. They should only use two half side rails when [R5] is in bed to prevent [R5] from rolling out of bed and for bed mobility. Side rail assessment should be completed on admission and before using the side rails to determine the correct side rails and if it's appropriate to use for the resident." V2 stated that the side rail assessment should be in R5's electronic health records (EHR). V2 stated that the staff should not use all four side rails up to the residents. V2 stated that if a resident has some confusion and some restlessness and all four side rails are up, the resident could fall hard. V2 stated, "They could potentially climb off the side rails and fall." V2 stated that R5 fell before coming in the facility. V2 stated that R5 had history of multiple falls and was considered high risk for falls upon admission. V2 stated that R5 had occasional confusion.

At 2:03 PM, an interview conducted with V21 (Clinical Care Coordinator). V21 stated that the use of side rails should be completed upon admission of the resident to the facility. Surveyor reviewed R5's EHR with V21 and confirmed that R5's use of side rails was not evaluated on 9/9/23 to 9/10/23.

On 10/19/23 at 11:15 AM, a phone Interview conducted with V23 (R5's Physician). V23 stated that R5 was quite sick and had previous falls before coming to the facility. V23 stated that R5 was at risk for falling and was in the facility for short term rehabilitation post fall to work on muscular deconditioning. V23 stated that R5 was confused, alert and oriented x 0-1. V23 stated

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that using two side rails up for R5 when in bed was appropriate for fall prevention not four side rails. V23 stated V23 cannot comment on if R5's subdural hematoma resulted from the fall. V23 stated it's a possibility.

On 10/20/23 at 9:29 AM, the facility provided R5's baseline care plan that shows fall risk as one focus with siderails as part of the intervention. However, it does not detail that the use of side rails were evaluated for appropriateness and if it was determined if R5 had a medical symptom that must be treated with the use of the four side rails. R5's EHR also does not show a consent was obtained for R5's side rails. R5's physcian order sheet (POS) does not show side rails were ordered for R5 on 9/9/23 to 9/10/23. R5's POS shows half side rails up when in bed for position and support ordered on 9/12/23.

The facility's policy titled; "Fall Occurrence" dated 7/17/23 reads in part:
Policy Statement
It is the policy of the facility to ensure that residents are assessed for risk for falls, that interventions are put in place, and interventions are reevaluated and revised as necessary.
Procedure
1. A Fall Risk Assessment form will be completed by the nurse or the Falls Coordinator upon admission, readmission, quarterly, significant change, and annually.
2. Those identified as high risk for falls will be provided fall interventions.

The facility's policy titled; "Side Rail" dated 7/28/23 reads in part:
Policy Statement
It is the facility's policy to comply with the federal requirements on the use of side rails.

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S9999	Continued From page 11 Procedures 1. Prior to the use of side rails, alternative devices like pillows, wedges, foams, and other repositioning devices will be utilized first for residents in need of repositioning. 3.If the alternative devices failed to assist the resident in repositioning, the resident will be assessed for the use of side rails, to determine risk for entrapment and other potential danger to the resident. 4.If side rails are appropriate for the resident, a verbal or written consent will be obtained by the facility prior to the use of side rails. The facility's policy titled; "Hazards" dated 7/28/23 reads in part: Policy Statement It is the facility's policy to ensure the safety of each resident in the building and remove hazardous items and correct situations to prevent accidents. A	S9999		