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	IL6009096	A. BUILDING: _____ B. WING _____	C 11/02/2023

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S 000	Initial Comments Complaint Survey: 2398649/IL165594	S 000		
S9999	Final Observations Staement 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 plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 were not met as evidenced by: Based on observations, interviews and records reviewed the facility failed to follow fall prevention interventions to include supervision/monitoring and use of assistive/safety devices to prevent the risk of falling. This affected three of three residents (R1-R3) reviewed for falls and fall prevention interventions. This failure resulted in R1 being involved in a fall incident sustaining a fracture of the L4 and L5, Lumbar Spine, and R3 being involved in a fall incident resulting in an Oblique Fracture of the Left Fifth Metatarsal and of the Neck of the Right Radius. Findings include: A.R3's diagnosis include but are not limited to Spinal Stenosis, Anemia, Dementia, Osteoarthritis, Difficulty in Walking, Age Relate Physical Debility, Altered Mental Status, Lumbago	S9999		

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S9999	Continued From page 2 with Sciatica, Right Side, and Radiculopathy - Lumbar Region. R3's Cognitive assessment dated 9/21/23 indicates mildly impaired. On 10/29/23 at 2:49PM The surveyor observed a star on the door, near R3's name, door closed. V3, Restorative Aid, in the room with the roommate. V3 sitting a chair near roommate. R2 opened the door and greeted the surveyor. R2 walking in the room then to sink to finish washing. R2 hanging washcloth on towel rack and then stumbled while turning, but regained balance, loud squeaking sound from shoe, before sitting on his bed. R2 said yes, I fell I was up alone in my room. R2 said I did not call for help. R2 said I was ashamed and did not call for help. R2 said I don't call for help when I need to use the bathroom or get something. No alarms sounding with the resident in the room. On 10/29/23 at 3:15PM V3, Restorative Aid, said I was in R3's room working with R3's roommate. V3 said I work with R3 for range of motion. V3 said R3 can walk with a standby. V3 said R3 was using the washroom I was in the room. V3 said I did not see him stumble. V3 said I would not have gotten to R3 from where I was if he was falling. V3 said R3 does not have alarms on and he should. V3 said I did not tun R3's alarms off when I went in the room. On 10/30/23 at 9:52AM V9, Fall Nurse, said R3 is a fall risk. R3's diagnosis include Spinal Stenosis, Arthritis, Debility, Lack of Coordination, and Altered Mental Status. V9 said R3 had one fall on 10/17/23. V9 said R3 should be supervision for ambulation. V9 said this means R3 should have a person in the room while ambulating. V9 said R3 is not stand by assist for ambulation. V9 said Staff should be standing when supervising	S9999		

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S9999	Continued From page 3 residents. V9 said staff don't need to sit so they can move faster for staff. V9 said R3 complained about the alarms being too loud so I stopped them. V9 said R3 is alert and can call for assist with the call light. V9 said she was unsuccessful in reaching the night shift agency staff to interview about R3's fall. V9 said it is unknown if the alarm was answered or if the alarm was in place and on at the time of R3's fall. V9 said R3 sustained a fracture on right foot. On 10/30/23 at 11:30AM V11, Therapy Director, said R3 is currently supposed to be walking with a walker and supervision, including yesterday. V11 said prior to R3's fall on 10/17/23 R3 required supervision for ambulation. V11 said supervision means staff should be in eyesight during ambulation. R3's Fall Risk Evaluation dated 10/17/23 score is 13, high risk. R3's care plan dated 9/15/23 identifies R3 at risk for falls related to Spinal Stenosis with Radiculopathy, Right Hip, Osteoarthritis, Altered Mental Status, Dementia, Depression, and Debility. Interventions dated 9/15/23 include bed alarm and chair alarm. R3's care plan for Activity of Daily Living and Fall Risk do not address R3's ambulation ability/status. R3's Functional Status dated 9/21/23 indicates he needs staff assistance during transfers and was not ambulating at the time. Incident Report dated 10/17/23 documents R3 notified staff he fell during the night and did not report or call for help. Resident statement, in part,	S9999		

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S9999	Continued From page 4 reads I was trying to use the rest room and fell. The facility Incident Report dated 10/18/23 documents after hospital evaluation R3 findings include Oblique Fracture of the Fifth Metatarsal and of the Neck of the Right Radius - initial encounter. R3's hospital record dated 10/17/23 states oblique fracture through the fifth metatarsal shaft. Closed non-displaced fracture of fifth metatarsal bone of left foot and closed non-displaced fracture of neck of right radius. B. R1's diagnosis include but are not limited to Fracture of Left Femur, Anemia, and Hypertension. On 10/29/23 at 1:27PM V2, Licensed Practical Nurse, said R1 fell because he had a Urinary Tract Infection and may have had a behavior change. V2 said R1 could not walk. V2 said I was called to the room and saw R1 on the floor. V2 said I don't know what CNA was assigned to him. V2 said I was not assigned to R1. On 10/29/23 at 2:08PM V12, Nurse Supervisor said on 9/11/23 when I went to R1's room I saw him on the floor. V12 said R1 either pulled the light or the alarm sounding. V12 said R1 did not know he was on the floor. V12 said when I asked R12 about the fall, he said "oh, I'm on the floor." V12 said I am not sure of R1's his mental status at the time. V12 said R1 was on isolation at the time and his room door was closed. V12 said R1 was on his back. He was right next to the bed. V12 said R1 was not a fall risk. V12 said I did not see him fall and I do not know what he was trying to do.	S9999		

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S9999	Continued From page 5 On 10/30/23 at 9:52AM V9, Fall Nurse, said V5,Nurse, and V13, CNA, were interviewed and said R1 tried to transfer without assistance. V13 said she did not see the fall, V13 said to V9 I was providing care to another resident. V9 said V5, Nurse, said V12, Nurse Supervisor, called me and said R1 was on the floor. V9 said she was told V12 was rounding and saw the call light on and when he entered the room R1 was on the floor. V9 said R1 is always in bed, he had not tried to get up. V9 said R1 was on antibiotic and could have been confused causing him to fall. V9 said R1's baseline was incontinent of urine. V9 said I don't know what R1 was trying to do when he fell. V9 said R1 required a mechanical lift for transfer, and he was not strong enough to stand. V9 said R1's door was closed for isolation. V9 said there was no other cnas involved in R1's care, V13 was the assigned CNA. V9 had no additional interviews for R1's fall. While reviewing R1's incident report/investigation with V9, she was unable to say when R1 was last turned, repositioned, or received incontinent care. V9 was unable to say who assisted in repositioning R1 during the shift. On 10/29/23 at 11:32AM V8, R1's wife, said R1 had fractures of the L4 and L5 in his back he did not have those before the fall. R1's care plan dated 2/18/2023 states R1 is at risk for falls related to left femur fracture status post surgery, anemia, abnormal gait and mobility. Interventions for R1 include bed alarm in place chair alarm in place, requires two staff participation to reposition and turn in bed. Incident report for R1 dated 9/11/2023 reads R1 verbalized pain to the right leg and facial grimacing was noted level of pain is 6 out of 10.	S9999		

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S9999	Continued From page 6 Review of R1's medication administration record and physician orders for September 2023 do not include treatment of urinary tract infection. Physical therapy discharge summary dated 8/13/2023 documents R1 to require partial/moderate assistance with sitting to standing. Transfers from chair to bed require partial/moderate assistance. Substantial/Maximal assistance for toilet use and patient was unable to ambulate. The facility's incident report to IDPH on 9/11/23 reveals R1 was transferred to the hospital on 9/11/23. R1 was admitted to the hospital with lower back trauma. A CT of the spine revealed L4 and L5 compression deformities that are new compared to 9/25/2022 and represent acute fractures. C.R2's diagnosis include but are not limited to Fall, Compression Fracture of Vertebra, Anemia, Difficulty in Walking, Weakness, and Osteoporosis. On 10/29/23 at 10:33 AM R2 called for the nurse in the dining room and asked V2, LPN, to check his blood sugar. V2 said in 2 minutes I will be there. The surveyor remained monitoring R2 until 10:45AM and V2 did not return him. On 10/29/23 at 1:27PM V2, LPN, said R2 is very alert but we must help him. V2 said R2 requires 2 person assistance to get from wheelchair to the bed we use the mechanical lift. On 10/29/23 at 3:32PM V4, Registered Nurse, said R2 used the call light around 6:45AM. V4 said R2 said he wanted to get up and sit in the	S9999		

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S9999	Continued From page 7 wheelchair. I asked him to wait for the CNA. V4 said R2 called again, he said I want to get up, I just need some help, he did not want to wait. V4 said on the third time R2 called I helped him to get up. V4 said I helped him lower his feet from the bed, I held his arms, he was helping, but then his feet were shaking, he got weak. V4 said I was about to fall. V4 said the safest thing to do was to put him on the floor. V4 said this was my first time working with the resident. The surveyor asked V4 how she knows the transfer status of the residents she is assigned to. V4 was unable to answer. V4 said R2 is 1 assist. V4 said R2 said he is going to help me, and he said he can help. On 10/30/23 at 9:52AM V9, Fall Nurse, said R2 is high risk for falls because he has fractures in the spine, lack of coordination weakness, and history of falls. V9 said R2 is a 2 person assist with a mechanical lift for transfers. V9 said to use the commode R2 is a 2 person assist. V9 said R2 has required 2 person since his admission. V9 said the cause of the fall on 10/12/23 was related to R2 asking to transfer out of bed. V9 said the Staff Care Binder is used to notify staff of resident transfer status. V9 said the V4 can look at the binder to know what care to provide. V9 said R2 is cooperative with the mechanical lift. Incident report dated 10/12/23 reads R2 requested to get out of bed and into his wheelchair. This writer, V4, told him to wait for his CNA. Report reads I still want to sit in my wheelchair. At 7:00AM writer attempted to transfer R2 from bed to wheelchair. R2's legs began to shake and R2 became unsteady. R2 assisted to the floor. Review of R2's Incident Reports identify falls on 9/16/23; 9/29/23; and 10/12/23.	S9999		

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S9999	Continued From page 8 R2's care plan dated 9/18/23 states R2 require 2 staff participation with mechanical lift transfers to prevent fall. On 10/30/23 at 9:52 AM V9, Fall Nurse, said a resident's diagnosis can increase the risk for falls such as Hypertension, Diabetes, Parkinson's, Impaired Memory, Dementia, Alzheimer's, Weakness, Debility, Seizure, and Syncope. V9 said the Root Cause Analysis is what led to the fall. V9 said the plan is developed from the cause. On 10/30/23 at 2:32PM V15, MDS Coordinator, said the purpose of the care plan is so the nurses can find the intervention for the plan of care of the resident. V15 said I expect the nurses to follow the careplan. V15 said when an intervention is no longer needed we do review and update the care plan. V15 said we can add and remove interventions or resolve them. The facility fall prevention program guidelines dated December 5th 2022 states fall prevention program guidelines shall be implemented to promote safety of all residents in the facility. safety interventions shall be initiated and implemented for each resident identified at risk for fall. All assigned nursing personnel and facility staff shall be responsible for ensuring ongoing precautions are put into place and consistently maintained. All file incidents shall be monitored, analyzed, root causes identified. The facility Fall Occurrence policy dated 7/17/23 reads 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. If a resident has fallen, the resident is automatically considered as high risk for falls. The falls	S9999		

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S9999	Continued From page 9 coordinator will add the intervention in the residence care plan. The interventions will be reevaluated and revised as necessary. (B)	S9999		